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First impressions : a Study of the Relationship Between Presenting Problems and Clinical Perception

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FIRST IMPRESSIONS:

A STUDY OF THE RELATIONSHIP BETWEEN PRESENTING PROBLEMS AND CLINICAL PERCEPTION

by

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ABSTRACT

An abstract of the dissertation of Holly Elizabeth Fussell for the Doctor of Philosophy in Systems Science: Psychology presented May 5, 2006.

Title: First Impressions: A Study of the Relationship between Presenting Problems and Clinical Perception

Processes involved in clinical perception typically result in tangible outcomes of interest to clients and practitioners (e.g., diagnoses). In developing an overall impression of clients, practitioners integrate information related to target problems clients present. Substance abuse counselors, in particular, are increasingly being asked to assess clients for co-occurring problems. Domestic violence has been identified as a particularly salient co-occurring problem associated with substance abuse.

This dissertation draws on theory by Solomon Asch (1946, 1952) to examine how presenting problems such as domestic violence shape clinical outcomes and processes in substance abuse assessment interviews. Most clinical interactions occur, however, under confidential conditions. Designed as an added component to a study funded by the National Institute on Drug Abuse, the dilemma of confidentiality was circumvented by using a standardized patient. Standardized patients (SPs) are actors trained to simulate a set of symptoms across multiple clinical encounters, allowing researchers to investigate therapeutic interactions.

Eighteen participating substance abuse counselors conducted one mock assessment interview each with a SP who alternated her presenting problem between a) a problem with violence in a domestic setting and b) a problem with methamphetamine use. Post interview questionnaires and transcribed videotaped interactions were analyzed using frequency counts, t-tests, content analysis, blind ratings of questionnaires on particular dimensions and narrative analysis.

Results include a serendipitous finding that counselors substantially referenced the SP's maternal role and associated status throughout analyses. However, divergent patterns in impression formation processes and outcomes occurred for the two groups, providing evidence that a dynamic interaction occurred between the SP's maternal status and her presenting problem in perception formation processes for counselors.

Findings support Asch's (1946, 1952) assertions on dynamic processes involved in interpersonal perception, drawing attention to implications of socially salient roles, including associated expectations, in clinical contexts. Social psychological theory as well as practice related to substance abuse counseling and domestic violence intervention benefit from identifying how socially defined information presented initially shape clinical encounters. The dissertation suggests lines of inquiry for future research on impression formation from multiple methodological perspectives using standardized patients, a combination supportive of bridging the gap between research and practice.

Acknowledgments

This dissertation is a culmination of an academic journey rich with inspirations, contributions, and support. My heartfelt gratitude goes to my dissertation committee chair, my advisor, my mentor, and my inspiration -- Dr. Janice Haaken. I once sat in an undergraduate class watching a woman educate students on subject matter that was clearly a product of deep understanding and critical engagement. A professor, an author, an activist and advocate; I had found an example of womanhood I would aspire to emulate. For that and the myriad of ways she supported my growth as a student and a person I wish to express my deepest thanks.

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I wish to express my admiration for my mother, Roxanne Richards. Her fortitude through academic and, more importantly, life processes serves as a source of ongoing reassurance that, although there are no guarantees as to what lies

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PART I

Introduction

First impressions carry substantial currency in developing overall perceptual frameworks of individuals (Asch, 1946, 1952). This phenomenon occurs in all contexts where interpersonal interactions take place. However, some interpersonal interactions have more readily apparent consequences for impression formation than others. Clinical interactions between counselor and client present one context where impressions of clients result in tangible outcomes of interest to both parties (e.g., diagnoses). Most clinical interactions occur, however, under confidential conditions, minimizing opportunities for exploring interpersonal social psychological processes. An innovative clinical technology – standardized patients -- offers full access into diagnostic and therapeutic interactions. Standardized patients (SP's) act out a set of symptoms across multiple clinical settings (Colliver & Swartz, 1997; Swartz & Colliver, 1996). They are "fake" patients. Holding constant the client role opens up a range of possibilities for examining how social psychological phenomena operate across clinician/client interactions. This dissertation specifically examines how first impressions shape clinical diagnoses and interpersonal approaches in the context of addictions treatment counseling.

Solomon Asch (1946, 1952) pioneered the study of how individuals use first impressions as guides for developing *overall* impressions of other people. His seminal research on impression formation substantially impacted subsequent lines of inquiry on the topic (McCauley & Rozin, 2003). Operating within a gestalt

approach to psychological phenomena, Asch drew attention to the human tendency for organizing limited aspects of experience into comprehensive easily labeled units. Specifically, Asch recognized the universal human tendency to create "whole" perceptual frameworks of other people from limited pieces of information. Resonant with work generated throughout Asch's career, this line of inquiry emerged out of and impacts "real life" human interaction. However, Asch investigated the real life experience of forming impressions during a time when the field of psychology was invested in asserting itself as a "real" science, compatible with the hard sciences. As such, experiments served as the primary design employed to address the complexity of perception formation, a process occurring in interpersonal interaction. Asch's career reflects an interest in unraveling mysteries associated with processes such as impression formation in order to affect progressive social change (McCauley & Rozin, 2003). Consequences of interpersonal processes motivated Asch toward exploring impression formation. The controlled environment in experimental design provided a location for discovering constructs informing perception processes. However, experiments may also decontextualize constructs, particularly when research addressing a given psychological phenomenon relies substantially on the controlled design (e.g., Haaken, 1988). In such instances, conceptualizations of complex psychological processes risk becoming distanced from relevance to real life, including consequences (e.g., Haaken, 1988).

The impact of impression formation and its consequences become critically salient in the human interaction between counselor and client. In clinical contexts diagnosis and subsequent treatment plans directly result from a counselor's "read" of their client. In the addictions treatment field assessment/intake interviews offer a specific location to examine the potential impact of first impressions. During assessment interviews drug and alcohol counselors typically have no more than one and a half hours to obtain enough information about a client to appropriately diagnose the person and develop a treatment plan.

In addition, the substance abuse counseling field grapples with a unique dilemma. The overarching outcome of interest for any client is consistent: sobriety. Yet, unlike a medical setting where the treatment for a torn ligament is the same regardless of the patient, in the addictions field each client requires tailored approaches to achieving sobriety and/or additional outcomes of interest (e.g., regaining custody of children). Overall impressions formed during the assessment interview guide those tailored approaches. Clients' presenting problems (i.e., first impressions) may shape counselors' approach to clinical interaction including salient judgment based outcomes.

Not all first impressions carry the same significance (Asch, 1946). First impressions that matter must be salient for the perceiver (Asch, 1946). Historically, certain problems gain momentum in society. For example, in the 1980's stories of sexual abuse became particularly salient in the mental health field. Haaken (1998) describes how ambiguous symptoms such as body twitches presented in a clinical

context were attributed to repressed memories of sexual abuse, and how repressed memories of sexual abuse became the clinically understood mechanism explaining Multiple Personality Disorder (MPD). Finally, with MPD dominating the diagnostic arena, sexual abuse gave way to satanic ritual abuse as the root cause of severe psychological diagnoses. In this example, sexual abuse acquired so much societal "weight" that popular discourse of its origins moved from possible repressed memories to satanic ritual abuse.

This dissertation reflects a shared interest with Dr. Haaken, as her student, in female narratives of distress that acquire broader social symbolic loading. Similar to the individual tendency to organize limited pieces of information about a person into an entire representation of their character, societal processes (e.g., dominant ideologies, the media) often condense women's experiences of distress into stereotypical accounts. These accounts, in turn, become sources through which social psychological processes become available, allowing for examination of how interpersonal perceptions are shaped.

Currently, domestic violence mobilizes support across a vast social and political spectrum. As one indication of the strength of the movement against domestic violence, the United States Department of Justice established the Violence Against Women Office, distributing over one billion dollars to local governments and organizations since 1995 (Family Violence Prevention Fund, 2001). These funds have supported the development and implementation of community-based resources and programs for women who have experienced

domestic violence (e.g., Sullivan, 2003). While these domestic violence services are still arguably chronically under-funded they have not suffered the rollbacks of other programs for women.

These governmental interventions indicate the strength domestic violence carries as one form of female distress. As with stories of sexual abuse, a societal script has emerged for what it means to be a victim of domestic violence and those assisting with the problem also function within that script. Specifically, a common, feminist informed guide for clinical training on domestic violence asserts that violent victimization is a function of a male partner's exertion of power and control (Pence & Paymar, 1993). This dominant explanation of the dynamics of DV allows little to no room in clinical contexts for exploring the role of female aggression or complex experiences of ties to painful relationships. According to Haaken (1998) there is good reason for feminist resistance to acknowledging female conflict or stories of ambivalence in relation to the oppressive men in their lives. Historically, women who suffered from the ailments born of domestic confinement were cast as "hysterics," irrational and lacking self-control. The movement against domestic violence took place during second wave feminism and included a reaction against clinical practices that emphasized female irrationality. This included drawing attention away from "why women stay" in violent relationships and toward why men batter (e.g., Walker, 1979). In further reaction to a clinical history of "blaming the victim," clinicians became overly cautious in exploring female experiences of living with domestic violence.

This inhibition toward exploring female experiences of violent interpersonal relationships may also operate in clinical assessment of women with substance abuse problems. Alternatively, substance abuse counseling sessions may provide a context that allows for more exploration of how and why violence operates in women's lives.

Research demonstrates associations between substance abuse and domestic violence, and the subsequent need for addressing them simultaneously (e.g., Becker, Noether, Larson, Gatz, Brown, Heckman, & Giard, 2005; Elliot, Bjelajac, Fallot, Markoff, & Reed, 2005; Gatz, Brounstein, & Taylor, 2005; Gatz, Russell, Grady, Kram-Fernandez, Clark, & Marshall, 2005; Huntington, Moses, & Veysey, 2005; Salasin, 2005; Weiner, Sussman, Sun, & Dent, 2005). Particularly in the context of drug trends, such as methamphetamine, a substance highly associated with violent behavior (Cohen, Dickow, Horner, Zweben, Balabis, Vandersloot, & Reiber, 2003; Maxwell, 2005; NIDA, 2004; Zweben, Cohen, Christian, Galloway, Pharm, Salinardi, Parent, & Iguchi, 2004), the traditional conceptual framework for understanding domestic violence and substance dependence points to a need for further exploring the terrain.

The drug and alcohol counseling context provides an ideal setting to explore how the co-occurring problem of domestic violence gets incorporated into overall impression formation and subsequent treatment recommendations. Specifically, by alternating between domestic violence and methamphetamine abuse as the presenting problem offered to addictions treatment clinicians, this dissertation

addresses the question, "How do first impressions shape clinical interactions?"

This question poses methodological difficulties. As noted earlier, clinical interactions between drug and alcohol counselors and their clients are confidential, as are treatment recommendations. How is it possible, then, to map *across* clinical interactions how first impressions shape clinical interactions? This dissertation draws on the technology of standardized patients to address the guiding research question.

Standardized patients (SPs) portray health care consumers with specific conditions. As an indication of the popularity of this technology, passing a test that includes SPs became mandatory for all medical school graduates for the 2005 academic year (Efrati, "New Requirements," 2004).The Educational Commission for Foreign Medical Graduates (ECFMG) uses SPs to test applicants' clinical skills for access to U.S. residency training (Ziv, Ben-David, & Gary, 1998). When unannounced SPs are sent to doctors' offices, physicians are usually unable to distinguish SPs from their "real" patients (Colliver and Swartz, 1997), pointing to SPs' validity.

Prior to 2004 standardized patients were not used in the addictions treatment field. However, as SP technology advanced it became clear that SP's offer a teaching and evaluation tool that may prove just as useful in the addictions counseling field as in other clinical contexts. Through developing larger, more complex character portrayals reflective of real substance abuse clients, SPs offer the chance to compare interpersonal dynamics across counselor/client interactions.

This dissertation makes use of data generated as an added component of a feasibility study entitled "Standardized Patients as Drug Abuse Treatment Clients," carried out by Dr. Bentson H. McFarland, MD PhD (Primary Investigator), Dr. Colleen Lewy, PhD (Research Assistant Professor), and Holly Fussell, M.S. (Research Assistant), and funded by the National Institute on Drug Abuse. That study consisted of creating four SP protocols, recruiting and training the SPs, recruiting addictions treatment clinicians, conducting assessment interviews with SPs and clinicians, monitoring and assessing the SPs performance, and assessing key dimensions of counselors' performance.

With the assistance of Dr. Lewy and Dr. McFarland the author of this dissertation designed one specific SP protocol in order to explore how the distinct presenting problems of domestic violence and methamphetamine addiction shape the clinical interactions between client and counselor. Debby Patterson—the name assigned to the woman in this protocol -- is a 24 year old unemployed, married woman. Debby's story includes an addiction to methamphetamines/crack cocaine and possibly alcohol as well as a history of domestic violence. As a result of her addiction/abuse history, her two young children were placed in the custody of Child and Family Services. Debby is Caucasian.

A key design element created specifically for this study includes Debby alternating her presenting problem with different counselors. This variation in the role was introduced in order to identify how first impressions may shape the clinical interactions including outcomes such as diagnoses and prognoses, overall

reception to Debby, and interpretations of her larger story. The two opening statements include, 1) "Me and my husband have been fighting a lot lately and this last time the police came and they took my kids." and 2) "I've been having some pretty bad problems with meth." The first option provides a first impression indicative of being in a violent relationship, a situation often associated with more sympathetic responses to female distress (e.g., Haaken, 2005, July). The second option – addiction to methamphetamine – carries with it harsher societal impressions (e.g., Rose, "Oregon's Meth Epidemic," 2005). The second option operates as a normative, albeit "colder" first impression in that counselors expect problems with substances given the context. This juxtaposition of first impressions offers a mechanism for addressing the research question "How do first impressions shape clinical interactions?"

The dissertation is comprised of three parts each with sequential chapters. Part I begins with an introduction outlining the conceptual framework for the dissertation followed by five literature review chapters. Chapter one provides a review of research on impression formation with an emphasis on Asch's (1946,1952) leading work on the topic. Chapter two reviews the addictions treatment field including the potential contribution of studying first impressions in that context. Chapter three incorporates literature emphasizing societal level salience of domestic violence, and offers two theoretical frameworks – role theory and systems perspectives – informing discussions of impression formation. Chapter four reviews literature on standardized patients including why the technology lends

itself well to answering social psychological questions within a clinical context. Chapter five summarizes the literature review and reiterates the guiding research question.

Part II of the dissertation begins with a structural orientation for the eight subsequent chapters in the section. Chapter one describes methods and design of assessment type interviews that operate as the data source for the dissertation. Chapter two discusses practical and epistemological premises related to analytic choices. Chapter three introduces an outline for results. Chapter four includes methods and results specific to phase one of analyses. Chapter five summarizes analytic findings from phase one. Chapters six, seven and eight describe methods and results to phases two, three and four of analyses.

Part III of the dissertation begins with chapter one – general discussion. Chapter two provides limitations of the study. Finally, chapter three explores implications for theory and future research.

Chapter One

Impression Formation

According to Solomon Asch (1946, 1952) key elements of interpersonal interactions inform how people perceive others. First impressions, in particular, play a crucial role in developing overall perceptions of others. So much so, that information about a person contradictory to that provided initially tends to be ignored. However, a paucity of research actually informs theories of how we develop overall impressions of others, particularly theories amenable to Asch's (1946) guiding research on perception formation constructs. This chapter examines research and theory on impression formation, focusing on Asch's (1946, 1952) seminal contributions to a Gestalt approach to the line of inquiry. The chapter concludes by demonstrating how contradictory findings on first impressions support the need for future research. Finally, descriptions of methodologies employed to investigate first impressions introduce promising potential for approaches taken in this dissertation.

Order Effects and Memory

Research on memory (e.g., Ebbinghaus, 1964) first recognized the tendency for increased memory of items presented initially (i.e., the primacy effect) and increased memory for items presented last (i.e., the recency effect). According to undergraduate text book summaries on the topic (e.g., Franzoi 2004; Nairne, 2004), in the 1950's these two functions related to memory led researchers to theorize that two distinct memory systems (i.e., short-term and long-term memory) may operate

to store information differently depending, in part, on the serial order of information presented. Recent neuroimaging studies of the brain do show different parts of the cerebral cortex firing when people are asked to recall items from different temporal locations (e.g., Ranganath, Johnson, & D'Esposito, 2003; Zhang, Snowden, & Sue, 1998). However, the brain also communicates information back and forth between memory systems. For example, information stored in long-term memory may function in short-term memory if certain cues operate to recall that information, thus retranslating the information as short-term memory. Finally, recent research also cautions against over-emphasizing distinctions between those components of the brain that function in relation to short-term versus long-term memory, as those areas most involved in long-term memory appear to operate in sustaining both capabilities (Ruchkin, Grafman, Cameron, & Berndt, 2003).

Memory research on possible implications of order effects allows for conceptualizing bio-physiological processes occurring "behind the scenes." Descriptions of those processes point to a transactional relationship between aspects of the brain, where information takes on more or less salience depending, in part, on the order in which information is processed. A glimpse of the physiology behind the psychology of first impressions leaves, therefore, the latter terrain open for investigation. In moving outside the realm of biology and into psychology, the question of how information gets recalled becomes more complex when considering the human tendency to develop entire perceptual frameworks of others.

Gestalt psychology offers one psychological theoretical orientation particularly oriented toward understanding perceptual processes.

Perception and Solomon Asch

Gestalt psychology asserts that people create "whole" perceptual frameworks out of limited "parts." A dilemma of this tendency includes the additional Gestalt and later systems (e.g., Hall, 1989; Linstone, 1999; & Senge, 1990) truism that "the whole is different that the sum of its parts." Using impression formation as an illustration of this paradox, consider being provided a long list of information describing another person. Gestalt psychology asserts that we utilize this list and organize the items into a coherent overall perceptual framework of the person. If the person's true "character" were the sum of the listed parts, it seems reasonable that we could add the items together creating an overall balanced impression. However, similar to the parts of a watch lying on a table not providing us with the sensory experience of "the watch," examining a list of words describing a person cannot provide us with a picture of "the person" in his or her entirety. Research demonstrates that humans do take lists of attributes describing another person and organize them into coherent wholes (e.g., Asch, 1946), including in medical diagnoses (e.g., Chiaramonte & Friend, in press; Curley, Young, Kingry, & Yates, 1988; Dreben, Fiske, & Hastie, 1979; Stewart, 1965) and clinical judgments (Chapman, Bergus, & Elstein, 1996; Chapman & Chapman, 1969; Dailey, 1952; Endicott, Spitzer, Fleiss, & Cohen, 1976; Fischhoff, 1975, 1977; Friedlander & Phillips, 1984; Friedlander & Stockman, 1983; Levin, 1984;

Pain & Sharpley, 1989). People do not, however, go about the process in an additive way. We place inordinate emphasis on certain pieces of information including that offered first (Asch, 1946; Mensh, 1947).

In a series of experiments, Asch (1946) discovered that some information becomes more salient than other information provided at the same point in time. In his experimental process, Asch initially provided participants with two lists of words describing someone. The first list read "intelligent – skillful – industrious – *warm* – determined – practical – cautious." The second list read "intelligent – skillful – industrious – *cold* – determined – practical - cautious" (p. 51). He found substantial differences in overall impressions participants reported for each group. The qualities warm and cold considerably altered participants' interpretations of all the other qualities in the lists. Warm and cold operate as *central characteristics* actually transforming interpretations of the other *peripheral characteristics*. Kelley (1950) later confirmed the central quality warm and cold occupy in impression formation by introducing a guest lecturer in a university class two ways: both descriptions were identical except the addition of the word warm or cold. Additionally, two lecturers appeared before the participants in order to control for the individual qualities of them respectively. Results demonstrated substantially varied overall reported impressions of the lecturer depending on which introduction he received.

After additional experiments substantiating studies discussed thus far, Asch (1946), hypothesized that changing the order of the information alone would alter

impressions. He thought it possible to take the same information and transform it from peripheral to central by altering the order in which it was presented. In this experiment he again presented participants with two sets of characteristics describing someone. Set one read "intelligent – industrious – impulsive – critical – stubborn – envious." Set two read "envious – stubborn – critical – impulsive – industrious – intelligent" (p. 56). Results demonstrated different overall impressions of the two groups even though all the terms are the same, simply presented in a different order. The terms first presented took on central qualities. According to Asch, "the accounts of the subjects suggest that the first terms set up in most subjects a *direction* which then exerts a continuous effect on the latter terms. When the subject hears the first term a broad, uncrystalized but directed impression is born" (p. 57).

However, in another experiment Asch (1946) presented participants with only one word: either warm or cold. Participants were asked to choose from a list of peripheral characteristics (e.g., emotional, cheerful, imaginative, intelligent). They were asked to create an overall perception of a person using only one central characteristic and attaching peripheral characteristics. Participants were presented with the same list of peripheral characteristics regardless of whether they were associating the term warm or cold. Recall that, to this point, Asch (1946) understood central characteristics as altering the interpretations of peripheral characteristics. In this later experiment results indicated a trend in the choice of peripheral characteristics participants chose depending on if they were associating

them with warm or cold. Their perception of this "person" differed not only due to the central characteristic warm or cold, but also due to *shaping* what warm or cold means through peripheral characteristics. Asch interpreted this finding to mean that "central characteristics, while imposing their direction upon the total impression, were themselves affected by the surrounding characteristics" (p. 62). To the extent central and peripheral characteristics reciprocally shape each other, Asch concluded that dynamic processes inform impression formation.

Beyond the order in which they are presented, why do the terms warm or cold resonate more than others for people when creating overall perceptions of others? Not all characteristics, whether central or peripheral, carry equal importance in their meaning; "The given characteristics do not all have the same weight for the subject" (Asch, 1946, p. 53). Kelly's (1950) research corroborating the importance of the key terms warm and cold also demonstrated that it is *expectations* associated with certain characteristics which alter overall perceptions. Those expectations become the topic of later discussion in this proposal.

Asch (1946) described the implications of his findings by stating, "a given trait in two different persons may not be the same trait, and, contrariwise, that two different traits may be functionally identical in two different persons" (p. 62). Why is this so important? Implications of this theoretical insight offer a way to understand, for instance, why the trait "emotional" might contribute to an entirely different impression of a scientist versus a child care provider. Or, alternatively, why the trait "cold" might contribute to an impression of a scientist as hard

working and productive while the trait "warm" might contribute to an impression of a child care provider as hard working and productive.

Recent research by Chiaramonte & Friend (in press) illustrates how certain characteristics do carry more weight than others, including how the dynamic interactions between characteristics generate varied overall perceptions. Drawing on Asch's (1946) theorizing, the study addressed gender bias in medical treatment of coronary heart disease, a context in which women are chronically under-diagnosed. Two competing hypotheses were examined. One asserts that men are diagnosed with heart disease more than women due to stereotypes associating men with heart disease and not women (e.g., Martin, Gordon & Lounsbury, 1998). The second, which follows Asch's theorizing on impression formation, asserts that stress (i.e., anxiety) has become centrally associated with women but not with men in medical contexts, particularly when examining patients for heart disease. Medically, anxiety is considered a problem with psychogenic origins. Therefore, when women present with stress and cardiac symptoms the cardiac symptoms will likely be attributed to psychogenic origins. The combination of the central quality attributed only to women – anxiety – with cardiac symptom will interact to produce physician perceptions that the cardiac problems have psychogenic origins. Chiaramonte & Friend (in press) further asserted that attributing cardiac symptoms to psychogenic origins would occur less when women present with cardiac symptoms alone, men present with both stress and cardiac symptoms, or when men present with cardiac symptoms alone. The dynamic interaction hypothesis was

supported thus corroborating Asch's (1946) theory that certain indicators (i.e., stress, a state associated primarily with women), dynamically interact initiating a directive force in interpreting women's cardiac symptoms.

Inconsistencies: From Research Results to Methodology

While the previous illustration substantiates Asch's (1946) conclusion that central and peripheral characteristics interact in creating *predictable* overall perceptions, contradictory findings also define available knowledge on the effect of central characteristics (i.e., first impressions). For instance, Chapman et al., (1996) found that information presented *last* guided their sample of family practice physicians in making clinical judgments. Alternatively, in a study of counseling psychologists, Pain & Sharpley (1989) found that, when presented first, bad (i.e., negative) information about a client affected interpretations of good (i.e., positive) information presented later. Other studies point to inconsistencies in findings on the primacy effect as well (e.g., Curley et al., 1988; Endicott et al., 1976). Experience levels of clinicians also contribute to postulations explaining differing outcomes of studies examining order effects (e.g., Friedlander & Phillips, 1984; Adelman, Tolcott, & Bresnick, 1993). A commonly cited belief adjustment model (Hogarth & Einhorn, 1992) asserts that both length and complexity of information as well as whether judgments are given at the end of a sequence versus step-by-step should result in more or less of a primacy effect. Specifically, assessments provided at the end of brief encounters include stronger primacy effects. As pointed out, however,

research points to discrepant findings in relation to the belief adjustment model as well.

Discrepant findings of studies examining the primacy effect may, in part, reflect the frequent use of experimental designs to study perceptions. The complex social experience of developing overall perceptual experiences of others (i.e., impression formation) may be less visible when studies make use of discreet sets of words or paragraphs describing a person as "independent variables." In instances such as perception formation, removing the construct from real life social context risks "omit(ing) a broad-based view of how everyday social experience influences the phenomenon under investigation" (Haaken, 1988, p. 312). People operate in a social world. Vignettes and lists of terms, while reflective of reality, typically are not part of interpersonal interactions. However, the complexity of interpersonal interactions including the idiosyncratic nature of them, have arguably necessitated simplifying impression formation in order to isolate constructs such as central characteristics. Asch (1946) recognized this tension between acknowledging the complexity of perception formation and studying related constructs through experimental designs wherein participants operate within a forced context and are given limited lists of terms from which they can make associations between central and peripheral characteristics. At the close of Asch's (1946) extensive report on his research he asserted that "It is a task for future investigation to determine whether processes of this order are at work in ... relations between one person and another" (p.67). This dissertation re-situates Asch's first impression construct in actual

interpersonal interaction in order to assess *how* perception processes appear to operate outside of vignettes or lists of terms. Specifically, this study carries Asch's challenge forward, focusing specifically on the role first impressions play in ongoing dialogue within a clinical context.

Chapter Two

Substance Abuse Counseling: A Platform for Studying Impression Formation

Studying "relations between one person and another" begins with identifying which two people to study. Understanding interactions between two people depends, however, on the broader social context. This dissertation focuses on one specific social context – substance abuse assessment (intake) sessions -- where consequences of impression formation can include life-altering events for the client (e.g., in patient placement for extended time periods or the prolonged loss of children removed by a state agency). Substance abuse counseling sessions, similar to other clinical interactions, also offer a clinically choreographed interpersonal exchange conducive to examining how first impressions may or may not be implicated in the perception formation process outside of an experimental design. For example, relatively consistent processes operate within assessment interviews. Most importantly to studying impression formation, good practice in facilitating clinical interactions includes beginning the session with an open-ended question such as "what brings you in today." According to Asch (1946), information salient to the counselor initially divulged by the client should operate as a first impression or central defining factor of the client. That first impression should establish a direction for interpretations of subsequent peripheral information which in turn reshapes how the salient first impression takes on meaning in defining one particular person (i.e., a dynamic process).

Substance Abuse Counseling: Dilemmas in the Field

Recent research suggests a decline in quality of care for drug abuse clients (McGlynn, 2003; McLellan, 2003, 2004). Understanding processes involved in forming perceptual frameworks of clients certainly should lend itself to improving quality of care in a field where a counselor's assessment of the larger picture for a client guides all outcomes of interest. Dumont and Lecomte (1987) substantiate dilemmas of impression formation in any therapeutic clinical context and point to the need for teaching tools that draw attention to erroneous social judgments. The authors state that, "The most dangerous consequence of (relying on information presented initially in clinical contexts) is that each of us in unguarded moments is in danger of making causal attributions that are more a function of when certain ideas first come to mind than of their connection with the effect in question" (p. 4). If research indicates that first impressions are associated with systematic differences in outcomes for clients, disseminating that information to the addictions treatment field could result in better education on the topic for providers. Similar to mental health practitioners noticing countertransference and, therefore, addressing its role in therapeutic interactions with clients, drug and alcohol counselors may benefit from awareness of the role first impressions play in interactions with clients. "Knee jerk" diagnoses based on strong first impressions limit the search for additional important information related to the client's overall profile.

Evidence suggests that primary care screening and brief intervention can be helpful for patients with substance abuse (Bertholet, Daeppen, Wietlisbach,

Fleming, & Burnand, 2005; Bien, Miller, & Tonigan, 1993). However, according to Kruglanski & Freund (1983), primacy effects are stronger in brief interpersonal encounters. Does this mean first impressions guide these brief interventions? Results of research on the primacy effect in relatively longer (up to one hour and 15 minute) assessment interviews may contribute to understanding and addressing this question. Glimmers of success in the substance abuse field, such as the finding that brief interventions are helpful for patients, carry with them the possibility of increased emphasis on applying brief interventions. In the context of evidence indicating that the primacy effect may be stronger in brief interactions, research also demonstrating first impressions influence longer clinical interactions would point to the need for examining primacy effects in these brief interventions as well.

Finally, and most important to this study, mental illness and/or other issues such as domestic violence often accompany chemical dependency (Substance Abuse and Mental Health Services Administration, 2002). In scenarios where clients present with multiple problems, accurate diagnosis becomes even more crucial and more difficult. Understanding impression formation in assessment interviews also becomes more complicated when considering co-occurring problems. A prototypical example in this study involves a woman addicted to a substance who is also a victim of domestic violence. Which components of her profile become central vs. peripheral for the clinician? Implications of this question include possibly highly divergent treatment plans, prognoses, receptions to the client and formulations of the client's experience.

Theoretically Orienting Co-Occurring Problems in Impression Formation

Drawing on Asch's (1946, 1952) theoretical framework, three aspects of the former clinical scenario would shape impression formation. First, the temporal order in which the client offers her story should matter. If, for example, in response to an open-ended question such as "what brings you in today," she replies "I'm addicted to a drug," the information establishes a different direction for impression formation than if she responds, "I'm a victim of domestic violence."

Second, the weight the counselor places on either of those options should influence impression formation. Similar to the terms "hot" and "cold" meaning more to participants in Asch's (1946) research than the term "industrious," "drug addict" and "victim of domestic violence" may or may not carry equal importance for counselors.

Substance abuse counselors operate with one overarching goal in mind – sobriety. One way of conceptualizing the differential weight counselors may place on differing opening statements includes an inordinate emphasis on drug use alone regardless of what other problem the client presents. Alternatively, the consistent presence of chemical dependency within this clinical context may actually serve as a "constant" or "given." Therefore, any salient information indicating a cause for chemical dependency may operate as a central characteristic, particularly if the information is provided first. Finally, given the substantial societal interest in both substance dependency and domestic violence, they both most likely qualify as "having weight" for an addictions counselor. Therefore, according to Asch (1946),

if a client offers one or the other as their interpretation of "what brings them in today" that first impression should establish a direction for subsequent dynamic processes in the interview.

Trends in substance abuse counseling offer support for the latter theoretical option. Increasingly, expectations for counselors include the ability to conceptualize substance abuse within a larger context. Counselors are being asked to form impressions of their clients outside the "addict" box in order to increase chances for sustained positive outcomes. To illustrate the extent of this expectation consider that State legislation in Oregon requires that 75% of substance abuse services incorporate "evidence based practice" by 2009. Multnomah County, which includes Portland, the most densely populated metro area in Oregon, found this change in practice so important that it voluntarily moved the deadline up to July of 2004. Evidence based practice includes three levels: 1) Substance abuse counseling methods must be supported by scientifically sound randomized controlled studies that have shown consistently positive outcomes. Further, those outcomes must be achieved in both controlled and routine care settings 2) Addictions counseling methods must be supported by scientifically sound experimental studies demonstrating consistently positive outcomes, and 3) Practice applied to populations that differ from those studied may modify evidence based practice yet must stay within general guidelines. (Nikkel, July 2004)

The ASAM PPC-2R (Mee-Lee, 2001) is an assessment and diagnostic tool considered good evidence based practice and required in Oregon as of 2002. When

utilizing the ASAM, counselors must be able to assess their clients on six dimensions including 1) acute intoxication and withdrawal potential, 2) biomedical conditions and complications, 3) emotional, behavioral, or cognitive complications, 4) readiness to change, 5) relapse potential, and 6) recovery environment. In order to achieve relatively accurate assessment on these six dimensions counselors must "weigh" the importance of co-occurring problems such as domestic violence.

As part of the ASAM PPC2R, current approaches to counseling include assessing the client's readiness to change (Prochaska, diClemente, & Norcross, 1992). This process includes determining how clients conceptualize their relationship to substance use. Therefore, although counselors often deal with clients with substance dependence, how they plan to help the client recover depends greatly on the impression the counselor forms of what *the client sees* as the cause of their substance use. The statement "I am addicted to a drug" vs "I am a victim of domestic violence" impart different first impressions for clinicians as to why *the client* thinks they would need to see a counselor and therefore, how ready the client is to change.

Considering Asch's (1946) theory of impression formation and applied practice trends in substance abuse counseling, initial information provided to clinicians that a client is a victim of domestic violence should result in outcomes oriented more toward dealing with the domestic violence than if that information were not initially provided. In addition, if domestic violence information is obtained *after* the first impression of the client's substance dependence is

established results should trend toward a lack of emphasis on the domestic violence compared to if it is offered as the first impression.

The scenario of a woman addicted to a substance who is also a victim of domestic violence seems appropriate for examining first impressions in substance abuse counseling assessment interviews. However, one substantial theoretical concern remains: being a victim of domestic violence is a social position rather than an individual characteristic. Research on impression formation described thus far included "trait" type descriptors of people (i.e., warm, cold, industrious). Asch's (1952) use of these types of characteristics makes sense in the context of his additional observation that people tend to ignore the role of the environment when forming overall perceptions of others. However, although Asch did not study impression formation with lists of life circumstances, he did emphasize that the role of the environment would be taken into consideration in cases where its relevance is obvious. This dissertation operates from the perspective that current societal interest in domestic violence (e.g., Haaken, Fussell & Mankowski, 2005) satisfies this criterion.

Chapter Three

Conceptualizing Perceptions

Thus far the literature review on impression formation has focused on the characteristics of the target person – the one being perceived. This chapter reviews literature on the perceiver in relation to the perceived and explains how violent victimization has become a salient topic for substance abuse counselors. The review also examines tension between the domestic violence (DV) field and substance abuse in establishing the social context for primacy effects. Two theoretical frameworks are introduced – role theory and dynamic systems – with an emphasis on systems perspectives. These theoretical frameworks offer options for conceptualizing interactions between a counselor and a client, including how those interactions may shape impressions. Finally, methodological concerns of a dynamic systems model lead into subsequent chapters on methodology employed in this study.

Domestic Violence & Substance Abuse

In recognizing the dynamic nature of impression formation, Asch (1946) drew attention to the role of the perceiver. Personal characteristics are not immutable objects. Characteristics of others and the perceiver interact dynamically to create particular overall impressions. Viewing phenomena through various "lenses" alters the target of interest. Similar to the lens of a camera or the human eye, many objects may appear in one's perceptual field. However, far fewer of those objects actually appear in full focus. *Which* item the camera or eye "zooms in

on" depends, in part, on what society emphasizes as particularly salient at a given period of time. Further, *how* the focus of attention appears depends on societal level interpretations of the particular phenomenon. Whether any given substance abuse counselor focuses on domestic violence versus the substance abuse alone depends on the salience of domestic violence for that counselor. This dissertation proceeds from the premise that DV is highly salient as a social problem. Further, that society provides divergent interpretations of DV and substance abuse, which inform perceptions of people dealing with either or both problems.

Domestic Violence: A Feminist Analysis

Ammerman & Hersen (2000), describe family violence as "one of the most critical problems facing society" (p. xiii). Previously relegated to the private domain, it wasn't until the women's movement of the 1970s that domestic violence emerged as a public concern (Haaken & Yragui, 2003; Dutton & Gondolf, 2000). According to Haaken, Fussell & Mankowski (2005), the growth in domestic violence programs in the United States stands as perhaps the most striking, unparalleled victory of second-wave feminism. This victory has resulted in over one billion dollars in funding for community-based assistance to women who have experienced domestic violence (e.g., Sullivan, 2003).

Most of the community-based resources and programs reflect conceptualizations of family violence developed by the feminist anti-domestic violence movement. Radical feminist politics, in particular, have been at the forefront of shaping domestic violence discourse in the United States (Haaken,

2002) and have been the guiding anima behind anti-domestic violence efforts (Donovan, 1996).

Feminism connotes a general critique of patriarchal practices and their effects on women. Multiple forms of feminism operate in society and emphasize differing aspects of social problems such as domestic violence. For example, liberal feminism views DV as primarily an individual problem operating in individual families. Therefore, families serve as the location for change. Raising individual boys to be more sensitive, for example, might be a focus for liberal feminist reform around domestic violence. Socialist feminists, alternatively, emphasize the differences in women's experiences of oppression under patriarchy, including a critique of capitalism and its role in isolating and alienating people in a way that cuts them off from bases of support. This version of feminism also pays particular attention to disparities in class and race. With patriarchy serving as the umbrella under which oppression takes multiple forms, DV is seen as having both structural origins and consisting of individual differences. Solutions are found not only in dismantling patriarchy but also in a critique of economic systems that "batter" people differently depending on their station in life.

However, radical feminists stress the argument that violence against women and children is universally and definitively rooted in male systems of domination (i.e., patriarchy), including that men benefit from these systems both economically and psychologically. As a group, it is in men's best interest to maintain a certain threat of violence against women in order to quell possibilities of resistance.

Because of the deeply engrained nature of the problem and the intentionality associated with it, socially endorsed punitive measures such as imprisonment operate as the primary albeit temporary solution for separating women from the source of their domination.

Little room exists within this line of feminist analysis, however for explanations of abuse other than willful intent. In fact, discourse on domestic violence supports one primary explanation for the problem – men's need for power and control (e.g., Pence & Paymar, 1993). From this perspective, drawing attention to how chemical dependence or socioeconomic status contributes to men's violence merely hinders progress toward addressing the "real" problem of male abuse of power.

Domestic Violence & Substance Abuse: Pragmatically Connected Theoretically Independent?

This narrow focus on power and control continues to guide the DV field. However, current trends suggest some broadening of focus (e.g., Haaken, 2003, August). Current research argues for the relevance of investigating DV in the context of substance abuse, in particular. To illustrate, the Journal of Community Psychology dedicated an entire July, 2005 issue to the co-occurrence of substance abuse and violent victimization (e.g., Becker et al., 2005; Elliot, et al., 2005; Gatz, et al., 2005; Gatz, et al., 2005; Huntington, et al., 2005; Salasin, 2005). Each of the articles points to the need for integrated counseling with a focus on uncovering how substance abuse and violent victimization co-occur. In a longitudinal study of

continuation high school students Weiner, Sussman, Sun, and Dent (2005) found that illegal drug use predicted violence and victimization five years out. Further, they found that previous victimization was related to subsequent illegal drug use. In a study of Latina perceptions on drug use and family violence, Bonifaz and Nakano (2004) indicate a need for programs that take into account drug use as a specific risk factor for domestic violence. Reports on researching this topic reach similar conclusions in South Africa (Affinnih, 2005) and Hawaii (Austin, 2004).

Research also points to the need for integrated theoretical models of substance abuse and violent victimization (e.g., Affinnih, 2005; Becker et al., 2005; Bonifaz & Nakano, 2004; Gatz et al., 2005; Weiner et al., 2005). Based on a paucity of frameworks integrating the role of substance abuse in domestic violence, recent explorations emerge on the topic examining biological explanations (e.g., Pihl & Hoaken, 2002), developmental psychopathology perspectives (e.g., Crittenden & Claussen, 2002), personality factors (e.g., Flett & Hewitt, 2002) and social learning components of the two problems (e.g., Wekerle & Wall, 2002).

Finally, the destructive nature of one drug, methamphetamine, introduces a specific example of how substance abuse and domestic violence operate in tandem. Research clearly demonstrates methamphetamine's association with increased violent and psychotic behavior (Cohen, et al., 2003; Maxwell, 2005; National Institute of Drug Abuse, 2004; Zweben, et al., 2004). This includes possible long term biological damage that increases the likelihood of violent behavior over a life time (Buffenstein, Heaster & Ko, 1999). Methamphetamine is a low-cost stimulant,

contributing to the overwhelming use of the substance in poverty stricken communities (Wermuth, 2000). Chemical dependency in general disproportionately affects poor and minority communities characterized by minimal access to health care (Schafer & Caetano, 2002). These combined findings suggest that a range of social problems co-exist with domestic violence.

Feminist anti-battering efforts drew international attention to a deeply embedded social problem. Theories incorporating a critique of patriarchal practices where men wield power and control over women and children offered much needed insight. Without a "hard line" approach to unmasking domestic violence, recent research examining substance abuse in relation to DV may not have emerged. That research paints a more detailed picture of DV, implicating chemical dependency including recent trends such as methamphetamine in violent behavior occurring in homes and elsewhere.

In summary, domestic violence occupies center stage in contemporary feminist resistance to male domination. DV advocates continue to emphasize the importance of men recognizing their abuse of power and control while researchers seek to understand how substances increase likelihood and severity of violence. "Has society imparted the salience of domestic violence?" The answer seems to be a resounding "yes." To that extent, theory suggests that drug and alcohol counselors presented with a first impression of a female victim of domestic violence should interpret subsequent information through that lens. Knowledge substance abuse counselors hold on the dynamics of DV most likely includes the

dominant discourse that abusive men perpetrate violence to maintain power and control over their partner. Extrapolated one step further, substance abuse counselors may interpret the woman's chemical dependency as a product of coercion or force by the male abuser or a means of coping through self-medicating.

On the other hand, what if the substance abuse counseling field operates with similar blind spots as the DV field? Just as women's advocates separate DV from substance dependence, do substance abuse counselor similarly considers drug abuse separate and distinct from domestic violence? The implications of addressing these questions include 1) speaking to the need for integrating applied and theoretical work in the respective fields, 2) informing Asch's (1946, 1952) theories on impression formation, and 3) contributing research on impression formation in a "real life" interpersonal interactive context where multiple levels of complexity operate.

Domestic Violence & Methamphetamine: "Warmer" & "Colder" Perceptions

Interpretations of DV and methamphetamine, in particular, draw attention to how key components of Asch's research on impression formation may be implicated in substance abuse counseling. One of Asch's (1946) substantial findings included how the terms "warm" and "cold" carry more weight for people than other terms. "Warm" and "cold" functioned as central characteristics regardless of the order in which they were presented. They provided a direction for interpreting subsequent information. Having established the societal salience of domestic violence and the destructive nature of methamphetamine use, it becomes

useful to consider these situations in relation to their "warmer" vs. "colder" affects on impression formation.

This dissertation operates from the perspective that violent victimization in a domestic setting elicits a more sympathetic (i.e., warmer) response than methamphetamine addiction. The media account of Hedda Nussbaum suggests the influence of DV in shaping interpretations of women's actions. Hedda Nussbaum and Joel Barnet Steinberg, her partner of several years illegally adopted a child, Elizabeth, whom they were subsequently accused of murdering after abusing. However, charges against Nussbaum were dropped. The following excerpt from transcripts of Larry King Live Show (Whitworth, 2003) intended to summarize the story for their audience provides an illustration of the scenario:

> "Lisa Steinberg, age 6, the illegally adopted daughter of Nussbaum and Joel Steinberg, died of abuse and neglect last year. The two were arrested together, but Steinberg faces the charge of second degree murder alone. Calling her a zombie battered beyond will, the prosecutors cleared Nussbaum and made her their star witness. She testified that Steinberg would beat Lisa and that she would do nothing about it."

Lisa Steinberg was left unconscious in the Nussbaum/Steinberg household for several days following Joel Steinberg striking her and throwing her to the floor. Hedda Nussbaum was consciously aware of the circumstances and did not call 911 until the day Lisa stopped breathing. While one interpretation to this series of

events includes complete *lack* of sympathy for Hedda Nussbaum, instead a more commonly adopted reaction to her story reflects a wave of sympathy for a woman "battered beyond will." Reactions to her story also demonstrate how even drug abuse and dependence can be interpreted entirely as a function of domestic violence. Statements appeared in newspaper articles such as "'Hedda is a victim,' (a man who knew her said). "'She is a woman who has undergone brutalization for many years, mental and physical. But she was totally in thrall to (Steinberg). And I'm sure he got her involved with drugs'" (Erlanger, "Bright Promise," 1987). This story represents an extreme illustration of how DV dynamics shape interpretations of women's actions in a way affording them substantial sympathy in society, a situation quite juxtaposed to social representations of methamphetamine users.

Methamphetamine use elicits a decidedly "colder" response than violent victimization. The following excerpt from a story on children of methamphetamine users appeared on the front page of the Oregonian, the dominant newspaper in the Porltand, Oregon metro area. It illustrates the kind of information available to general society informing perceptions of "meth" users:

> "When Sadie's parents were ramped-up on methamphetamine, they fought vicious fights, with fists, screams, guns and blood ... the 9-year-old girl recalled standing in the driveway, watching her dad, high and wild-eyed, hammer on her mother's head with the butt of a pistol .... one night, the gun was left out, her parents asleep. Sadie

described for the doctor how she pressed the barrel between her eyes and struggled to hook her finger around the trigger." (Rose, 2005)

The article continues, "'Meth orphans' are the children of the epidemic, abused and neglected, taken from moms and dads *who nurture only their addiction* [emphasis added]." This media report also includes graphic depictions of a refrigerator filled with nothing but rotten liquids, a baby doll wrapped in a tube used for cooking methamphetamine, and trash filled hallways where rats reportedly come to eat, forcing children into bedrooms. Also common are media representations of methamphetamine users as criminals against property (e.g., "Cash for meth," 2005). Even depictions of successful recovery from methamphetamine emphasize the horrific behavior of methamphetamine addicts. For example an article titled, "Mom loses two years, but wins back her kids" (2005) reads as follows:

> "Langford (a mother addicted to meth) lost her job. Kicked out of the home, she moved the girls into an apartment in Forest Grove. She married a meth user who had done time for murder. Langford let friends cook meth in the kitchen. Ticia (the child) peeked. Cans of chemicals. Pill boxes. Blow torches. Scales. Syringes. 'I'd (Ticia, the daughter) open the freezer to get a Fudgsicle and I'd see the stuff they boiled in a pan,' she said. Langford went grocery shopping once a month, the day the food stamps came. She bought Fudgsicles because they didn't need to be cooked. Then she would go into her

> room and close the door, leaving the girls on their own. Ticia became the mom, feeding and cleaning her sister, picking up garbage left by people who bought drugs from her mom's bedroom. Buyers showing up at night prompted Ticia to make a sign for the front door: "Nobody after 9. Me and my sister have school. Late one night, a man infected with hepatitis C used the toilet and it overflowed into the girls' rooms. Ticia said that "mom's husband" pulled them from bed and made them stand in a pan of bleach water as he cleaned up the mess."

These excerpts offer a glimpse of the media trend toward methamphetamine users as not only "cold," but distanced from the general public. Animalistic portraits of methamphetamine addicts go some distance in ensuring a central impact on a perceiver, shaping interpretations of subsequent information about a person beyond their drug use.

A woman subjected to violence in a domestic setting tends to elicit a sympathetic (i.e., warm) response. A woman addicted to methamphetamine tends to elicit an appalled (i.e., cold) response. Illustrations for each respective situation offered in this proposal include child abuse. However, both illustrations also demonstrate how, child abuse and even murdering a child take on divergent warm and cold interpretations depending on whether attention is drawn to the role of DV or methamphetamine addiction. What then, of a woman who is both a victim of domestic violence and a methamphetamine addict? This dissertation analyzes how

Solomon Asch's (1946) research on *first* impressions applies to such a complex and realistic scenario. If both circumstances do operate as central factors in impression formation does it make a difference which factor is presented first?

Roles, Expectations and Impression Formation

Assertions of violent victimization in a domestic setting versus methamphetamine dependence provide counselors with differing ways to initially orient themselves to a client's subsequent story. However, questions of process remain unaddressed. Role theories provide a conceptual framework for understanding how particular "actors" engaged in dialectic clinical interactions may be implicated in emergent plot lines and final perceptual conclusions. Biddle (1986) draws attention to the amenability between studying impression formation as process and role theory in stating,

> "... role...theory began life as a theatrical metaphor. If performances in the theater were differentiated and predictable because actors were constrained to perform 'parts' for which 'scripts' were written, then it seemed reasonable to believe that social behaviors in other contexts were also associated with parts and scripts understood by social actors" (p. 68).

Viewed through this lens, analogies may be drawn between impression formation processes and the unfolding of a person's story. Similar to a drama on a stage, the protagonist moves through a plot line, one that changes and typically involves other roles. Unlike a true "scripted" stage drama, however, interpersonal interactions

typically reflect dynamic processes, in which expectations of behaviors associated with particular roles alter the course of perceptual processes and outcomes. Asch (1946, 1952) addressed the content – the information – that may alter overall perceptions. Role theories address how expectations associated with relevant information may facilitate predictable processes and outcomes.

How to define expectations: Prior to further conceptually framing the present study through a role theory lens it becomes useful and necessary to address issues of language. When mapping any existing theoretical tradition onto new terrain turning attention to the words used to describe phenomena serves pragmatic ends and, more importantly, concerns deference to those who defined them. In the instance of role theories, Biddle (1986) describes vast disconnects existing across specific intellectual traditions. Definitions of "role" have included characteristic *behaviors*, *parts* to be played, and "*scripts* for social conduct" (p. 68). When addressing expectations, the frequently used terms include norms and stereotypes. Some consider norms expectations with moral implications (e.g., Gahagan, 1984) whereas stereotypes explain general expectations of behavior based on group membership. Again, according to Biddle (1986) definitions of "norm" have included expectations of other's behavior that are "prescriptive in nature," beliefs associated with other's behavior that "refer... to subjective probability" and preferences aimed toward other's behavior "or attitudes" (p. 69). However, within the context of an extensive analysis of differences in how role theory is applied in analyzing different social systems, Biddle (1986) settles on emphasizes that,

barring "terminological differences" (p. 68), role theories concern expectations, among other key constructs. Not inconsistent with the latter point, this dissertation makes use of expectations as a conceptual "net," one that contains stereotypes and norms with the intent of avoiding distraction toward value judgments associated with either. For this study, the emphasis in addressing how first impressions shape clinical interaction concerns assessing dialectic processes and products. While expectations associated with DV and methamphetamine dependence are central to understanding impression formation processes, their linguistic title is not a topic of investigation.

Whether norms or stereotypes or a combination of both, this dissertation operates from the perspective that expectations may carry enough weight for substance abuse counselors that they serve as central characteristics. Put another way, expectations associated with violent victimization or methamphetamine addiction may actually be central characteristics. If a client divulges certain information initially that, alone, is not a central characteristic (i.e., has been fighting with partner to the point of social consequence), yet that information elicits expectations (i.e., victim is powerless), that inferred state may be strong enough to guide interpretations of subsequent information. The inferred sates/characteristics elicited through expectations may also dynamically interact with subsequent key pieces of information the client provides to produce predictable patterns and outcomes. The client does not provide information to a vacuum, however. The

additional dynamic interaction occurring in substance abuse assessment interviews involves the actors: client and counselor operating in a particular environment.

Returning to the stage performance analogy, all performances between "actors" occur on a particular "set." Some dyadic interpersonal roles cannot exist without a "set" or context. In articulating a theory of the relationship between victim and perpetrator in work place settings, Aquino and Lamertz (2004) make the point that some roles, "...can only be performed in conjunction with a corresponding counter role... enactment of relational roles by (two people) tends to mutually cue and sanction their actions toward each other..." (p. 1025). Interpreting behaviors of one person engaging a particular role requires turning attention to how those behaviors interface with another role acted out by another person, particularly when shared social context defines a boundary within which participants must operate. Counselor and client roles arguably necessitate a counseling session take place or, at minimum an arranged meeting. Counseling requires a client and being a client requires having a counselor.

Although intended for longer, more complex human sets of role engagement, Montgomery (2000) offers a relational role theory conceptually congruent with understanding interpersonal interactions and their implications for perceptual change within counseling sessions. Broadly, the model asserts that the "self" functions as a product of dialectic processes between one's subjective interpretation of appropriate behaviors and roles and the emphasis other people place on the behaviors associated with those roles. Human self-concepts are made

up of roles and associated expected behaviors (i.e., norms). Engaging with other people involves behaving consistent with norms associated with apparent roles. Other people observe behaviors consistent with preconceived ideas of the associated role. Further, others may place more or less substantial loading on the uniformity of behaviors associated with a given role and, therefore, "over attribute roles" (p. 262) to the other person's "self," or as Montgomery discusses it, "ego" (p. 262). Through this process the self internalizes the importance others place on certain roles, resulting in also prioritizing roles that others reinforce. In summarizing theorizing on how the "self" is situated in relation to others when considering roles, Montgomery (2000) states, "...this preliminary specification of the role- person merger (indicates) that the self changes through a dialectic process" (p. 263). The dialectic process in this example is with a generalized "other." In the current study the dialectic process involves a client and a counselor. The client is the target of perception processes by counselors. The question is whether presenting problems elicit counselor expectations to the extent that counselors over-attribute client behaviors to those presenting problems. Following Mongomery's (2000) model, if the former occurs, client behavior should reflect the overinvestment of counselors in expectations associated with presenting problems, resulting in divergent and predictable dialectic patterns and outcomes.

To summarize, role theory offers a view of interpersonal interactions amenable to Asch's (1946) postulations on impression formation. In particular, role theory situates how expectations might form based on first impressions that guide

subsequent outcomes and interactions between counselor and client. Extrapolating role theory and impression formation to substance abuse assessment interviews, a picture emerges where counselors' expectations associated with domestic violence and methamphetamine use may narrow their perceptual lens, supporting a "holding pattern" of escalating emphasis on those initial pieces of information that results in establishing a direction for subsequent dynamic impression formation processes.

Systems Thinking & Interpersonal Interaction

In Asch's (1946) report of his experiments on impression formation he concluded that, even when testing his hypotheses with lists of attributes as opposed to examining "real life" human interaction, dynamic processes were operating. This section elaborates how dynamic processes in impression formation exist within a broader framework. The discussion concludes by describing a key methodological concern in working with dynamic interactions, segueing into methodology employed in this study.

A key dilemma with studying interpersonal interactions includes their dynamic nature, particularly when trying to isolate certain constructs and examine how they operate. "Dynamics" refers to "systems of elements that change over time" (Thelen & Smith, 1998). Lendaris (1986) defines a system as "a) a unit with certain attributes perceived relative to its (external) environment, and b) a unit that has the quality that it internally contains subunits and those subunits operate together to manifest the perceived attributes of the unit" (p. 604). Interactions between standardized patients and counselors comprise a dynamic unit with

attributes relative to its environment. Societal level discourse primarily on domestic violence and also methamphetamine use represent the relative environment. Alternating opening statements offered by the SP function as sub-units operating together with the perceiver (i.e., counselor) to "manifest the perceived attributes of the unit." See chapter five "methods" for analyses.

Multiple options exist for orienting assessment interviews from a systems perspective. For example, elaborating Lendaris's (1986) definition of a system further would include describing SP/clinician interactions in terms of "supra-systems, systems, and sub-systems." A central task would be orienting the broad and detailed components informing the target system and recognizing that, which aspects are considered broad (i.e., "supra" or part of the environment) versus detailed (i.e., "sub" or components of the system) depends on choices made by the researcher. Or, a theoretical framework offered by Deaux & Major, (1987) emphasizes the reflexive nature of interpersonal interactions. Specifically, applying their theory would include demonstrating how the "back and forth" nature of dialogue occurring in these sessions would change at each step, necessitating a micro examination of conversations as they take place. Orienting assessment interviews through the lens of Senge (1990) might include mapping one or more of his many "archetypes" onto the interpersonal interactions. For instance, researching interpersonal interactions from a "Sengerian" approach might include demonstrating how reinforcing processes may or may not occur in the exchanges between counselor and SP; noting how certain dynamics create a "snow ball" effect

whereas others might balance the interaction leading to less severe diagnostic outcomes. Or, utilizing Linstone's (1999) theoretical "TOP" framework would include examining how technical, organizational, and personal perspectives on substance abuse assessment interviews would provide a balanced overall view of interpersonal dynamics occurring based on varying first impressions.

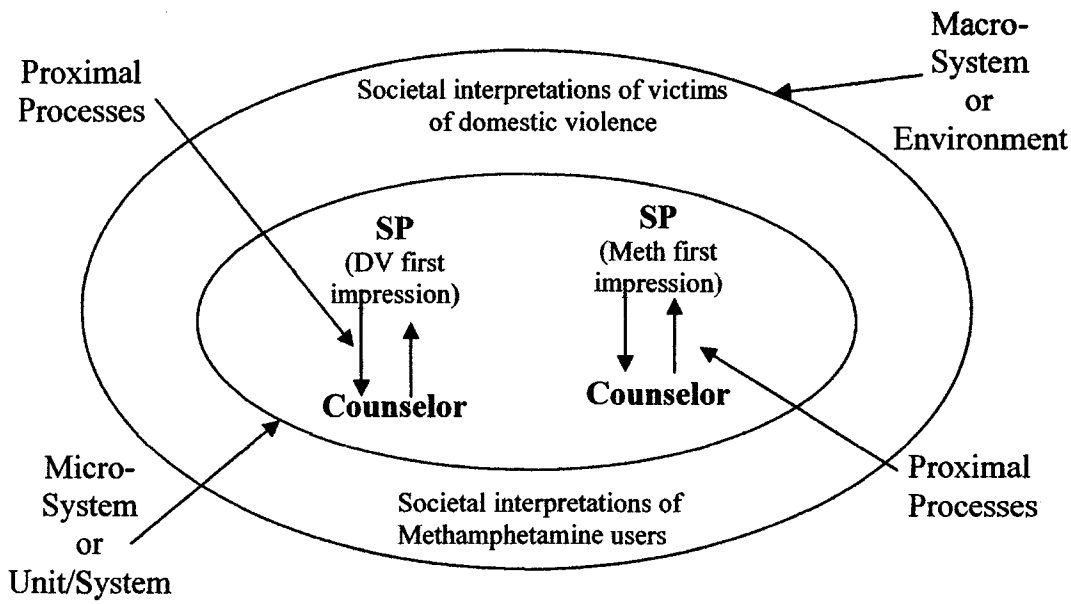
Thus, drawing on one of many systems theoretical frameworks would elucidate and draw out certain aspects of assessment interviews. However, Bronfenbrenner's (1998), developmental approach to interpersonal engagement offers one systems theoretical lens which incorporates key aspects of multiple systems theories allowing for broad and detailed conceptualizations of dynamic interpersonal interactions without over-emphasizing either respectively. "Proximal processes" are central to Bronfenbrenner's (1998) systems thinking on human interaction. He defines proximal processes as "particular forms of interaction between organism and environment that operate over time ..." (p. 994). These processes exist within a "micro-system," which consists of the target person and the particular aspect of their environment (which can be a person) they engage. Micro-systems, then, consist of the people engaging in the proximal process. Micro-systems are not bound to one setting. To illustrate, in this proposal the standardized patient is the target person. She interacts with multiple counselors. Each interaction between the SP and a counselor is a proximal process. Each proximal process exists within a micro-system, which consists in this case of the two people.

Recall Lendaris's definition of a system as "a unit with certain attributes perceived relative to its (external) environment, and a unit that has the quality that it internally contains subunits and those subunits operate together to manifest the perceived attributes of the unit" (p.604). Detailed descriptions by Lendaris on conceptualizing systems beyond this definition will not be explored in relation to this proposal. However, mapping Lendaris's (1986) "unit" onto Bronfenbrenner's (1998) micro-system elucidates the conceptual framework this dissertation operates within. Both terms connote a system including a proximal process: the target person (SP) interacting with their immediate environment (counselors) over time (in this case the duration of the interview).

According to Bronfenbrenner (1998), micro-systems are situated within three additional systems, including, 1) meso-systems, defined as the relationship between the micro-system under examination and other micro-systems, 2) a macro-system, defined as cultural, societal, or economic organizing factors for the micro-system, and 3) an exo-system, defined as systems that do not include the micro-system. Illustrating key over-lapping components of Lendaris's (1986) definition of a system and Bronfenbrenner's (1998) theoretical schemata for understanding proximal processes demonstrates the connections between societal level discourse on DV and methamphetamine use and assessment interviews described in this proposal (see figure 1).

Figure 1

A Combined Systems Model for Conceptualizing Dynamic Interactions between a Standardized Patient and a Substance Abuse Counselor.



This research emphasizes, then, three embedded systemic levels related to how first impressions might alter outcomes of interest. First, the proximal processes, or interactions between the SP and multiple counselors, may vary in particular ways depending on altering opening statement within those proximal processes. Second, the micro-system serves as a container defining the boundaries around which these interactions occur. Third, the macro-system contains societal influences related to DV and methamphetamine use, which may or may not influence the micro-system and the proximal processes occurring therein.

With a conceptual framework in tact, this dissertation addresses the question: "How do first impressions shape clinical interactions?" Recall, the goal of assessment interviews – diagnoses and treatment plans, and the theoretical framework of particular interest to this study – Asch's primacy effect. Drawing on role theory and systems thinking, the properties most likely to change given specific first impressions should be diagnoses and treatment plans. However, dynamic interpersonal interactions evolve. To that extent, the interaction itself becomes the emergent property of interest.

Finally, commentary on methodology most appropriate for studying dynamics systems including proximal processes emphasizes the importance of "looking at an activity, process, or system in terms of how it really works" (Richmond, 1997, p. 2-6). While the former is intended to encourage building computer generated models of a system, used here it draws attention to the need for examining the proximal process between clinician and client as "they really work." Put another way, this component of systems thinking points to the importance of examining actual interactions between counselors and clients. Typically, the confidential nature of most clinical encounters and certainly addictions counseling precludes the option of seeing the interaction unfold. However, an innovative clinical technology – standardized patients – provides the mechanism for not only accessing these private interactions but also controlling client profiles, including first impressions.

Chapter Four

Standardized Patients: A Methodological Mechanism

This dissertation aims to better understand social psychological processes involved in first impressions in a substance abuse assessment interview "as they really work." The theoretical context in which this must be accomplished includes Asch's (1946) observation that "a given trait in two different persons may not be the same trait, and, contrariwise, that two different traits may be functionally identical in two different persons" (p. 62). The challenges become then, how to view assessment interviews and how to control for human qualities appearing different in different people while maintaining the integrity of a dynamic system changing over time. Standardized patients offer one partial methodological solution.

Standardized patients (SPs) also known as "simulated patients" (Barrows, 1987) are "fake" patients trained to act out a script (Colliver & Swartz, 1997; Swartz & Colliver, 1996) in a clinical encounter. Because they are not real clients, they allow for full access into diagnostic and therapeutic interactions thus ameliorating risks to real client confidentiality. Video tapes allow viewing "what really is going on" between counselor and client without jeopardizing any aspect of real client experiences. And, because one actor portraying one SP protocol interacts with multiple clinicians, they provide a way to control for characteristics being interpreted differently based on the individual differences between real clients.

While utilizing SPs allows for a certain amount of control in understanding the effects of first impressions on counseling sessions, the controlled aspects of the SP also inhibit a completely *dynamic* interaction; SPs do not veer off their script regardless of counselor differences. Therefore, only counselors engage in dynamic behavior, altering the trajectory of their interview depending on the SP. This proposal operates, however, from the perspective that spontaneous changes in the counselor alone sufficiently support emergent properties. SP scripts contain information about life events and characteristics appropriate to the clinical encounter. These include physicality, emotionality, and a complete social background. SPs interact with clinicians as if they were the people described in their scripts. In general medical care settings, well trained SP's are indistinguishable from actual (real) patients (Colliver and Swartz, 1997). Further, although the story for an SP is the same across clinicians, they are trained to provide particular information only upon particular cues. If for instance, one clinician repeatedly asks the same or similar questions for which the SP was trained to provide a rote response, the response will occur more often. Additionally, if clinicians fail to ask particular questions or overemphasize a particular topic, SPs are trained to respond with certain affect, for instance apparent annoyance (albeit with the same response) to a clinician who continues to ask one question repeatedly. To this extent, the counselors' component of the interaction proceeds in a dynamic fashion, albeit with limited client response options.

In real clinical contexts, patient-to-patient variation sufficiently hinders comparing providers with one another (Bindman, 1999). For example, estimates indicate a need for at least 100 patients per provider in order to compare primary care clinicians on their management of people with diabetes (Hoford, Hayward, Greenfield, Wagner, Kaplan, & Manning, 1999). Inconveniently, primary care providers rarely care for more than 50 to 75 diabetic patients (Hoford et al., 1999). On the other hand, utilizing standardized patients, each clinician sees exactly the same "patient." Common or anticipated clinician questions provoke the same answer by the SP. Thus, between seven to ten SPs per clinician yield meaningful estimates of clinician performance and demonstrate variation among clinicians (McLeod, Tamblyn, Gayton, Grad, Snell, Berkson, & Abrahamowicz , 1997; Rethans, Sturman, Drop, & VanderVleuten, 1991; Swartz and Colliver, 1996).

At least 80 percent of medical schools in the United States utilize SPs for training and evaluation purposes (Brownell et al., 1994; Rosenberg, 1997). SPs assist in evaluating and teaching dentists (Hazelkorn and Robins, 1996), nurses (Marchiondo and Kipp, 1987), physician assistants, pharmacists, and others (Madden, Ross-degnan, & Kafle, 1997). As of 1993, SPs became the central evaluation mechanism employed by the Canadian national medical licensing examination (Colliver and Swartz, 1997). Beginning with the class of 2005, the National Board of Medical Examiners (NBME) requires an SP exam as part of the United States Medical Licensing Examination for physician licensure in the United States.

Multiple clinical fields benefit from using standardized patients. For example, Famuyiwa, Zachariah, & Hechukwu (1991), Hanson, Hodges, McNaughton, & Regehr (1998), and Hodges, regehr, Hanson, & McNaughton (1997) found SP examinations appropriate for assessing psychiatric clinical skills in third year medical students. Loschen (1993) reached the same conclusion for evaluating psychiatry residents. Badger, deGruy, Hartman, Plant, & Leeper (1994) studied primary care providers' ability to detect major depressive disorder using SPs. More recently, investigators found positive results after sending unannounced SPs to the offices of volunteer primary care clinicians in order to further study the effectiveness of SPs playing roles of people suffering from mental health disorders such as depression (Cloe, Raju, Barrett, Gerrity, & Dietrich, 2000; Gerrity, Cole, Dietrich, & Barrett, 1999). International interest in SPs demonstrates similar studies and results (Shahabudin, Almashoor, Edariah, & Khairuddin, 1994).

A small but growing literature exists on the use of SPs portraying people with substance abuse (usually alcohol abuse) in the primary care sector. Several authors have reported on medical student education programs that involve SPs trained to portray people with alcohol problems (e.g., Christison, 2003; Eagles, Calder, Nicoll, & Sclare, 2001; Eagles, Calder, Nicoll, & Walker, 2001; Mathews, Kadish, Barrett, Mazor, Field, & Jonassen, 2002; Roche, Stubbs, Sanson-Fisher, & Saunders, 1997; Wagner, Lentz, & Heslop, 2002; Walsh, Sanson-Fisher, Low, & Roche, 1999; Walsh, Roche, Sanson-Fisher, & Saunders, 2001). Interestingly,

Eagles et al. (2001) reported medical students rating of SPs as more helpful than real patients or videotapes.

This dissertation makes use of data generated as an overlay to a project funded by the National Institute on Drug Abuse and conducted at Oregon Health & Science University examining specifically the feasibility of standardized patients as substance abuse clients. Particularly, in order to make use of the SP technology in studying first impressions, one SP protocol intentionally reflects theoretical issues included in this dissertation.

Chapter Five

Summary and Guiding Research Question

Both extensive studies by Solomon Asch (1946) and more recent research (e.g., Chiaramonte & Friend, in press) demonstrate the differential weight people place on certain information about others. Specifically, impression formation processes include inordinate emphasis on initial information provided about another person, particularly when that information resonates as important to the perceiver. Experimental designs comprise most, if not all research on these social psychological phenomena. Asch (1946) concluded his set of studies with the assertion that future work should pursue examining impression formation in interpersonal interactions.

Some interpersonal interactions offer more interesting contexts for studying multi-leveled systems than others. Further, some settings are more or less methodologically feasible for studying such interactions. Impression formation occurring in substance abuse assessment interviews offers both a socially salient and methodologically appropriate context to study interpersonal interaction. The expectations of a substance abuse assessment interview include (a) that the counselor will form a relatively accurate impression of the client, (b) that the impression will include relevant information outside of substance use that will contribute to diagnoses and treatment plans, and (c) that the interview proceed with some "typical" format allowing for inserted first impressions.

In order for any first impression to become "central" or guide interpretations of subsequent interactions, it must be salient or "carry weight" for the perceiver. In a substance abuse assessment interview, domestic violence commonly operates as a "co-occurring" problem, particularly when the client is dealing with addiction to a drug such as methamphetamine. Therefore, alternating the opening statement of a client between having problems with methamphetamine versus being a victim of domestic violence might yield interesting outcomes.

Second-wave feminism, particularly radical feminism, brought domestic violence onto the clinical agenda in clinical contexts. However, with DV asserted primarily as a function of men's need for power and control, incorporating substance abuse as an explanation of DV is not encouraged. Nonetheless, studies outside the DV field demonstrate a clear connection between the two problems. Of interest to this proposal is how clinical inferences based on social level discourse on DV and methamphetamine abuse may or may not influence how substance abuse counselors evaluate a client.

Role theory provides one way of situating counselors' perception processes. Roles are associated with particular expected behaviors. By alternating between violent victimization and methamphetamine addiction as a presenting problem, counselors should develop certain expectations of the client's situation. This may initiate dialectic processes in which counselors over attribute client behaviors to expectations associated with either presenting problem respectively. In so doing, content of assessment interviews may too myopically focus on expected behaviors

associated with particular categories, thus eliciting more actual behavior indicative of those categories. Two dynamic interactions should guide consistent processes and outcomes in the clinical interviews, including, 1) processes between role occupants (i.e., counselor and client) and 2) processes between central factors and additional client information. The former is not a topic of direct analysis in this study. However, the particular perspective on dyadic interactions as they may apply to perception formation warrants discussion and is revisited in part three, chapter one.

Role theory is one form of systems thinking, encouraging conceptualizations of assessment interviews that recognize their imbeddedness in other systems. Dynamic systems conceptualizations of the dialectic interaction between counselor and client as well as particular components of one person's story elucidate the importance of studying impression formation as a non-static construct. Recognizing impression formation as a dynamic process implicates time in outcomes. In particular, because dynamic systems change over time, it becomes critical to analyze processes not just products involved in impression formation. To examine process means looking at the phenomenon as it really works, an analytic premise guiding methods employed in this dissertation.

Real substance abuse assessment interviews protect the confidentiality of clients. Therefore, this study makes use of standardized patients to achieve a full view into the clinical interview processes and outcomes. Standardized patients are actors trained to portray a specific client profile. They ameliorate confidentiality

concerns as well as offer a vehicle for consistency, given one person portrays the same patient across clinicians. This allows for both cross-clinician comparisons in outcomes of interest and the ability to control for Asch's (1946) concern that the same characteristic looks different in different people. However, utilizing SPs also ameliorates the dynamic aspect of the client component in interpersonal interactions. Because each individual counselor interacts with the SP *as if* the client is real, the clinician's flexible reactions and actions sustain integrity to viewing the dynamic interaction as it really works.

This dissertation makes use of a standardized patient in multiple substance abuse assessment interviews in order to explore the research question "How do first impressions shape clinical interactions?" Empirical materials from the assessment interviews provide sources for multiple analytic phases discussed in Part II, including a questionnaire asking counselors diagnostic questions and associated reasoning for decisions and video-tape footage of the interviews.

Part II

Methods and Results

Structural Orientation

Prior to describing methods and results of this study, a brief orientation to the structure of Part II becomes necessary given particular divergences from traditional format. Chapter one provides methods and design relevant to assessment interviews between one standardize patient and real substance abuse counselors – the data source for this dissertation. Chapter two discusses analytic premises, focusing on how qualitative methods employed in this study pragmatically and epistemologically map onto the aims of the study. Chapter three introduces multiple analytic approaches used in this study, including a brief description of content analysis processes and narrative analytic technique. Chapters four, five, six, seven, and eight are structured as follows: Each chapter (excluding a summary chapter five) describes four phases of data analysis in temporal order. Each phase of data analysis utilizes distinct analytic methods in addressing the research question. Therefore, chapters four through seven each include an "analytic methods" section and an "analytic results" section. The analytic methods component provides descriptions of how particular empirical materials are examined, and the analytic results component provides the product of those analyses. Chapter eight addresses reliability and validity of results in the context of qualitative analyses.

Chapter One

Assessment Interviews: Methods and Design

This dissertation was conducted as an overlay to a study funded by the National Institute on Drug Abuse (NIDA) and conducted at Oregon Health & Science University. That study examined the feasibility of using standardized patients in an addictions treatment clinical context. The research team included Dr. Bentson McFarland, Ph.D, M.D. (Primary Investigator), Dr. Colleen Lewy, Ph.D. (Research Assistant Professor) and the author of this dissertation, Holly Fussell (research assistant). In carrying out the study, the team developed four standardized patient (SP) protocols, hired and trained four actors to portray the cases, and collected data generated as a product of video-taped mock assessment interviews between SPs and clinicians as well as clinician responses to a post-interview questionnaire. Finally, quantitative and qualitative analytic methods were employed to assess the four SPs on multiple indicators of authenticity.

One SP scenario – "Debby Patterson" – was specifically designed to include content methodologically matched to this dissertation, with the proviso that data generated from this case scenario contribute to the feasibility study. In addition, the post-interview questionnaire designed to acquire clinician diagnoses, treatment recommendations, hopefulness and ratings of SP authenticity (see Appendix A) intentionally included substantial qualitative assessments of *why* clinicians' would provide any quantitative diagnostic or treatment information. The choice to include these qualitative components was, in part, to maximize possibilities of detecting

how first impressions might have impacted numerically indicated clinician choices relative to Debby.

Debby's protocol includes an addiction to methamphetamine and violent victimization in her domestic setting. In order to assess how first impressions may shape clinical interactions between Debby and individual substance abuse counselors, the SP alternated her opening statement (i.e., presenting problem) between, 1) "Me and my husband have been fighting a lot lately and this last time the police came and they took my kids," and 2) "I've been having some pretty bad problems with meth." To summarize distinctions between the NIDA study and this dissertation, Debby's general story is a product of both. The decision to alternate her opening statements, the statements themselves, analytic choices and findings relevant to distinctions between presenting problems are dissertation specific.

Alternating Debby's presenting problem between counselors provided two distinct data sets allowing for comparison between two groups of counselors. This section includes a description of the participants, measures, settings, and procedures. As an added component to the NIDA study, many methodologies map directly to those employed with all four standardized patients. However, descriptions are intentionally constrained to those allowing for adequate understanding of the present study.

Participants

Eighteen participants (72.2% female, n = 13; 27.8% male, n = 5; Mean Age = 42, *SD* = 11.37) interviewed Debby who was portrayed by one actor. Reported ethnicity included ten Caucasian (55.6%), three African American (16.7%), two Asian/Pacific Islander (11.1%), one Hispanic (5.6%), one "other" (5.6%) and one "multiple" (5.6%). Highest level of education completed included "some college" (n = 2, 11.1%), "associates degree" (n = 5, 27.8%), "bachelor's degree" (n = 5, 27.8%), and "master's degree" (n = 6, 33.3%). Three of eighteen participants had no clinical experience other than from their substance abuse counselor training at the time of the study. Five counselors (28%) interviewed Debby only. They did not interview any other SP in the NIDA study. Eight (44%) interviewed one other SP. Four (22%) interviewed two other SPs, and one (6%) interviewed three other SPs. Additionally, of the 13 counselors who interviewed additional SPs, five participants (28%) interviewed Debby first, seven (39%) interviewed Debby second, and one (6%) interviewed Debby third.

Nine participants were exposed to either presenting problem yielding two comparison groups; DV group (n=9) and Methamphetamine group (n=9). Demographics were similar for each group. Domestic violence group included six females (66.7%) and three males (33.3%), mean age = 38, *SD* = 10.28. Ethnicity: four Caucasian (44.4%), two African American (22.2%), two Asian/Pacific-Islander (22.2%), one Hispanic (11.1%). Highest level of education completed: "associates degree" (n = 3, 33.3%), "bachelor's degree" (n = 3, 33.3%), "master's

degree" (n = 3, 33.3%). Two of nine participants (22%) in the DV group had no clinical experience other than from training. Methamphetamine group included seven females (77.8%) and two males (22.2%), mean age = 45, *SD* = 11.90. Ethnicity: six Caucasian (66.7%), one African American (11.1%), one "other" (11.1%), one "multiple" (11.1%). Highest level of education completed: "some college" (n = 2, 22.2%), "associates degree" (n = 2, 22.2%), "bachelor's degree" (n = 2, 22.2%), "master's degree" (n = 3, 33.3%).

The order in which counselors interviewed Debby was similar for both groups. Within the DV group, six participants (67%) interviewed Debby prior to interviewing any other NIDA study SPs, and three participants (33%) interviewed Debby second. Within the methamphetamine group, four participants (44%) interviewed Debby first, four (44%) second, and one (11%) third. Fourteen of 18 participants (78%) who interviewed Debby conducted additional interviews for the NIDA study on the same day. Four of 18 (22%) interviewed Debby on a different day than other interviews. Two of those four (50%) interviewed Debby first and came back another day to interview other SP(s) and two (50%) interviewed Debby second after interviewing another SP on a previous day. Finally, three of the four (75%) interviews occurring on separate days than interviews with other SPs were conducted by counselors in the methamphetamine group and one of the four (25%) were conducted by counselors in the DV group.

Procedure

This section includes multiple aspects of procedures relevant to the assessment type interviews. Descriptions begin with recruiting participating clinicians as well as the standardized patient portraying Debby. A description of the overall design employed for data collection follows. Finally, setting is established and a summary of interview process follows.

Recruiting. Participant recruiting was based primarily on networking in the alcohol and drug counseling community in the Portland, Oregon metropolitan area. This consisted of contacting key personnel of two alcohol and drug treatment programs. Establishing contact occurred through either phone or email in order to arrange subsequent face to face meetings. Public discussion about the project, solicitation of feedback from people engaged in multiple levels of the addictions treatment field, and further recruiting of participants occurred through attending the 2004 Northwest Institute of Addiction Studies (NIAS) conference. Additionally, contacts created at that conference facilitated the inclusion of a recruitment flyer in general conference materials at the 2005 NIAS conference. The one standardized patient portraying Debby was a professional actor recruited through referral by a third party. The need for physicality consistent with particular roles is tantamount to authenticity of standardized patients. The candidate was screened for, among smaller details, ability to portray affect and physical dispositions consistent with presenting problems. As an employee of OHSU and the Department of Psychiatry

the SP portraying Debby was paid $15.00 an hour including time spent on training and homework as well as actual time spent in clinical interviews.

Design. Mock substance abuse assessment interviews between counselors and the standardized patient portraying Debby were the source of empirical material analyzed in this dissertation. Definitions of a quasi-experimental design (e.g., Cook & Campbell, 1979) apply most appropriately particularly given that random assignment was not possible. Scheduling counselors occurred based on their availability. Further, which SP counselors interacted with depended on SP and counselor availability. Finally, Debby's opening statements were alternated each time she saw a new counselor. However, due to the approach to scheduling, it cannot be said that any counselor had an equal chance of seeing any SP at any given time. Therefore, it cannot also not be said that any counselor had an equal chance of an encounter with Debby in which she would use either of the opening statements. Counselors knew they were interacting with a standardized patient in an environment outside their usual work place. What follows is a detailed description of the interview process from the perspective of a participating counselor. Data collection took place over a four month period between May 20th and August 16th 2006.

Interview process. Upon entering the particular building where sessions took place, clinicians were escorted to the specific location where pre-interview paperwork could be confidentially completed. Clinicians were seated and presented with a folder containing consent forms, a pre-interview questionnaire, a post

interview questionnaire (see Appendix A), a Global Assessment of Functioning Scale (see Appendix B), and blank paper for taking notes. At this time the researcher verbally described the project to the clinician and verbally went over the informed consent forms. Clinicians were told that they would be video-taped during the meeting but that the camera would not be turned on until the session with the SP began. Clinicians were given the opportunity to ask questions and once any questions and/or concerns were fielded, the clinician was left alone with the consent forms and the pre-interview questionnaire. After reading and signing the consent forms, the clinicians indicated they were done by calling the researcher by name or knocking on the office door across the hall. The researcher then retrieved the signed copies of the consent forms (a second unsigned copy was provided for each clinician) and provided the clinician with a brief written statement about the standardized patient case they were going to see. Providing the brief statement was a necessary inclusion to the NIDA study, as it most closely mimics real circumstances where counselors would have some identifying information about their client before conducting an interview. Debby's statement read,

> "Debby is a 24 year/old unemployed, married mother. Her children have been placed in protective custody on grounds of neglect. The district attorney has strongly suggested that Debby undergo an assessment interview with a drug and alcohol counselor. You have one hour and fifteen minutes to assess her potential problems, come

up with an initial diagnosis, and determine what (if any) follow-up is needed."

NOTE **This statement was designed to reflect typical circumstances under which a female person dealing with domestic violence and methamphetamine use would attend a substance abuse assessment interview. However, *careful attention was paid* to including *the least amount of information* possible while maintaining integrity to the authenticity of information. Further, the statement *intentionally does not include reference directly to DV or methamphetamine use* – pieces of information essential to assessing the dissertation research question as it pertains to either respective socially defined problem.**

While the clinician read the synopsis the researcher turned on the camera and read aloud the reference number, session number and date of the interview that was about to proceed. Following this, the researcher ushered the standardized patient into the room, introducing her as Debby Patterson and shut the door upon exiting the room. All of Debby's behaviors with counselors were trained to be consistent, albeit manifesting at different junctures in interviews depending on counselor cues. The *key alteration to Debby's performance occurs consistently and verbatim*. In order to facilitate alterations in the first impression provided by Debby, two specific presenting problems were offered to alternating clinicians including, *1) "Me and my husband have been fighting a lot lately and this last time the police came and they took my kids" and 2) "I've been having some pretty bad problems with meth."* These statements were in response to whatever opening

question was offered by the clinician. This typically was an open-ended question (e.g., what brings you here today?) Even if the first verbal interaction did not include an open ended question (e.g., so you're here because the DA recommended you see someone?) Debby was instructed to go directly to the appropriate presenting problem.

Counselors were instructed to behave as they normally would in an assessment type interview, that they were not expected to be working for any particular agency and that they could use materials if they brought them. The clinicians were made aware that he/she would have one hour and 15 minutes to interview the SP and that, if they were not done by one hour and 10 minutes into the interview, a researcher would knock on the door to inform them they had five minutes left. If the clinicians interview ended earlier than the allotted time, they were to close the interview naturally and either send the SP back to our office (across the hall) or the clinicians could come themselves to let us know they were done and we would usher the SP back to our office. Once the assessment interview was complete and the SP securely removed from the premises the camera was turned off and the clinicians were allowed time to complete the post interview questionnaire. The clinicians would then indicate either by calling our name or accessing us by knocking on the office door that they were done. The researcher then made sure any further questions or concerns were addressed. In instances when the clinician was to see two or three SPs, the process began again with providing a second case synopsis, changing the video tape, indicating via codes

what session it was for the camera, and ushering in the next SP. Upon completion of the participation process clinicians were asked to fill out a receipt and paid in cash ($25.00 an hour) for their time.

Settings. Interviews were conducted at OHSU in the administrative wing of the Department of Psychiatry. All interviews took place in a private and secure room. Assessment interviews were video taped using a camcorder placed on a tripod in the corner of the room where interactions took place. In all instances, the SP and interviewing clinician were the only occupants of the room during the video taping process.

Measures

One goal of this research was to see how socially relevant information offered as first impressions relates to predictions for diagnostic outcomes as per the post-interview questionnaire (see Appendix A). As previously noted, the questionnaire was designed to achieve goals consistent with the NIDA study. However, particular items are theoretically relevant to detecting divergent diagnostic outcomes within the context of divergent presenting problems. The following description provides the scope and type of questions on the measure. Chapter four provides specific theoretically driven expectations associated with particular items on the questionnaire.

The post-interview questionnaire measure included the following broad categories: Determining if the counselor believed the client had a problem with substances, and if so what label they would apply. Determining if the client had a

co-occurring problem or disorder and, if so what label they would apply including their reasoning. Counselors were to rate the client on the Global Assessment of Function scale (e.g., "GAF On-line Training," 2005). For an exact copy of the GAF used in the NIDA study see Appendix B. This scale provides categorical information counselors could access to provide an associated number rating for how "functional" a client has been during a particular time frame. Multiple questions on the post-interview questionnaire assessed counselors' comfort level and level of agreement with using certain typical diagnostic tools (e.g., the Diagnostic and Statistical Manual). Items assessed client's risk for hurting other people as well as risk of suicide. Counselors were asked to rate the client on multiple dimensions on the American Society for Addictions Medicine (ASAM) crosswalk (Mee-Lee, 2001). The goal was to develop a combined sense of an overall placement rating (Prochaska & DiClemente, 1983) for the client including counselor reasoning for a particular placement. Barriers to recovery were assessed and counselors were asked to provide five treatment goals for the client including their order of importance. Counselors reported how hopeful they were for recovery and their associated reasoning. Finally, authenticity ratings using the Maastricht Assessment of Standardized Patients scale (e.g., Wind, van Dalen, Muijtjens, & Rethans, 2004) provided essential information to the NIDA study.

The pre-interview questionnaire administered to all participating clinicians provided demographic information for this dissertation. Video taped interviews of Debby provide a source for narrative analysis described in "analytic results."

Debby's scenario. The research question, "how do first impressions shape clinical interaction" was examined in the context of the assessment interviews previously described. Authentic substance abuse assessment interviews include a client with an entire life story. Typically, the interviews take up to two and one half hours. This requires a standardized patient scenario containing enough information to satisfy that level of inquiry. The information included in an SP scenario is also typically designed to capture adequate clinical professional practice. Therefore, the information must be authentic and delivered consistently. What follows is an outline of Debby Patterson's scenario, specifically those aspects that apply to subsequent analyses in examining the research question.

Debby is 24 years of age, married, unemployed, and has children who have been removed into protective custody. She is participating in the assessment interview by court mandate. Other key elements to Debby's story revealed only with appropriate probes include that she is focused almost entirely on getting her children back as a motivation for being at the interview and doing "whatever it takes" with regard to treatment plans. *The protocol intentionally included affect and behaviors by Debby that go "over the top" toward the emphasis on children.* In addition the SP *is not to assert any other stimulus for wanting to get clean.* The design intention was to assess counselors' detection that Debby is not that motivated toward change outside of one instigator – her children.

Debby's script also includes a great deal of denial regarding her violent victimization. Eric, Debby's husband, is in jail at the time the interviews take place.

He had an outstanding warrant for failure to appear to court for a DUI and police found trace amounts of methamphetamine on the premises upon entering Debby and Eric's trailer. Police involvement initially resulted from neighbors calling the police because of loud fighting. Debby spent one night in jail as a "cooling off" period. Eric's release date is unknown. If adequately prompted (i.e., direct questions or repeated investigation on the topic) Debby reports escalating violent victimization by her husband Eric. Eric physically abuses Debby and specific instances are written into her script. Debby states upon initial questioning, however, that "she hits him too," "he really loves his kids and is a good dad," and that, "jail will really wake him up," and Debby thinks "jail will make him change."

Debby's relationship with her mother is tenuous. Her mother has recently stopped talking to Debby and doesn't come over to see the kids any more. Debby thinks her mom knows about the drug use and that is the reason for her absence. Debby also thinks her mother will help her if she asserts she is in a drug treatment program. Given Debby's history with her mother – a picture depicting a teenager whose mother is never around – Debby's beliefs about her mother's loyalty may or may not be founded.

Dilapidated living conditions provided much of the source for the removal of her children, Tyler age 4 and Hope age 2, into protective custody. At the time of arrest, one week prior to the assessment interview, Debby and Eric had no electricity, no phone, close to no food in the home, and belongings were strewn throughout the trailer.

Debby is also in denial about neglecting her children. She asserts upon appropriate questioning that Tyler changes Hope's diapers, bathes her and that the children go into their room when mom and dad smoke methamphetamine, which occurs constantly. When "crashing" Debby goes in her room for up to two days at a time and when she re-emerges she gets high. Tyler has reported to Debby's mother that Debby and Eric "never pay attention to them" (Tyler and Hope). Debby knows this because her mother told her at their last encounter two weeks prior. Debby is to assert this state of affairs as being totally unrealistic and a lie. She does not understand the gravity of her parental, relationship or methamphetamine problems. Of the three, she is most clear on the detrimental effects of methamphetamine but blames her use on Eric, a man who she fully intends on reincorporating into her life upon his release from prison. Overall the design goal was to paint a picture of an abused, addicted woman in denial about many detrimental elements in her life.

How counselors constructed Debby's story is the topic of this dissertation. Specifically, this study examined how alternating presenting problems between violent victimization and problems with methamphetamine use shaped clinical interactions in the context of the existing "real" information described.

Chapter Two

Analytical Premises

This dissertation conducted a four phase analytic framework that utilized both quantitative and qualitative analyses, with an emphasis on the latter. This section situates qualitative analysis, in particular, as practically and epistemologically amenable to addressing the research question, "How do first impressions shape clinical interactions?"

One goal of this research was to see how socially relevant information offered as first impressions relates to predictions for diagnostic outcomes. Quantitative analyses are well suited to particular items on the post-interview questionnaire and, therefore, provide quantitative indicators relevant to addressing theoretically driven hypotheses related to the research question. However, dynamic interpersonal interactions characterizing these "quasi-real life" contexts, yield complex yet subtle findings. Qualitative methodologies are particularly well suited for capturing a rich view of complex dynamic processes. In addition, qualitative methodologies allow for placing this rich view in the context of preliminary exploration and discovery (Ambert, Adler, & Detzner, 1995). The goal was to provide an in depth description of how first impressions operate in these specific clinical interactions.

In describing how first impressions may be shaping clinical interactions, this dissertation operates from a tradition in psychology that recognizes findings as becoming available to the investigator through examination of the discourse, or use

of language including story telling. Potter and Wetherell (1995) explicate this point stating, "rather than seeing the important business of psychological processing taking place underneath (the content of what people say, discourse analysis) treats this content as literally where the action is" (p. 82). This narrative analytic approach draws on the notion that human experience, including impression formation, becomes organized into stories (e.g., Bruner, 1990). Further, creating stories about others involves shaping and reshaping of available information. Shuman (1998) makes the point that stories frame experience and that experiences are organized into events. Those events "make experience accessible to understanding by providing a language for talking about experience" (p. 20). The experience counselors engage while forming impressions of Debby guides analyses in this dissertation.

Recall Asch's (1946; 1952) assertion that impression formation is a dynamic process informed by reciprocating processes between particular characteristics available to a perceiver. In discussing narrative as a potent form of "data," Haaken (1998) makes the point that, "social interactions require different forms of remembering and different strategies for communicating retained knowledge" (p. 54). Capturing processes of impression formation includes attending to how counselors create a story (i.e., impression) of Debby. This includes recognizing that what counselors report in the post-interview questionnaire and what they say during the interview process reflects how they are arranging a perception of Debby – her story. This dissertation draws on guidelines for narrative

analysis available in *A Listening Guide* (Gilligan, Spencer, Weinberg, & Bertsch, 2003). While some approaches to narrative analysis include elaborate coding systems, Gilligan et al., (2003) provide an adaptable framework for interpreting narrative that attunes the reader to both broad emergent themes and individual voices in any given story construction. All analyses presented in this study emphasize thematic trends related to respective first impressions as well as more subtle results.

Chapter Three

Introducing Analytic Results

This dissertation addressed the research question, "How do first impressions shape clinical interactions?" Quantitative and qualitative analyses were conducted in order to gain a broad and rich view of how substance abuse counselors, in particular, developed perceptual frameworks of one client offering two different first impressions substance abuse assessment interviews. Specifically, 18 different substance abuse counselors saw one standardized patient (i.e., "fake" patient) and engaged in mock assessment type interviews. The standardized patient's (SP's) case included an in depth history adequate for one and a half hour interviews. The SP, a professional actor, was also trained to consistently portray particular affect given certain cues. Participating counselors determined the SP's depiction highly authentic as indicated by a study conducted at Oregon Health & Science University[1]. In order to examine theoretical propositions included in this dissertation, one standardized patient – "Debby Patterson" – alternated her opening statement between, 1) "Me and my husband have been fighting a lot lately and this last time the police came and they took my kids," and 2) "I've been having some pretty bad problems with meth."

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[1] This dissertation was designed as an overlay to a study funded by the National Institute of Drug Abuse (NIDA) and conducted at Oregon Health & Science University. That study examined the feasibility of using standardized patients in an addictions treatment clinical context. The research team included Dr. Bentson McFarland, Ph.D, M.D. (Primary Investigator), Dr. Colleen Lewy, Ph.D. (Senior Research Associate) and Holly Fussell M.S. (research assistant).

Chapters four, five, six and seven provide methods the results specific to four phases of analysis respectively. The methodological choices and analytic results were designed to examine outcomes and processes related to how substance abuse counselors organized an overall impression of Debby given these differing presenting problems. Phase one included quantitative and qualitative analysis of specific items on a post-interview questionnaire (see Appendix A). The questionnaire was designed to assess both diagnostic outcomes of counselor/SP interviews and the believability of the SP. This measure was not designed specifically for purposes of assessing perception processes. However, outcomes of clinical assessment interviews are the product of counselors forming impressions of clients and articulating those impressions in the form of diagnoses and treatment recommendations. Additionally, multiple items on the measure were theoretically relevant to diagnoses and treatment recommendations.

Phases two and three assess additional facets of perceptual processes not available through analysis of the discrete items on the post-interview questionnaire alone. Specifically, phase two enlists clinicians outside the data collection process in order to assess counselor receptions to Debby as warm, cold, neutral or ambivalent, demonstrating connections between societal level information on key opening statements and Asch's (1946) findings on the importance of these particular interpretations of others. Drawing on guidelines available in Gilligan et al's (2003) *Listening Guide*, phase three involves accessing dominant themes and overarching story lines that emerge in narrative transcriptions of nodal points in the

video-taped interactions between counselors and Debby. Phase four draws connections between outcomes and themes that emerged in phases one, two and three. A schematic of reemerging trends across phases allows for a visual "decision tree" type representation of findings on clinical judgment familiar to practitioners.

Phase one included quantitative and qualitative analysis of specific items on the post-interview questionnaire. Diagnoses, reasoning for those diagnoses, assessments of client's readiness to change, treatment goals and feelings of hopefulness for client recovery all relate to overall perceptions of the client. Clinicians must create coherent impressions of clients in order to make judgments on such items, even if the information available on the client is limited. This phase of analysis emphasizes themes in clinician reasoning for assessing the client on certain quantitative items. Drawing on premises previously described, a critical question for this dissertation is *how* counselors create impressions of the standardized patient.

Phase two originally included asking two mental health practitioners outside the context of this study to conduct blind ratings of the post-interview questionnaires, reading the documents as case reports rather than as a set of discreet outcome items. The clinicians were not aware of which first impression was associated with any respective document. The task was to assess whether the raters believed the counselor who reported on Debby in the post-interview questionnaire had a warm, cold, neutral or ambivalent reception to Debby. This phase specifically addresses the level of congruence between Asch's (1946, 1952) theories on the

relevance of warm and cold characteristics in impression formation and the choices to include domestic violence and methamphetamine addiction as first impressions. Dr. Janice Haaken, chair of the dissertation committee, also carried out blind ratings of the post-interview questionnaires as a form of quality control and establishing inter-rater dependability.

Phase three involved a narrative analysis of transcribed material gleaned from the video taped assessment interviews between counselors and the standardized patient, Debby. Transcribed components of the interactions included nodal points in the interview in which counselors asserted statements indicative of subjective construction of Debby's story. Eighteen separate documents resulted from this process, each indicative of locations in the interview process in which counselors verbalize their perceptions to the client. As opposed to a coding system in which words and phrases are examined individually, the transcriptions were analyzed from a gestault perspective consistent with premises asserted in introducing these analytic results. Framing analyses using a Listening Guide (Gilligan et al., 2003) the transcribed nodal points were analyzed on multiple dimensions including, a) the primary, overarching theme operating in all transcriptions, b) a closer examination of how Debby's story emerges differently in respective presenting problem groups, and c) how the former relate to the guiding research question, "How do first impressions shape clinical interactions?"

Phase four integrates the results of analyses conducted in phases one, two and three. This final task elucidates how utilizing multiple methods in assessing

perceptual processes in these interviews yields a complex analysis of clinical interactions, yet one with broad practical implications. Drawing connections between separate forms of analysis supports the goal of developing a broad and rich framework for understanding how first impressions may be shaping these clinical interactions.

Chapter Four

Phase One: Analytic Methods and Analytic Results

Phase One: Analytic Methods

Phase one included quantitative and qualitative analyses of particular items included on a post-interview questionnaire counselors completed following interviewing the standardized patient. As described in chapter one of part two, the post-interview questionnaire included anywhere from one to several items addressing one topic. For instance, three items – one quantitative and two qualitative – assessed the client for co-occurring disorders. Therefore, results are provided in "topic blocks." Each topic block includes one or more expectations related to items on the post-interview questionnaire, theoretical grounds for the expectation, the specific question(s) related to the topic, the results of analyses pertaining to each question and, when relevant, researcher interpretation. The term "expectations" was chosen as a header for what, from a quantitative perspective, would be considered hypotheses. This decision reflected a strategy of retaining structural consistency throughout phase one considering the pairing of quantitative and qualitative items. Recognizing the non-traditional approach to initially asserting the expectations at this point in the study, the decision was based on the necessity of providing sufficient conceptual and methodological context for each topic block. Asserting the expectations at any juncture prior to this would have been conceptually non-instructive.

Expectations related to ordinal scale, Likert-type response items were tested using independent sample t-tests. Given small sample sizes (n=9 per group), reports of t-tests include effect size (*d*), reporting of mean values for outcomes items, and standard deviations, allowing the analyst to comment on directional relationships between variables and non-trivial effect sizes. In instances where additional illustration of differences between groups proved instructive, box plots and/or stem and leaf plots provide visual representation of results.

Frequency counts are provided for yes/no dichotomous response options. Within condition percentages related to frequency counts provide additional clarification. Finally, Chi-Square tests for many yes/no dichotomous response items allow for assessing whether differences in responses between groups within this sample may generalize to other populations. While Chi-Square tests are a rougher estimate of confidence than t-tests, they are acceptable in a wider range of research contexts. Chi-Square tests were not conducted on items particularly amenable to content analysis based on the level of complexity narrative responses provided. Procedures for narrative analysis follow. However, to clarify, the aim of content analysis as used in this dissertation was to identify *what* people in this one sample were offering as *self-interpretation to their quantitative responses*. Significance testing to possibly generalize beyond the sample was not necessary to fulfill that aim.

Content analysis was conducted on qualitative response items where counselors were asked to reflect on a topic in narrative form. The content analytic

process included categorizing post interview questionnaires according to presenting problem and examining written responses to open ended items for each group. Tracking content included two procedures. First, frequencies of recurring statements were documented and illustrated by including associated counselor identification numbers. The sum of counselor identification numbers allowed for clarity as to the number of times a certain response occurred. Second, in reporting the content analyses, comments reflecting connections between the qualitative item and the preceding quantitative item conceptually elaborated results for respective topic blocks. See appendices C, D, and E for complete content analyses of responses related to presenting problems one (DV) and two (methamphetamine) as well as a combined analysis of all responses related to Debby's case. Responses for each item were noted by presenting problem group and as a combined group.

Phase One: Analytic Results

Topic Block One: Co-Occurring Problems/Disorders

Expectation 1

The situation where domestic conflict was presented first would be related to increased recognition of domestic violence as a co-occurring problem including related discussion.

Related theory. Developing overall perceptions of substance abuse clients includes incorporating information available to the counselor. Initial information should have established direction for interpreting subsequent information. Presenting the socially and professionally salient information that Debby's

domestic context included intense fighting should have resulted in counselors diagnosing it as a co-occurring problem, including providing bases for what led them to name the problem.

Questionnaire item # 4. "Is this client suffering from one or more co-occurring problem(s)/disorder(s)?"

Results. The domestic violence group responded "yes" the client is suffering from a co-occurring problem/disorder more frequently (n = 7, 78%) than the methamphetamine group (n = 4, 44% of total sample). The domestic violence group responded "no" the client is not suffering from a co-occurring problem/disorder less frequently (n = 2, 22%) than the methamphetamine group (n = 5, 56%). The results were in the expected direction. Counselors who were introduced to Debby as a potential domestic violence victim noted that she does have a co-occurring problem more frequently that the methamphetamine group. The differences between groups are minimal $\chi^2(1, N = 17) = 2.10, p = .15$. This small difference between groups was anticipated. Qualitative responses to the following questionnaire items were expected to yield more illustrative results.

Questionnaire item # 5: "If yes, what labels/diagnosis(es) would you use to describe the problem?"

Results. No counselors reported domestic violence per se as the co-occurring problem. See Table 1 for diagnoses/labels according to presenting problem. Items in parentheses are counselor identification codes.

Table 1

Content Analysis: Counselor Diagnoses or Problem of SP by Presenting Problem Group

Co-Occurring Diagnosis or Problem	**DV Group Frequency & Associated Counselor IDs**	**Meth Group Frequency & Associated Counselor IDs**
Depression	n = 4 (172,117,144,39)	n =1 (140)
Substance Induced Mood Disorder	n = 1 (150)	n = 2 (115, 20)
Co-Dependency	n = 1 (144)	n = 1 (76)
Adjustment Disorder w/ Anxiety	n = 1 (81)	0
Mood Disorder	n = 1 (22)	0
Parental Abuse Victim	0	n = 1 (76)
Situational Difficulties (e.g., needs GED, needs job)	0	n=1 (36)

A substantial number of counselors from the DV group responded that Debby was suffering from a co-occurring problem or disorder and a moderate number of counselors from the methamphetamine group responded that Debby was suffering from a co-occurring problem or disorder. Specifically, seven of the nine counselors from the DV group indicated that Debby had a co-occurring problem or disorder. All seven counselors labeled the co-occurring problem as mental health related. Four of the nine counselors from the methamphetamine group indicated

that Debby had a co-occurring problem or disorder. Two of those five counselors who indicated Debby did have a co-occurring problem labeled the problem as situational.

The majority of listed situational problems were obtained from one counselor. Therefore, multiple listed situational problems were collapsed to one label – "situational difficulties." Of the two counselors reporting situational difficulties, one counselor noted that Debby was a parental abuse victim. The second counselor indicated Debby had multiple "problems in living" (i.e., needs education, lacking job skills, lacking support, lack of marital cohesion, and parenting skills). This counselor did note Debby had problems with self-esteem, a label that could be interpreted as mental health related. However, in reporting that problem the counselor included it as the first item listed after the words "problems in living encompassing." Therefore, the label is included as situational rather than a mental health diagnosis.

A chi-square analysis was conducted in order to examine differences between groups on frequency of mental health labels. Seven of seven (100%) DV group counselors who indicated Debby had a co-occurring problem provided co-occurring diagnoses indicating mental health problems. Three of four (75%) methamphetamine group counselors who indicated Debby had a co-occurring problem provided mental health labels, $\chi^2 (1, N = 12) = 3.36, p = .07$. One of the four affirmative respondents in the methamphetamine group diagnosed one

situational difficulty – parental abuse victim – and one mental health problem – co-dependency.

Groups differed on the number of listed mental health or situational labels as well as the certainty of their responses on the post-interview questionnaire. Seven of seven diagnoses/labels in the DV group were mental health related. Seven of ten (70%) listed labels for problems in the methamphetamine group were situational. While six of the seven situational labels in the methamphetamine group were gleaned from one counselor's responses, only four counselors from that group responded that Debby even had a co-occurring problem. Further, within the mental health responses of the methamphetamine group two were substance induced and one is strictly mental health. The one "depression" response from the methamphetamine group actually read "perhaps depression" on the post-interview questionnaire, indicating the counselor was unsure of this diagnosis. "Moderate" and "somewhat uncertain" responses were included for all respondents in the methamphetamine group regardless of the specific mental health related diagnosis. All mental health diagnoses in the DV group were unambiguous and straight forward. Qualitatively, the methamphetamine group's overall responses to this questionnaire item were uncertain and emphasized Debby's situational difficulties and the DV group's overall responses were reported without disclaimers and unanimously focused on mental health. The emphasis on internal attributes of the standardized patient by the DV group is a topic of discussion in phase four.

Questionnaire item #6. Whether or not you believe this client is suffering from one or more co-occurring disorder(s), what led you to this conclusion?

Results. Content analysis results for this item were categorized by presenting problem and diagnosis/problem. Counselor identification numbers follow each item. Diagnoses/labels with no associated narrative indicate the diagnosis only occurred in the alternative presenting problem group. See Table 2 for complete content analytic results by presenting problem group.

Table 2

Content Analysis: Reasons for Co-Occurring Diagnosis or Problem by Presenting Problem Group

Diagnosis/Problem	**DV Presenting Problem**	**ID(s)**	**"Meth" Presenting Problem**	**ID(s)**
None	Further assessment needed	39,165	Client report	70, 170
	Rule out depression after withdrawal	39,165	Reasonable responses to a difficult situation	52
	Frequency & amount of use does not warrant further diagnosis	59		
Depression	Reports of feeling bad, low mood	172	Flat affect	140
	Reports of low mood after coming down off cocaine	117	Tired	140
	Reports of being a poor mom	172	Running nose	140
	Reported fighting w/ boyfriend	117		
	Client report	144		
	Client Demeanor	144		
Substance Induced Mood Disorder	Depression following withdrawal only	150	Client Report	115
			Depressed w/ use	20
Co-dependent	Client Report	144	Partner introduced her to meth	76
			Partner support of meth & alcohol	76
Adjustment Disorder w/ Anxiety	Two major changes in life, husbands arrest, children removed	81		
	Withdrawal from meth contributes to fear of future	81		
	Nervous, jittery, worry	81		
Mood Disorder	Slow speech	22		
	Poor self-image	22		
	Lack of social networks	22		
Parental Abuse Victim			Her report	76
			Hesitant to discuss step-dad	76
Situational Difficulties			Client in withdrawal	36
			Needs support	36

Content analysis examining responses to what led counselors to diagnostic conclusions demonstrated a trend toward inferences into Debby's psychology in the DV group and more behaviorally and situation oriented explanations in the methamphetamine group. While the DV group offered explanations such as "nervousness, poor self-image, or report of being a bad mom," the methamphetamine group offers explanations such as "flat affect, lack of education etc., or partner introduced her to methamphetamine."

Interpretation. General conclusions did not indicate direct support for the guiding expectation for block one that domestic conflict first impression would be related to increased recognition of domestic violence as a co-occurring problem including related discussion. However, trends distinct trends within each presenting problem group pointed to possible differences in perceptual processes by counselors. Mental health labels are quite different than situational labels. Further, constructions of Debby's story to this point appeared to diverge within presenting problem groups. One explanation for these differing trends is the category domestic violence may establish a direction for processing of subsequent information that differs from methamphetamine as a presenting problem. The variation in established direction of interpretations appeared to be internal (i.e., intrapsychic) in the DV group versus external (i.e., situational) in the methamphetamine group. Domestic violence may elicit either a therapeutic pathologizing of the client (i.e., over emphasis on mental health problems) or, alternatively, may provide space for

deeper explorations of Debby's story resulting in a more in depth impression of the client.

Topic Block Two: Assessments of Client's Levels of Functioning

Six separate items addressed this general topic. Likert-type response items characterized five of six items and a yes/no dichotomous response characterized one item. For five items, independent sample t-tests were conducted to examine differences between means in order to assess whether a strong enough relationship exists between presenting problem groups and multiple dependent variables to make assertions beyond this sample. T-tests were conducted in the context of a limited sample size, requiring very large effect sizes to establish a statistically significant outcome. Results of all t-tests were not significant. Nonetheless, t-tests results are reported, including effect size and differences between means. Non-trivial effect sizes in the context of non-significant results encourages future investigation of these specific outcome items utilizing a larger sample. A Chi-Square test was conducted for the one dichotomous yes/no response item in order to see if differences between groups may generalize other populations. Expectations related to each relevant item for this topic block provide context for each question and results. As such, results include multiple sets of expectations, questions, and results.

Expectation 1

Counselors in the domestic violence presenting problem group would rate Debby lower on the Global Assessment of Functioning Scale than counselors in the methamphetamine presenting problem group.

Related theory. Domestic violence contributed a substantial layer to the problematic nature of Debby's story. If that first impression shaped subsequent interpretations of information, counselors should have rated Debby as more rather than less impaired.

Questionnaire item # 7. For this question, you will need to refer to the Global Assessment Scale (a copy of the scale is on page 10). Highest GAF past year:_____

Results. Respondents had the option to place Debby within a set numerical range that reflected her level of functioning on multiple dimensions (see Appendix B). The otherwise categorical response options were converted into an ordinal scale with the rationale that lower ratings indicated lower levels of functioning and each rating category indicated incremental yet subjective increases in level of functioning. A t-test was conducted to examine the guiding expectation. The results were not significant, $t(16) = .000$, $p = 1.00$, $d = 0$. As the reported non-existent t value indicates, there was NO effect size and means between groups on a scale ranging from one to ten were identical ($M_1 = 5.78$, $M_2 = 5.78$). Figure 2 demonstrates actual responses by group on a stem-and-leaf plot. Although means were the same, the majority of the counselors from the methamphetamine group

(67%) responded "6" and smaller majority of the DV group (45%) responded "5." Frequencies do support the expectation that counselors in the DV group rated Debby as lower on the Global Assessment of Functioning than counselors from the methamphetamine group. The majority DV response read, "Serious symptoms OR any moderate impairment in social, occupational, or school functioning." The majority methamphetamine response read, "Moderate symptoms OR any moderate difficulty in social, occupational, or school functioning" (GAF on-line training scale).

Figure 2

Highest GAF Past Year Stem-and-Leaf Plot for Debby: DV Presenting Problem vs. Debby "Meth" Presenting Problem.

DV	*"Meth"*
5. 0000	4. 0
6. 000	5. 00
7. 00	6. 00000
	7.
	8.0

*Note: Numbers to the left are counselor scores. Zeros are the number of counselors providing any particular score.

Expectation 2

Counselors from the DV group would rate Debby at lower risk for hurting other people than counselors from the methamphetamine group.

Related theory. Both methamphetamine and domestic violence are associated with violent behavior. However, discourse on domestic violence includes the assertion that much of women's behavior while in violent relationships directly results from male exertions of power and control. Debby's husband's current incarceration should have, theoretically, made most volitional acts Debby could have been engaging (i.e., violent behavior) less of a concern for counselors.

Questionnaire item # 9. "What is this client's risk of hurting other people?"

Results. Responses included, 1) very high, 2) somewhat high, 3) somewhat low, and 4) very low. An independent sample t-test was conducted to examine the guiding expectation. The results were not significant, $t(16) = -1.60$, $p = .13$, $d = .75$. The results were counter to the research hypothesis. Descriptive differences of means between groups reveal that counselors in the DV group rated Debby at higher risk for hurting other people ($M = 3.56$, $SD = .53$) than the counselors in the methamphetamine group ($M = 3.89$, SD .33). An effect size ($d = .75$) indicated group scores differed by .75 standard deviation. According to Cohen (1988) this effect size may be considered close to moderate and, therefore, further study on a larger sample may prove fruitful. Specifically, a sample size of 46 would be required to achieve a significant p value of .05 with a .75 effect size and conducting a one-tailed independent sample t-test with this dependent variable.

Expectation 3

Most counselors, regardless of group should indicate that Debby was not in physical danger. In most instances counselors knew that Debby's husband was

incarcerated at the time of the interviews, removing him as an immediate threat. In the event of differences in responses between groups, the DV group should have reported Debby as in danger more frequently than the methamphetamine group.

Related theory. Publicly available knowledge on domestic violence includes an increased risk for violent victimization. Therefore, interviews emphasizing DV as a topic, based on DV as a presenting problem, should have resulted in knowledge on DV translating to concern for Debby's safety.

Questionnaire item # 10. "Is this patient currently in physical danger?"

Results. Nine of nine (100%) of the DV group indicated that Debby was not in physical danger. Seven of nine (78%) of the methamphetamine group indicated Debby was not in physical danger and two of nine (23%) of the methamphetamine group indicated Debby was in danger. Results were counter to the expectation. Differences between groups were minimal $\chi^2(1, N = 18) = 2.25, p = .134$.

Interpretation. Of interest, two counselors from each group included comments next to their yes/no responses. From the DV group comments included "Eric is in jail," "not at this time due to husband being incarcerated." From the methamphetamine group comments were noted next to the two "yes" responses. Comments included "spouse, but she doesn't seem to think she is," and "possibly, if husband continues to use." The DV group comments placed next to the "no" responses both directly stated that the reason the respondents circled "no" is because Eric was in jail. The methamphetamine group comments placed next to "yes" responses indicate ambiguity counselors experienced in their response. One

comment in the methamphetamine group reflects counselor concern that, although Debby was in danger, she does not believe it. The counselor seems to be "teaching" Debby that she was in danger by providing a "yes" response. The second comment was directly related to methamphetamine use and appeared to indicate that the counselor would have circled "maybe" if it was an option. Including commentary on these dichotomous responses is not intended as a justification of an outcome counter to expectations. Rather, analyzing reasoning counselors present is consistent with content analysis informing results of many quantitative outcomes.

Expectation 4

Counselors who experienced the first impression that Debby was a victim of domestic violence should rate her less ready to change than counselors who experienced the first impression that she was having problem with methamphetamine.

Related theory. A predominant theme in contemporary discourse on domestic violence centers on societal latitude granted men in exerting power and control over women. Abused women often internalize male supremacy and learn that they control very little in their lives. In response to appropriate probes, Debby's asserted she only used because of Eric (i.e., he controlled this aspect of her life). With DV as a presenting problem, clinical questions should have included more emphasis on Debby's marriage, leading more often to knowledge of Eric's incarceration. With Eric's incarceration comes a decrease in his immediate control over Debby's use. Therefore, counselors should rate her less severely (i.e., more

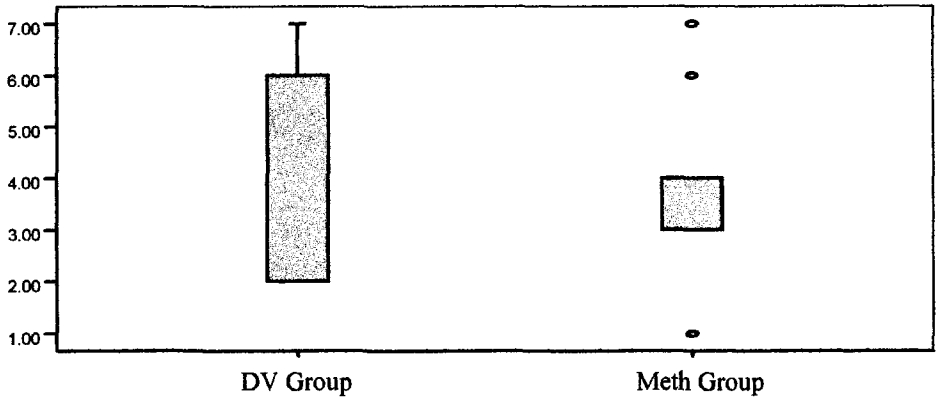
ready to change).

ASAM questionnaire item # 18. "Dimension 4: Readiness to Change." (Note: this and the following two items are prefaced on the post-interview questionnaire with directions stating, "Please rate the client on each of the following American Society for Addictions Medicine (ASAM) crosswalk dimensions.") The ASAM crosswalk is a multi-dimensional diagnostic tool. Clinicians assess clients on multiple dimensions with the end goal of an overall rating. Lower quantitative responses on this "readiness to change" item indicate a belief that Debby was not as ready to change as if she were rated with higher quantitative indicators.

Results. An independent sample t-test was conducted to examine the guiding expectation. The results were not significant, $t(16) = -.12$, $p = .46$, $d = -.03$. Scores for the two groups differed by .03 standard deviations. Although results were not significant and the differences were negligible, results trended in the expected direction. The DV group rated Debby as less ready to change ($M = 3.67$, $SD = 3.67$) than the methamphetamine group ($M = 3.78$, $SD = 3.78$). Providing a box plot (see Figure 3) of actual responses indicating Debby's readiness to change demonstrates that, although means between groups are VERY similar, scores in the methamphetamine group vary considerably while scores in the DV group hang closely together. One interpretation of this distribution of scores could include a more coherent perception of Debby in the DV group.

Figure 3

Counselor Indications of Debby's Readiness to Change.



*Note: The boxes contain 50% of the data. The upper edge indicates the 75th percentile and the lower edge indicates the 25th percentile. The end of the line for DV group indicates the maximum data value. The circles for the meth group indicate SPSS considers those values outliers.

Expectation 5

Counselors in the DV group would consider Debby at higher risk for relapse, continued use, or continued problem potential than the methamphetamine group.

Related theory. Methamphetamine is a powerful, highly addictive drug. However, Debby's scenario included her being "clean" for one week prior to the interview. This information should have provided a source of optimism that Debby could remain drug free. However, the DV group should have centered more on Eric's influence on Debby's use even though he was in prison. Further, the DV group should have expressed more concern about his influence on Debby's

continued use upon release from prison.

ASAM questionnaire item # 19. "Dimension 5: Relapse, Continued Use and/or Continued Problem Potential."

Results. An independent sample t-test was conducted to examine the guiding expectation. The results were not significant, $t(16) = .55$, $p = .59$, $d = .26$. Group scores differed by .26 standard deviation. Although results were not significant, the direction of the relationship between opening statement groups and level of concern for relapse was consistent with the research hypothesis. Counselors in the DV group rated Debby at higher risk for relapse, continued use and/or continued problem potential ($M = 4.33$, $SD = 1.80$) than counselors in the methamphetamine group ($M = 3.89$, $SD = 1.62$). However, in examining a stem and leaf plot (see Figure 4) evidence indicated that the distribution of scores was quite similar between groups.

Figure 4

Stem and Leaf Plot of Scores for Relapse, Continued Use and Problem Potential.

DV Group	*Meth Group*
3. 00000	1. 0
4. 0	2.
5.	3. 000
6. 0	4. 00
7. 00	5. 0
	6. 0

*Note: Numbers to the left are scores counselors indicated. Zeros are the number of counselors providing any particular score.

One score of "1" in the methamphetamine group accounted substantially for the lower overall mean score. The majority of scores in the methamphetamine group were similar to the DV group. Therefore, statements postulating meaning of descriptive differences between groups becomes non-instructive.

Expectation 6

Counselors in the DV group would rate Debby's recovery environment as more of a substantial problem (i.e., have placed her in a more severe category) than counselors in the methamphetamine group.

Related theory. Although Eric was in prison, the amount of time he would be there was unknown. If DV was asserted first and it should have established a direction for the interview. Therefore, counselors should have more often ascertained that Debby believed her drug use was due to her relationship with Eric.

As long as she stayed in the home shared with Eric, counselors will should have asserted that her recovery environment should change (reflected in a higher rating).

ASAM questionnaire item # 20. "Dimension 6: Recovery Environment."

Results. An independent sample t-test was conducted to examine the guiding expectation. The results were not significant, $t(16) = .40$, $p = .70$, $d = .18$. Groups scores differed by .18 standard deviation. Although results were not significant, the direction of the relationship between first impressions and recognition that Debby was not living in an environment conducive to recovery supported the expectation. The DV group rated Debby's recovery environment as more impaired ($M = 4.44$, $SD = 1.74$) than the methamphetamine group ($M = 4.11$, $SD = 1.83$).

Although topic block two is characterized by non-significant p-values, relationships between presenting problem groups and specific items on the outcome measure followed the expected direction in most instances. Compared to the methamphetamine group, the DV group rated Debby lower on the global assessment of functioning scale, less ready to change, at higher risk for relapse, and as living in a less conducive environment for recovery. Two relationships between presenting problem group and outcomes ran counter to hypothesized directions – Debby's risk for hurting other people and an assessment of whether or not Debby was in physical danger.

Interpretation. Interestingly, Debby's risk for hurting other people was also characterized by a moderate effect size, substantially larger than all other effect

sizes in this topic block. Recall that for this item, the DV group rated Debby as at higher risk for hurting other people than the methamphetamine group. There was a .75 difference in standard deviation between the two groups. Increasing the sample size by 26 people would produce a significant .05 p-value for this item. One explanation includes a belief by both groups that Debby really does "hit him too," a statement she was instructed to assert indicating denial of her dilemma. Another unexpected outcome for this topic block included that two of nine counselors from the methamphetamine group and zero from the DV group rated Debby as in physical danger. In the context of the DV group asserting Debby was actually the one who was at risk for hurting other people, this outcome fits from a conceptual point of view. If perceptions included Debby as the one hurting others, it follows that she was not in as much physical danger. Finally, the DV group rated Debby as less ready to change. This directional relationship was expected. Interestingly, the relationship was not supported in the first question of topic block three assessing where Debby is at on the Transtheoretical Model of Change (e.g., Prochaska & DiClemente, 1992), an assessment tool designed specifically to assess her level of motivation.

Topic Block Three: Stage of Change

Expectation 1

Domestic violence first impression would be related to counselors rating Debby as less ready to engage the recovery process than the methamphetamine first

impression. Explanations for these ratings should have included stronger emphasis on interpersonal conflict in the DV group than the methamphetamine group.

Related theory. Counselors guided by the methamphetamine presenting problem should have emphasized Debby's 7 day abstinence prior to the interview, considering it evidence of her readiness to change. Alternatively, if DV guided interpretations of subsequent information about Debby, Eric should have been viewed as a substantial reason for her use and his level of involvement in her life after he got out of jail was unknown. Debby's related assertions that Eric would change upon release from prison should have casted doubt on her readiness to change.

Questionnaire item # 24. "Where is the client at in the Transtheoretical Model of Change Process (Prochaska & DiClemente, 1983)?"

Results. Responses to this item ranged from "a) precontemplation" to "e) maintenance" with one additional option "f) I don't know what (it) is." An independent sample t-test was conducted to examine the guiding expectation. The results were not significant, $t(16) = -.27$, $p = .79$, $d = .15$. Group scores differed by .15 standard deviation. Although the results were not significant, the direction of the relationship between first impression and placement on the model of change occured as expected. Counselors in the DV group rated Debby as less ready to change ($M = 2.44$, $SD = .73$) than counselors in the methamphetamine group ($M = 2.56$, $SD = 1.01$). Debby's affect and statements regarding motivation for recovery were as similar as possible between counselors. This small difference between

groups for this item was, therefore, not surprising. Qualitative responses to the following questionnaire items were expected to yield more illustrative results.

Questionnaire item # 25. "What led you to this conclusion?"

Results. Content analysis results for this item are categorized by opening statement and reported stage of change. Counselor identification numbers are provided following each item. Stage of change categories with no associated narrative indicate the placement only occurred in the alternative opening statement group. See Table 3 for complete content analytic results by presenting problem group.

Table 3

Content Analysis: Reasons for Placement on Transtheoretical Model of Change Process by Presenting Problem Group.

Placement	DV Presenting Problem	IDs	"Meth" Presenting Problem	IDs
Precontemplation	Wants kids back	81	Kids are her motivation	140
	Awareness of effects past may have on future is low (including good parenting	81	Wants to be a good mom	36
	Willing to participate in any treatment	81	Thoughts are about getting kids back	140
	Low awareness of addiction dependence	81	Entirely external motivation	36
			Required by DA to attend assessment	36
			Pleasant and cooperative	36
Contemplation	Do whatever it takes to get kids back	39	Will do whatever it takes	115
	Ambivalent toward treatment	39	Wants kids back	115
	Showed up for assessment	144		
	Aware of consequences of use	39		
	Considering abstinence	39		
	Open to discussing needing help/negligence	144		
Preparation	Motivated by kids	59,22,172,165,150,117	Wants kids back	95,70,20
	Admits to having problem	59,150,117	Will do whatever it takes general	95,76
	Needs skill for action stage	59,150	Wants old life back	76,95

Table 3 Continued

Content Analysis: Reasons for Placement on Transtheoretical Model of Change Process by Presenting Problem Group.

Placement	DV Presenting Problem	ID(s)	"Meth" Presenting Problem	ID(s)
Preparation	Abstinent for 5 days	22,150	Showed up for assessment	95
	Willing to start treatment	172,117	Has goals, GED, job	70
	Open to change	22	Willing to comply w/ required steps	70
	Has made changes	22	Open to suggestions	76
	Successful resistance to relapse	22	Wants to quit substances	52
	Precontemplation for smoking	165	Admits to problems w/ substances	52
	Precontemplation for underlying marital/DV issues	165	No drug use for one week	70,20
			Knows what she needs to do	52
			Awareness meth is responsible for loss of children, neglect	70
			No current plan of action	20
Action			Client report	170

This content analysis included two notable outcomes. First, in both groups, explanations for each distinct placement (other than action) included some or all aspects of Debby's asserted desire to "do what it takes to get her kids back."

Interpretation. Debby's retrieving her children dominated explanations of perceptions of Debby throughout the analysis. Debby's emphasis on wanting her children back from state custody operated in the precontemplation stage as an indicator of her *not being ready* to fully contemplate taking action toward recovery. Instead her desire to get her kids back was interpreted as too external a motivation to place her in the contemplating stage. Counselors who placed Debby in the contemplation stage used Debby's desire to get her kids back as an *indication of*

Debby's ambivalence about recovery. Finally, those counselors who placed her in the preparation stage, just one stage before action, also explained their decision by stating that Debby was motivated by getting her kids back. These multiple, and substantially different interpretations of the same recurring theme, point to variations in ways that individuals arranged their perceptions of others.

Asch (1946) concluded his publication of multiple experiments on perceptions of others by acknowledging how central characteristics both establish directions for interpretations of subsequent information, but also operate in a dynamic interaction with other characteristics. Recall that counselors in this study were provided a small piece of paper with a brief description of their client. This procedure is in keeping with realistic processes that occur prior to meeting a client for a substance abuse counseling session. That description was intentionally designed to be as neutral as possible. In particular, the note left open the possibilities for what Debby would assert as her interpretation of why she was at the assessment interview. The note included her age, employment status, marriage status, maternal status, and that her two children had been taken into state custody. Finally, the brief explanation stated that the district attorney recommended she attend the assessment interview. Counselors did not know why Debby's children were taken, whether she wanted them back, or her reason for attending the interview. Given the outcome of the content analysis, results pointed to Debby's maternal status as a central characteristic, guiding interpretations of subsequent

information. Regardless of whether counselors thought Debby was ready to change, they implemented the explanation that she wanted her children back.

First impressions also appeared to function as central characteristics – albeit more subtle – and operating in a dynamic interaction with Debby's maternal status. In the precontemplation and contemplation stages the emphasis on maternal status as an explanatory theme operated quite similarly for both first impression groups. For counselors who rated Debby in the preparation stage, explanations for that decision began to diverge, depending on the presenting problem. For the DV group all six counselors (100%) included her motivation to "get her kids back" as one explanation. For the methamphetamine group three counselors out of six (50%) who rated Debby in preparation included Debby's desire to get her kids back as explanation. Six total counselors from each group of nine rated Debby as in the preparation stage of change. A unanimously stated explanation from the DV group included Debby's children. Half of the methamphetamine group included Debby's children as an explanation/statement. In addition, the DV group included seven additional explanations and the methamphetamine group included twelve additional explanations/statements. The DV group more frequently reported the children as a key reason Debby was in the preparation stage and reported fewer additional explanations. This trend suggested maternal status and domestic fighting as presenting problems may have interacted resulting in a stronger emphasis on maternal status as indicating readiness to change.

These results did not lend support for the expectation that the DV group would consider Debby less ready to change and that associated discussion would emphasize domestic conflict. However, the theme of Debby as a mother whose children had been forcefully taken from her more substantially dominated discussions of her readiness, particularly in the domestic violence group.

Topic Block Five: Barriers and Goals

Expectation 1

The DV group should have reported barriers to recovery related to domestic conflict more frequently than those who experienced methamphetamine as a presenting problem.

Related theory. Presenting problem groups differed on responses acknowledging Debby's domestic scenario as problematic to her recovery. This indicated discrepant perceptual paths counselors may have been engaging. If one group interpreted Debby's story through a DV lens and one group through a methamphetamine addiction lens alone, related perceived barriers should have applied. Further, treatment goals should have reflected relational steps in the DV group and more strictly substance recovery steps in the methamphetamine group.

Questionnaire item # 28. "Given this client's overall clinical picture, what are his/her barriers to recovery?"

Results. Content analysis results for this item are categorized by presenting problem and reported stage of change. Counselor identification numbers are provided following each item. Stage of change categories with no associated

narrative indicate the placement only occurred in the alternative opening statement group. Organizing reported barriers to recovery according to associated stage of change allows drawing direct connections between how motivated a counselor believes Debby to be as well as how that translates to barriers. See Table 4 for complete content analytic results by presenting problem group.

Table 4

Content Analysis: Barriers to Recovery by Presenting Problem Group.

Placement	DV Presenting Problem	ID(s)	"Meth" Presenting Problem	ID (s)
Precontemplation	Love for husband	81	Husband's continued use	140
	Husband's recovery uncertain	81	Lack of support, needs husband & children	36
	Influenced by husband	81	Husband's in prison	140
	Desire to keep family together	81	Never experienced another way to live	36
			Her mood	140
			Needs parenting skills	36
			Unemployment/money	136,140
			Housing	36
			Needs medical care	36
Contemplation	DV charges	39	Fighting w/ partner	115
	Legal issues	39	Living environment	115
	Co-dependency	144	Support	115
	Lack of support	39	Using patterns	115
	Housing	39		
	Transportation	39		
	Employment	39		
	Depressive disorder	144		
Preparation	Husband still using	165	Husband's continuing to use, general	70,52,20
	Husband still abusive	165	Economically dependent on husband	20
	Continued involvement w/ husband	117	Single parent for now	76
	Husband uses & deals	59,150	Lack of support	76,20
	Husband's release from prison	59	Lack of parenting skills	70
	Social environment, husband's continued use	22	Low mood w/out kids	95
	Husband primary support	150	Lack of interests or goals	20
	Feels like between mom & husband	159	Employment	95
	Living environment	59,150	Money	95
	Lack of support	59,165	Transportation	95

Table 4 Continued

Content Analysis: Barriers to Recovery by Presenting Problem Group.

Placement	DV Presenting Problem	ID(s)	"Meth" Presenting Problem	ID(s)
Preparation	Toileting issues w/ daughter	165	Housing	76
	May be staying clean only for legal obligations	117		
	Employment	122,165		
	Financial problems	165		
	Needs medical care	117		
	Needs life skills	22		
Action			Husband's continued use	170

Content analysis of Debby's barriers to recovery clearly supported the expectation that those from the DV group would emphasize problems associated with domestic violence more than those from the methamphetamine group. Across all stages of change, the DV group reported 15 statements (54% of total statements) directly related to Debby's husband's presence or possible presence as a barrier to recovery. The methamphetamine group reported six statements (22% of total statements) directly related to the problematic nature of Debby's husband's presence or possible presence. Within the preparation stage of change, the DV group reported nine statements (45% of 20 preparation statements) indicative of concern that Debby's husband's presence would hinder her recovery process. Within the preparation stage of change, the methamphetamine group reported four statements (25% of 16 preparation statements) indicative of concern that Debby's

husband's presence would hinder her recovery process. Five of seven total DV group counselors (71%) reporting on the preparation stage included statements relaying concern about Debby's husband hindering her recovery. Seven counselors constitute 78% of the total sample for the DV group. Three of five total methamphetamine group counselors (60%) reporting on the preparation stage included statements relaying concern that Debby's husband's presence would hinder recovery progress. Three counselors constitute 33% of the total sample for the methamphetamine group. All quantitative indicators provided evidence that the DV group did make use of Debby's domestic conflict(s) in interpreting barriers for Debby's recovery process. Finally, the statements "lack of support...needs children...needs husband," "husband's in prison," and "single parent for now" from the methamphetamine group were excluded from the total DV statement frequency count because they indicated counselors' belief that Debby's husband's presence *would be helpful.*

Expectation 2

In listing the client's goals toward recovery, the DV group would include more statements related to improving her domestic scenario than the methamphetamine group.

Questionnaire item # 29. "What is/are the treatment goal(s) for this client?"

Results. Responses to this item are categorized by presenting problem. Counselor identification numbers are provided following each item. Note, that responses to this item indicated that some counselors interpreted the question to

mean "what does the client see as the treatment goals" while others interpreted it to mean "what do you – the counselor – see at the treatment goals." These were not entirely polarized interpretations given that counselor treatment goals should have been related to the client's reported goals. See Table 5 for complete content analytic results by group.

Table 5

Content Analysis: Treatment Goals for SP Presenting Problem Group.

DV Presenting Problem	*"Meth Presenting Problem*
Get kids back (81) (59) (172) (150)	SCF requirements (95) (76)
Abstinence (81) (59) (165) (150)	(70) (52) (36) (170) (140)
Employment (39) (172) (165) (150)	Employment (95) (76) (52) (170)
(140)	
Parenting classes (39) (165) (117)	Abstinence (70) (52) (140)
Psychiatric assessment (39) (144) (117)	Gaining support
Develop non-using social support (22) (172) (165)	(95) (52) (20)
Discover triggers (22) (117)	Couples counseling…family issues
Relapse prevention (39) (117)	(170) (115)
Family therapy (39) (172)	Identify what chemical does for
her…	
Couples therapy (39) (144)	address substance use (76) (170)
Self-esteem (81)	12-step meetings (95) (20)
Self-confidence (81)	Get husband back (36)
Her needs (81)	Parenting classes (115)
Increase motivation (39)	Be proactive in treatment (95)
Talk to husband (59)	Contact case worker (95)
Develop relationship with husband (165)	Housing (76)
Leave husband if he won't do treatment (165)	Pay bills (52)
Contact support options (59)	Inpatient/outpatient treatment (20)
12-step meeting (59)	Increase sense of self (20)
DHS requirements (39)	Alcohol and drug education (115)
Drug & alcohol education (39)	DV education (115)
Learn problem solving strategies (22)	Living skills (115)
GED (150)	Self-esteem building (115)
Complete legal obligations (117)	

A predominate qualitative theme emerged in the methamphetamine group -- that a treatment goal for Debby was getting her kids back. Seven counselors in the

methamphetamine group (78%) reported this goal. Four counselors in the DV group (44%) reported this goal $\chi^2(1, N = 18) = 2.10, p = .147$. Five counselors in the DV group (56%) reported goals related to Debby's husband while three counselors in the methamphetamine group (33%) mentioned husband related goals. Finally, three counselors in the DV group (33%) reported getting a "psychiatric assessment" as a goal. This goal was not listed in the methamphetamine group.

Interpretation. The decision to collapse "get children back" with "satisfy Services for Children and Families requirements" was based on the latter needing to occur before Debby could get her children back. The substantial presence of this goal in the methamphetamine group appeared initially counterintuitive to the finding that the DV group included Debby's desire to get her kids back as a substantial justification for placing her in the preparation stage of change category. Thus far, the DV counselors' perceptions appeared to include that the children served as a strong motivator for Debby, thus justifying placement in a more advanced stage of change. Yet, compared to the methamphetamine group, counselors in the DV group did not report that getting the kids back should necessarily be a treatment goal for Debby. It appears that sources of motivation and courses of action operated somewhat distinctly in the perception formation process. While the children may motivate Debby, the DV group did not weave that aspect of her story in to her future tasks as much as the methamphetamine group.

Goals related to Debby's husband did appear more frequently in the DV group. However, a more pronounced difference between groups involved

psychiatric assessment in the DV group and no associated commentary in the methamphetamine group. This finding related to the DV group diagnosing Debby with co-occurring disorders related to mental health more frequently than the methamphetamine group. Together, both encouraging psychiatric assessment and more frequently diagnosing psychiatric co-occurring problems in the DV group supported a trend in perception formation processes.

Expectation 3

In listing the order of priority for Debby's treatment goals, the DV group would include more domestic reparative comments (i.e., partner related, parenting related, housing for children related) and more mental health related comments than the methamphetamine group and those comments would appear higher on the priority list.

Questionnaire item # 30. "Please list, in order of priority, the necessary steps that would be included in achieving your treatment goal(s) with "1" being the highest and "5" being the lowest.

Results. Results of the content analysis for this item include reporting items by opening statement and related to DV, children or mental health – three themes previously identified – as well as arranging items listed in order of priority for each group. Counselor identification numbers are provided following each item. See Table 6 for complete content analytic results by group.

Table 6

Content Analysis: Treatment Goals for SP in General & in Order of Priority by Presenting Problem Group.

DV Presenting Problem	*"Meth" Presenting Problem*
Safety...ensure husband is not a threat (39)	Contact SCF & caseworker (95) (76)
Plan to stay clean when husband returns (59) (36)	Secure housing...self and children
Identify relapse patterns & influences (150) (117)	Mental health evaluation (140)
Explore relationship with drugs and other people (81)	Address family issues (170)
Explore family history, patterns of relationships (81)	Satisfy DA & DHS (36)
Couples counseling (165) (144)	DV education (115)
Family therapy (172)	Parenting classes (140) (115)
Reunite w/ family (172)	Reunite family w/ supervision (136)
Parenting classes (144) (165)	Get kids back (52)
Identify requirements from caseworker (150)	Esteem issues (20)
DHS requirements (39)	Family counseling w/ kids (115)
Address self-esteem, self-confidence, her needs, happiness (81)	
Accept self and let go (81)	
Mental health counseling (144) (39) (117)	

Prioritized	*Prioritized*
1. Safety...ensure husband is not a threat (39) Identify requirements from caseworker (150)	1. Secure housing (36) Contact SCF, caseworker (95) (76) Mental health evaluation (140)
2. Family therapy (172) Couples counseling (165) Identify relapse patterns & influences (150) (117) Address self-esteem, self-confidence, her needs, happiness (81) Mental health counseling (144)	2. Address family issues (170)
3. Couples counseling (144) Explore relationship with drugs and other people (81) Parenting classes (165)	3. Get kids back (52) Family counseling w/ kids (115) Esteem issues (20)
4. Plan to stay clean when husband returns (59) Accept self and let go (81) Psychiatric assessment (39)	4. Reunite family w/ supervision (36) Parenting classes (115)
5. Explore family history, patterns of relationships (81) DHS requirements (39) Reunite w/ family (172) Mental health evaluation (117)	5. Get kids back (52) Family counseling w/ kids (115) Esteem issues (20)

Expectations for this item were partially met. The DV group included 11 goals and the methamphetamine group included nine goals related to domestic experiences. In the DV group those 11 goals accounted for 31% of total goals and for the methamphetamine group the nine goals accounted for 28% of total goals. The DV group did report more domestically related goals and those goals accounted for more of the overall percentage of goals listed.

Both groups prioritized dealing with domestic problems, yet related treatment goals also appeared in all priority options. Both presenting problem groups prioritize included domestic comments in all five priority categories. For priority number one, one counselor from the DV group identified dealing with the husband as a goal and one identified a child related goal. No counselors from the methamphetamine group identified husband related items as first priority. Instead, three of four counselors from the methamphetamine group reported child related items as first priority. For priority number two, four of five counselors from the DV group reported relationship related items as goals. The only reported second priority goal from the methamphetamine group was relationship related. If analysis stopped at priority number two, the counselors from the DV group listed seven total goals and the counselors from the methamphetamine group listed four goals. Eight counselors from the DV group were responsible for listing those seven goals (for one goal two counselors agreed). Four counselors from the methamphetamine

group account for four responses. To conclude, in the first two priority slots, the DV group included more counselors responding with more domestically related goals than the methamphetamine group. All responses not domestically related were mental health related.

Interpretation. The numbers reflecting differing content and prioritization of goals between groups were not so distinct that asserting a trend or theme was appropriate. However, the overall results for analysis of prioritization of treatment goals yielded information consistent with the expectation that the DV group would emphasize domestic goals more than the methamphetamine group and place them higher on the priority scale.

Expectation 4

The DV group would rate Debby's chances of recovery as less hopeful than the methamphetamine group.

Related theory. The complexity of Debby's domestic scenario along with negative effects DV holds for victims should have informed a less hopeful outlook for counselors in the DV group. In addition, the power and control discourse associated with DV should have contributed to conclusions by counselors from the DV group that Debby had less control over her scenario, making them less hopeful.

Questionnaire item # 31. "How hopeful do you feel about this client's chances of recovery (i.e., their prognosis)?"

Results. Responses to this item ranged from "very hopeful" to "very unhopeful." An independent sample t-test was conducted to examine the guiding

expectation. The results were not significant, $t(16) = 0.00$, $p = 1$, $d = 0.00$. Identical scores ($M_{DV} = 1.67$, $SD = .5$; $M_m = 1.67$, $SD = .5$) characterized both groups. Both the DV group and the methamphetamine group included three scores for "very hopeful" and six scores for "hopeful." Content analysis of the follow up question revealed possibilities for the similarity of scores.

Expectation 5

The original expectation was that the DV group would include more domestically related comments supporting their less hopeful response to item number 31. Even taking into consideration the identical nature of responses between groups, the expectation remained that the DV group would report more DV related comments.

Questionnaire item # 32. "What led you to this conclusion?"

Results. Content analysis for this question is reported by opening statement and a) how hopeful the counselors were for Debby's recovery and b) Debby's reported stage of change. Counselor identification numbers are provided following each item. See table 7 for complete content analytic results.

Table 7

Content Analysis: Reasons for Level of Hopefulness Ratings for SP Recovery by Presenting Problem Group.

Hopefulness Rating/Placement	**DV Presenting Problem**	**ID(s)**	**"Meth" Presenting Problem**	**ID(s)**
Very hopeful/Precontemplation			Short duration of use	140
			Life style must change	140
Hopeful/Precontemplation	Values children	81	Have to be hopeful	36
	W/ resources can get children	81	Debby is naïve	36
			Wants to be a better mom	36
			Open to getting better	36
			Not a train wreck	36
Very hopeful/Contemplation	Attachment to children	39		
	Awareness of consequences	39		
	Short duration of use	144		
	Willing to go through treatment	39		
	Mother will support	39		
Hopeful/Contemplation	Insight into problems	144	Admitted to progression of drug use	115
	Short duration of use	144		
	Treatment availability is a factor	144		
Very hopeful/Preparation	Motivated by valuing children	59,22,172,150	Desire to get kids back	70
	Has support	59,22,172	Motivated by involvement of law	70
	Acknowledges neglect of children	150	Sincere desire to change	70
	Always hopeful	22	High motivation	76

Table 7 Continued

Content Analysis: Reasons for Level of Hopefulness Ratings for SP Recovery by Presenting Problem Group.

Hopefulness Rating/Placement	DV Presenting Problem	ID(s)	"Meth" Presenting Problem	ID(s)
Very hopeful/Preparation	Honesty	59	Intelligent	76
	Determination	59		
	Mother will take children in	59		
	Open to suggestions	59		
	Counselor anticipates follow through on treatment plan	59		
	Admits to problem	172		
	Fear around arrest	172		
Hopeful/Preparation	Highly motivated	165,117	Wants kids back	52,20
	Short duration of use	117	Admits to problems w/ substances	52,170
	Open to new ideas	165	Motivated today	95
	Yet, lack of effort in quitting	165	Has support	52
	Naïve to difficulties in maintaining abstienence	165	Yet, in abusive relationship	52
			Yet, poor recovery environment	20
			Motivation	170
Hopeful/Action			Admits to problems w/ substances	170
			Motivation	170

The two most noticeable trends between the two groups included, 1) the brevity and reduced number of distinct responses in the methamphetamine group compared to more elaborative and higher number of distinct comments in the DV group, and 2) the lower percentage of negative (e.g., Debby is naive) comments in the DV group (8% of 25) compared to a higher rate of negative comments (27% of 22) in the methamphetamine group. Both groups contained one non-committal

comment. However, the DV group comment, "always hopeful" imparted a decidedly more positive tone than the methamphetamine comment, "have to be hopeful." Again, both groups emphasized Debby's motivation to get her kids back as support for their level of hopefulness.

Interpretation. This final content analytic component of phase one pointed to more quantity and more complexity of thought emerging from the DV group than the methamphetamine group. In addition, the trend re-emerged in which comments from the DV group reflected an emphasis on psychological factors informing their perception of Debby.

Chapter Five

Summary: Phase One

See Appendix F for a summary of t-test and Chi-Square results from phase one. Narrative summaries of key analytic findings follow.

- Although t-tests did not reveal a significant difference between groups in rates of detecting co-occurring disorders, relationships were generally consistent with expectations. The DV group detected co-occurring disorders more frequently by the extremely small margin of one counselor.
- In examining labels applied to co-occurring disorders, the first qualitative finding emerged, counselors from the DV group predominately reported mental health diagnoses (e.g., depression) while the methamphetamine group predominately reported environmental circumstances.
- Examining responses to what led counselors to diagnostic conclusions demonstrates a trend toward inferences into Debby's psychology in the DV group and focusing on external circumstances in the methamphetamine group.
- Examining modes rather than significance levels reveals that the DV group more frequently rated Debby as more impaired on the Global Assessment of Functioning Scale.
- Unexpectedly, counselors from the DV group rated Debby as more likely to hurt other people than did counselors from the methamphetamine group.

Although, results were not significant an effect size of .75 indicates that only 28 more people would be needed to establish a p value of .05. This outcome item, therefore, may be important to examine in future studies.

- Unexpectedly, two counselors from the methamphetamine group rated Debby as in physical danger compared to zero from the DV group.
- In considering Debby's readiness to change, counselors in the DV group scored Debby similarly, scores from counselors from the methamphetamine group varied more substantially.
- Most counselors in both groups rated Debby as in the preparation stage of change, the stage directly before action.
- In analyzing *why* counselors from each group placed Debby in certain stage of change categories, the second qualitative theme emerged – the emphasis on the removal of Debby's children as an interpretive lens regardless of the stage of change. Within the preparation category the additional theme included counselors from the DV group unanimously reporting Debby's children as a reason for placing her in that stage.
- Counselors from the DV group recognized DV related barriers to Debby's recovery in substantial quantity compared to counselors from the methamphetamine group.
- In examining goals counselors assert for Debby, an interesting trend emerged. Counselors from the methamphetamine group identified "getting

her kids back" as a goal more frequently than counselors from the DV group.

- Both groups rated their hopefulness toward Debby's recovery identically.
- In looking at why counselors placed Debby in different stages of change and associated hopefulness categories, the theme of the counselors from the DV group emphasizing Debby's psychology re-emerged.

Retracing findings from phase one allows an entry point into a key theoretical task addressed in phase two – establishing a connection between trends that emerged in phase one and their relationship with "cold" versus "warm" receptions to Debby.

Chapter Six

Phase Two: Analytic Method and Analytic Results

Phase Two: Analytic Method

Solomon Asch's (1946) findings included that the terms warm and cold, when inserted with other characteristics of a person, substantially altered perceptual outcomes. This dissertation makes the case that domestic violence discourse elicits warmer (i.e., sympathetic) responses from others and that methamphetamine addiction elicits generally colder (i.e., judgmental) responses from others. The goal of phase two included ascertaining counselors' receptions to Debby as either warm, cold, neutral or ambivalent in an effort to substantiate (or not) how respective presenting problems may have the same effect as actually inserting the terms cold or warm in a written list of characteristics. In this phase of data analysis two mental health clinicians outside the dissertation committee and one practitioner within the committee with experience in clinical assessment conducted blind ratings of the post-interview questionnaires.

Clinicians are particularly familiar with the discourse of case reports. The reports communicate information between clinicians. The reports also communicate unspoken aspects of clinical perceptions toward clients. From a psychoanalytic perspective, in particular, clinicians are specifically trained to recognize their emotional involvement in therapeutic interactions. Referred to within psychoanalysis as countertransference, recognizing this process of emotionally reacting to clients is integrated into many other forms of clinical

assessment as well. For example the 16PF personality test (16PF Fifth Edition, 1994) is used clinically to gauge a client on a variety of personality dimensions including "warmth."

Instructions to raters included reading the documents as case reports (see Appendix G). Clinicians were asked to rate the substance abuse counselors' receptions to Debby as either, "warm," "cold," "neutral," or "ambivalent." As a quality control step and in order to better assess convergent validity, Dr. Janice Haaken, the chair of the dissertation committee and clinical psychologist, conducted a blind rating of the documents identical to how the other two clinicians were instructed to proceed. At the stage of the research project when Dr. Haaken conducted her blind ratings, she had the same information about the questionnaires as did the two clinicians outside the dissertation committee. Tables 8, 9, 10 and 11 report on results of the blind ratings organized by presenting problems provided by the standardized patient. Items in parentheses indicate counselor identification numbers. Follow up information by rating clinicians is provided following table results. This provides context for how the clinicians interpreted their rating criteria within the framework of general instructions.

Phase Two: Analytic Results

Table 8

Clinician One: Blind Rating of Substance Abuse Counselors' Receptions to "Debby" as Warm, Cold, Neutral or Ambivalent.

Clinician One	**DV Presenting Problem** **"Me and my husband have been fighting a lot lately and this last time the police came and they took my kids."**	**"Meth" Presenting Problem** **"I've been having some pretty bad problems with meth."**
Warm	5 (150) (39) (22) (81) (59)	2 (36) (70)
Neutral	0	0
Ambivalent	4 (117) (172) (165) (144)	3 (76) (140) (52)
Ambivalent/Cold	0	1 (170)
Cold	0	3 (20) (95) (115)

The emergent trends in ratings included, a) The majority of warm ratings occurred in the DV group (DV: n = 5 vs. Meth: n = 2) and b) The only ratings including "cold" occurred in the methamphetamine group (n = 4), $\chi^2 (1, N = 11) = 5.24, p < .05$. Differences in warm and cold ratings by group suggested that presenting problem group may have influenced warm and cold ratings.

Clinician one notes and commentary. The first clinician to rate the post-interview questionnaires provided detailed written notes following categorical

ratings of counselor receptions to the standardized patient. Table 9 provides rater rationale organized by presenting problem and specific rating.

Table 9

Clinician One: Qualitative Indicators of Rating Rationale

DV Presenting Problem: Warm Rating Rationale

- Recognizes contributions of client's environment (e.g., lack of support) vs. client seen as pathological
- Uses "skills" in referring to client's needs - client is seen as capable of learning skills (hope) (both the former and latter de-pathologize client
- Client has been "unsuccessful" rather than resistant or failing (in trying to quit meth)
- Low risk factors
- Statement indicating how client "feels" suggests clinician empathy
- Clinician hopeful about chances of recovery
- States positive traits of client – honesty, determination, love for her children, willing to follow directions
- Despite low awareness of addiction clinician perceives clients "wants" her kids vs. just trying to get them back
- Addresses client's self esteem and self confidence and desire as clinician to support client's goal.
- Points to children as assets in recovery, client values kids
- Client is reported as open, already made changes, acknowledges wants to relapse but is fighting it
- Clinician is always hopeful about client recovery
- Open to further assessment of client
- Open to multiple causes of presenting issues including history
- Picks up on client's ambivalence – the client is not seen as completely resistant
- Notes safety as a top priority-shows concern for client
- Client is motivated, has awareness, recognizes use is out of control

DV Presenting Problem: <u>Ambivalent</u> Rating Rationale

- Not much detail given to presenting information on client, hard to tell what specifics were tuned into (e.g., depressive disorder is potentially there, but why?)
- Neutral responses
- Hard to say what end conclusion is to treatment plan
- Had enough time with client yet needs more of a relationship to do full diagnostic assessment? This is mixed message to rater.
- "None," barriers to recovery – hmm, not sure if knows difficulty of addiction and, at the same time, tuned into client's experience of depression and client's "willingness to admit to problems."
- Patient willing to do...yet clinician questions motivations of client
- States client may be completing treatment to complete legal obligations, yet this treatment goal is lower on the priority list.
- Notes there is "more" to client to find out through queries, implies not sure has the whole story.

Methamphetamine Presenting Problem: <u>Warm</u> Rating Rationale

- High Global Assessment of Functioning Scores...implies hopeful about client's getting improvements in treatment, is already on a good track, not seen as so pathological.
- Client has awareness
- Client willing to comply
- Client seems sincere
- Expansive description of problems – doesn't simplify the complex issues regarding substance abuse.
- Concerned that labels may follow client (i.e., pathological labels)
- Recognizes danger if husband continues to use

Methamphetamine Presenting Problem: <u>Cold</u> Rating Rationale

- Client motivated by "threat"
- Blaming tone toward client not having "constructive interests."
- In patient treatment – top priority
- Only 3 treatment goals in complex case – yet sees substance use impairing all aspects of client's life
- Missing answers to items "how tuned into client is clinician"

- Infers client is motivated "today," no comments on general state of motivation
- Poor simulation rating for SP
- Placed client at contemplation stage/client seems hesitant to counselor
- Emphasis on client needing education/implies client insight is low
- Considers client depressed but not addressed in treatment

Methamphetamine Presenting Problem: <u>Ambivalent</u> Rating Rationale

- Client faulted for many problems, even disputes with her husband, low GAF score, client not noting that she is in danger, yet positive toned comments, neutral about simulation
- "admitted to marijuana use" (implies she was hiding something, sees SP as in precontemplation stage, clinician is very hopeful, yet prioritizes residential treatment? Overall mixed messages.
- Not much info on what or why client reported, what husband decides to do = barrier to client (does she have decisions/choices/power?) Note: this commentary is related to her ambivalent/cold rating.
- Client is hesitant, minimizes her part in chemical experiences (implies client is not insightful to some degree...e.g., "mom not as supportive as she thinks"), yet client has high motivation and intelligence.

Table 10

Clinician Two: Blind Rating of Substance Abuse Counselors' Receptions to "Debby" as Warm, Cold, Neutral or Ambivalent.

Clinician Two	**DV Presenting Problem** **"Me and my husband have been fighting a lot lately and this last time the police came and they took my kids."**	**"Meth" Presenting Problem** **"I've been having some pretty bad problems with meth."**
Warm	3 (59) (165) (150)	2 (52) (76)
Warm/Neutral	2 (117) (172)	2 (95) (36)
Neutral	2 (22) (144)	3 (115) (70) (170)
Ambivalent	2 (81) (39)	1 (20)
Cold/Neutral	0	1 (140)
Cold	0	0

Clinician two ratings trended in the same direction as clinician one, albeit less severely. The majority of ratings including "warm" occurred in the DV group (DV: n = 5 vs. Meth: n = 4). The only rating including "cold" occurred in the methamphetamine group (n = 1). Chi-square analysis was non-significant, χ^2 (1, N = 10) = 1.11, p = .292. "Clinician notes and commentary" illustrate reasoning for less extreme ratings from clinician two.

Clinician two notes and commentary. Unlike clinician one, this clinician chose to express strategy applied to the rating process through dialogue with the researcher rather than utilizing written notes. During a post-rating follow up by the researcher this clinician verbally expressed several subjective dilemmas she encountered during the rating process which led to a high number of "neutral" ratings. First, she indicated that she "didn't want to rate people as cold." She actively, therefore, avoided this rating. Further commentary included that the former reaction/decision was related to empathy toward colleagues' efforts to avoid assessing clients as cold. She would hope her receptions to clients would not be rated as cold and that desire was reflected in her ratings of other clinicians. Second, the clinician indicated that her first inclination was to provide a cold rating to those post-interview questionnaires in which counselors placed children related items as highest on Debby's priority list for treatment. The clinician stated that this approach to prioritizing Debby's treatment goals reflects counselors believing Debby was "telling (the counselors) what they wanted to hear." Further, that prioritizing children as Debby's first treatment goal reflected a belief that Debby is simply "jumping through hoops" and is only at the sessions "to get kids back." The clinician also expressed that counselors make a "serious mistake (if they) focus on anything external" in assessing priorities for Debby's recovery process. In this clinician's professional experience, emphasizing external factors as sources for substance use or as sources for recovery produces detrimental effects. Children, in particular, present many new and difficult challenges to a person in the early stages

of recovery. A final retrospective statement representing what this clinician *almost did* included providing a warm rating to those questionnaires in which counselors indicated Debby was in the beginning stages of change according to the ASAM dimensions. This behavior by counselors displays a connection with Debby beyond just what she states. That is, Debby appears quite motivated in the interviews, almost solely due to the desire to get her kids back. For counselors to recognize that Debby is actually not as ready for change as she asserts requires a willingness to develop a framework of Debby making use of multiple indicators, not just that "she'll do what it takes to get her kids back."

The choices this clinician *did make* suggest that, for her, "the bottom line" became the level of hopefulness counselors expressed for Debby's prognosis. Item 32, which asked counselors to reflect on their quantitative response to hopefulness for Debby's chance of recovery was, therefore, the deciding factor for this clinician's ratings. Those answers that included "a longing for a hopeful outcome" were rated more warmly than those that appeared less invested in Debby's prognosis. The clinician provided neutral ratings to those questionnaires in which counselors responded to items with a "straight forward approach (with) less emotional verbiage." The clinician rating the questionnaires expressed that, her best guess was that this neutral approach to assessing Debby may reflect more experienced counselors. More experienced counselors may be less prone to revealing their reception to the client in written form.

For comparative, illustrative purposes Table 11 includes ratings of counselors' receptions to Debby incorporating the post-rating concerns and criterion expressed by the second clinician. The table includes comparisons between the clinicians' original ratings and inferred ratings. For those questionnaires in which content did not lend itself to reinterpretation of ratings, the numbers remained the same. Importantly, the inferred ratings did not take into account subjective balancing that most likely occurred regardless of clinician criterion. The adapted rating strictly followed verbatim criterion the second clinician stated she would have utilized. These criterion only drew attention to two post-interview items – priority of Debby getting her kids back as a goal (priority one or two and that questionnaire received a cold rating) and Debby's readiness to change (ratings of category one or two (i.e., less ready to change) resulted in warm ratings.

Table 11

Clinician Two: Comparative Illustration of Original Ratings and Inferred Ratings of "Debby" as Warm, Cold, Neutral or Ambivalent.

Clinician Two	**DV** **"Me and my husband have been fighting a lot lately and this last time the police came and they took my kids."** Original Rating	**"Meth"** **"Me and my husband have been fighting a lot lately and this last time the police came and they took my kids."** Inferred Rating	**DV** **"I've been having some pretty bad problems with meth."** Original Rating	**"Meth"** **"I've been having some pretty bad problems with meth."** Inferred Rating
Warm	3 (59) (165) (150)	5 (59)(165) (144) (22) (81)	2 (52) (76)	3 (140) (170) (52)
Warm/Neutral	2 (117) (172)	2 (117)(172)	2 (95) (36)	1 (36)
Neutral	2 (22) (144)	0	3 (115) (70) (170)	4 (115)(70)
Ambivalent	2 (81) (39)	1 (39)	1 (20)	1 (20)
Cold/Neutral	0		1 (140)	
Cold	0	1 (150)	0	2 (95) (76)

Inferred ratings maintained trends consistent with clinician one. The majority of warm ratings occurred in the DV group (DV: n = 5 vs. Meth: n = 3).

The majority of cold ratings occurred in the methamphetamine group (Meth: n = 2 vs. DV: n = 1). Majority neutral ratings occurred in the methamphetamine group (Meth: n = 4 vs. DV: n = 0). Chi –square analysis results were non-significant, χ^2 $(1, N = 14) = .88, p = .38$.

Table 12

Committee Chair: Blind Rating of Substance Abuse Counselors' Receptions to "Debby" Warm, Cold, Neutral or Ambivalent.

Committee Chair	**DV Presenting Problem** **"Me and my husband have been fighting a lot lately and this last time the police came and they took my kids."**	**"Meth" Presenting Problem** **"I've been having some pretty bad problems with meth."**
Warm	5 (22) (39) (144) (150) (81)	2 (115) (36)
Warm/Neutral	0	2 (70)(20)
Neutral	3 (172) (165) (59)	2 (140) (52)
Ambivalent	0	0
Cold/Neutral	1 (117)	2 (170) (95)
Cold	0	1 (76)

Dr. Haaken had access to no more and no less information on each post-interview questionnaire in relation to presenting problem and/or counselor ID than the other two clinicians. Her ratings remained consistent with trends in previous

ratings. The predominant warm ratings occurred in the DV group of counselors (n = 5 vs. n = 2). The only cold rating occurred in the methamphetamine group of counselors. Chi-square analysis was non-significant, $\chi^2(1, N = 13) = 1.04, p = .31$.

Clinician three notes and commentary. Criteria enlisted to differentiate receptions to Debby by substance abuse counselors included the following: Warm ratings reflected a judgment that the substance abuse counselors ascertained and articulated a complex clinical picture, counselor comments focused on subjective experiences of the client, and indications that the counselor seemed ready to form a therapeutic alliance, or was ready to see the client as workable – had a desire to work with the client. Warm/neutral ratings typically included only two of the three criterion listed for a warm rating. Neutral ratings corresponded to case reports with little descriptive material, lists of symptoms rather than a clinical picture, lack of affective tone to descriptions and brief. Neutral/cold ratings occurred when case reports were brief and characterized by distancing language and qualifiers. The one report receiving a cold rating included comments oriented toward compliance with external requirements and minimal subjectivity.

Chapter Seven

Phase Three: Analytic Method and Analytic Results

Phase Three: Analytic Method

In constructing the analytic framework for this dissertation, reviewing a random sub-set of video-taped footage of counselor interactions with Debby yielded an interesting preliminary finding. Nodal points occurred in the interviews in which counselors verbally reported accounts of their perceptual processes to Debby. Further, statements reflecting these processes demonstrated counselors constructing an account of Debby beyond the clinical material presented. These were interpreted as sites of clinical storytelling – locations in the clinical interview where counselors were offering a view of perceptual processes involved in forming impressions of Debby.

Phase three involved conducting narrative analysis of transcribed nodal points in each interview with Debby. See Appendix H for complete transcriptions. Specific transcribed statements by counselors included those in which, through communication to Debby, counselors indicated they were actively processing her story, or forming a coherent impression of the client. Analytic processes reflect basic premises asserted in a *Listening Guide* (Gilligan, et al., 2003), the most predominate of which supports multiple readings of narrative material in order to build layers of interpretation based on recognizing various perspectives operating in the narrative.

Returning to a core tenant of discourse analysis (e.g., Potter & Wetherell, 1995), the approach to this narrative analysis included paying close attention to *how* these interviews unfolded, what story was being told and then providing examples of what people actually said supporting interpretations of the discourse. Discourse analytic approaches to narrative material assume that what people say truly reflects their psychology, specific to this study, the psychology of developing perceptions of Debby. This is as opposed to coding word for word, which can have the effect of removing the words from their contextual meaning. The discursive approach to interpreting clinician processes of impression formation used in this dissertation produced several relevant themes that merged appropriately with findings in phase one and two.

Phase Three: Analytic Results

Reading one. The initial reading of transcribed interviews included paying close attention to how perceptions of Debby's story reflected (or not) a typical story line where a plot developed and multiple "characters" became situated in particular contexts, taking on roles within the larger story. It became immediately apparent that, in both the DV and the methamphetamine conditions, the plot centered tightly on the removal of Debby's children. Clinicians cast Debby as the despondent and desperate mother willing to do "whatever it takes" to "get (her) kids back." The statements in quotations were included in Debby's script and instructions to the SP included that she should respond to any questions related to her motivations with those statements. This aspect of the standardized patient's scripted behavior

intentionally reflected "overkill." Debby asserted no additional goals, motivators, or introspective statements, with the intention of actually creating clinical doubts about her level of motivation and stage of change. However, as opposed to recognizing Debby's fixation on being reunited with her children as a signifier of low motivation, most counselors attached extreme salience to this part of Debby's story, allowing it to guide interpretations of most subsequent information. Not all counselors made use of separation from children in the same interpretive way. For instance, some emphasized the difficulties of mothering while others emphasized the positives. In either instance, almost all counselors attached extreme importance to Debby's maternal status.

The following excerpts illustrate the importance this aspect of Debby's held for counselors' interpretation of her larger story. The excerpts include content beginning mid-way through transcribed material for any given counselor. The mid-way mark was chosen because the interview had progressed to the point that counselors most likely had incorporated multiple pieces of information on Debby, yet had not concluded the impression formation process. Counselor ID's allow for connections between asserted stage of change, reception ratings and interpretive comments centering on children. One example related to each stage of change and divided by presenting problem illustrates how the children operated differently yet centrally for counselors who interpret Debby as more or less ready for change. Including three ratings of the particular counselor's reception to Debby provides context and illustrates interpretations of children as a main theme within warm vs.

cold receptions to Debby. Quotations do not necessarily reflect statements made consecutively in the transcriptions. However, the direction always follows in congruence with the transcribed material.

The following excerpts were taken from transcriptions of counselor 81 from the DV group and whose reception to Debby was rated, warm, ambivalent and warm. This counselor placed Debby in the "precontemplation" stage of change. Items in parentheses provide context for counselor quotations. For complete transcriptions see Appendix H.

> "How do you think the situation will (work with) your goal, which is to get your kids back" (when Eric gets out of jail)?
>
> "Oh, I see you have some support..."(Debby has stated that she thinks her mom will help with the kids if she knew Debby was getting help).
>
> "So, she's (Debby's mom) concerned about your life and her grandkids, which are your children...that's great."
>
> "So, you have someone to talk to and what you need to do to get your kids back..." (Counselor is referring to Debby needing to contact the DA).

"Sounds like you really love your kids" (Debby has just stated again that she will do whatever it takes to get her kids back).

"His (Eric's) stress is influencing you to ... and eventually now your kids are taken away from you..."

These excerpts demonstrate how Debby's relationship to her mother, her mother's feelings, Debby's level of love for her children, and reasons for separation from the children all hinged on the counselor incorporating the removal of the children as a central characteristic guiding interpretations of subsequent information. In reality, Debby had no reason to believe that her mother woul help her once she entered a program, although she presented with hope on that topic. Debby's mom in the scripted narrative had actually severed ties with her in the two weeks prior to interviews due to believing Debby was neglecting the children. Debby dod not use the word "love" in relation to her children. The statement that she would do what it takes to get them back was consistently interpreted as an indicator of strong love for the children. Finally, Eric was influencing Debby. However, he influenced her most through verbal and physical violence, the true antecedents to her children's removal.

The following excerpts were taken from transcriptions of counselor 22 from the DV group and whose reception to Debby was rated warm, neutral, and warm. This counselor placed Debby in the "contemplation" stage of change. Items in

parentheses provide context for quotations. For complete transcriptions see Appendix H.

"So, it sounds like your kids are a really important motivating factor for you to stop using. At least they have been for five days."

"Wow, it's gotta be hard to be with the kids all day. They pretty well behaved? That makes it easier."

"I know sometimes with DHS if the other person in the house is still using or whatever that's a condition of it (getting kids back)."

"Let's say you get your kids back and you're looking for a job" (how are you going to stay clean?)

"Sounds like this has been a pretty big motivator, pretty big wake up. That's hard. It's hard to be separated from your kids."

"So when they said the kids had been neglected what were they talking about?"

"So, if the house was dirty and they found gear, what do you think they're going to ask for you to keep your kids if those were signs of neglect?"

This counselor utilized Debby's maternal status to interpret motivation for abstinence in the last five days, stressors for Debby, and most of all a clear sense of concern about Debby's maternal abilities. While the previous use of the children as central do Debby's story painted a more positive picture, the "what ifs" in this narrative indicated a less positive projection of Debby's future, albeit within a higher noted readiness to change.

The following excerpts were taken from transcriptions of counselor 117 from the DV group and whose reception to Debby were rated ambivalent, warm/neutral, and cold/neutral. The counselor placed Debby in the "preparation" stage of change. For complete transcriptions see Appendix H.

"Good" (Counselor's response to Debby stating her kids are pretty healthy).

"Ever around the kids, or..." (asking where in the house Debby uses meth).

"Is there a certain room you go into...and the kids might be left in another room..."

"Yeah, you pretty close to your kids...yeah...it's pretty hard isn't it.

Sometimes we all have to get to that rock bottom moment to realize, have it hit home to us..."(Counselor connect Debby's sadness about kids to her hitting rock bottom).

"Good, good..." (Debby states she will do anything to get kids back).

"Would you say you have an overall good relationship with your kids?"

"Did they ever sense any trouble between mom and dad?"

"Yeah" (Counselor response to Debby saying Tyler—her son—told Debby's mom that Debby and Eric never paid attention to the kids).

"So, you would say overall, that they're happy pretty balanced kids."

This counselor appeared determined to make use of ANY information on the children and their practical placement in the house or their relationship with

their mother as indications that Debby had "happy, balanced kids." This utilization of Debby's maternal status as a central characteristic guided interpretations of information to the point that, even Debby asserting that her own mother reported that the kids said Debby and Eric never pay attention to them resulted in a belief of "happy, balanced kids." This interpretation also occurred within the basic context of the children living in a trailer surrounded by methamphetamine use for the last two years.

Moving to the methamphetamine presenting problem group, the following excerpts were taken from transcriptions of counselor 36 from whose reception to Debby was rated warm, warm/neutral, and warm. The counselor placed Debby in the "precontemplation" stage of change. See Appendix H for complete transcriptions.

"It's (meth) interfered with your being a mom."

"So he (her son) takes care of his little sister."

"So, sometimes your kids, well more than sometimes, your kids are around people who use drugs."

"You need the money for...yeah, taking care of your kids"
(Counselor asked why Debby wanted a job. Debby did not refer to kids).

"I'm guessing that's what you want, to get your family back together."

"You know that's one of the strongest motivations going (she stated she just wants her kids back), so just hang in there."

"I'm sure your kids would like to have you more there."

"Well, having a dream is not so bad (Debby expressed not having any dreams) And, perhaps you'll learn from your kids. Sometimes kids want to do things and parents have a lot of fun doing them also."

"What comes to mind is you have kids and you probably celebrate Christmas" (Counselor is exploring if Debby has any spiritual beliefs. Debby is quite ambiguous and uninterested in the topic).

In this example, interpretations of Debby centered on her maternal status, up to and including her dreams, of which she stated she had none. Debby stated in the interview that if she had to choose she guesses she's Christian. However, the statement was delivered with indifference and, according to the script, Debby did not actually subscribe to Christianity. Nonetheless, the counselor painted a picture

of a family celebrating Christmas, an event symbolized by unity, happiness and prosperity. Debby's case scenario did not reflect any of these qualities.

The following excerpts were taken from transcriptions of counselor 115 from the "meth" group and whose reception to Debby was rated cold, neutral, and warm. The counselor placed Debby in the "contemplation" stage of change. For complete transcriptions see Appendix H.

> "Those are beautiful names...those are great names" (Debby's children's)
>
> "Part-time because of the kids" (Counselor infers why Debby just stated she had really only ever worked part-time).
>
> "Okay, Okay" (Counselor's affect becomes distant with this response upon Debby making statements indicative of her not taking very good care of kids).
>
> "Because you have two small kids...Hope is two and Tyler is four...you have the opportunity to go into a residential treatment center with your kids...we can make that happen."
>
> "During that time (while she's in residential treatment) you'll get some parenting skills. You'll get some uh...I was thinking of some

living skills for house cleaning, for cooking, for time management, to prepare meals, do baths have set bed times and that kind of thing."

"It (residential treatment) will help you get some clothes for your kids, some clothes for you. They can get a little schooling. They can be in an environment with other kids where they can be them. It's difficult for them to be them when they're in an environment where people are using. It's abusive and destructive."

Mid-way through this interview the counselor's interpretation of Debby's maternal role shifted from positive to asserting statements indicative of Debby not fulfilling even the basic maternal duties. As the counselor continued to draw on Debby's maternal status as a central characteristic, the picture grew even darker, finally concluding in the impression that Debby was abusive and destructive toward her children. Note that, in this interview, minimal additional information became available for the counselor after the point when the counselor's affect shifted along with her subsequent interpretations of Debby.

The following excerpts are taken from transcriptions of counselor 70 from the "meth" group and whose reception to Debby was rated warm, neutral, and warm/neutral. The counselor placed Debby in the "preparation" stage of change. For complete transcriptions see Appendix H.

"So, they were thinking the kids were neglected" (the authorities when they entered Debby's home).

"OK, Very good" (Debby states her goal is to get her kids back).

"That's a good move, not having used and that's a good move toward getting your children back. So, you're on the right track, okay?"

"So, you're determined to get your kids back and that's..." (This statement is an abrupt switch from talking about Eric).

"The good news about something like this happening is that it will put you in a place where you can get the help you need so that you can continue parenting. So, I'm gonna um...It makes sense...the kids are in custody...umm..."

This final example illustrates how directly this counselor (and others) linked Debby's recovery and most other attributes to her maternal status. Further, the link included a strong desire by the counselors to believe that Debby loved her children and that was enough to keep her on her path toward "continu(ing) to parent," a goal equally if not predominately placed central to Debby's recovery.

Reading two. Continuing to make use of basic processes outlined in the *Listening Guide* (Gilligan, et al., 2003), the second step of narrative analysis included developing an understanding of how the protagonist moved the story

along. Interpreting narratives often involves working with material delivered in the first person (i.e., "I" statements). The task of analyzing narrative in the context of this study included making use of counselor statements as indications of how the story of Debby – the protagonist or main character driving and driven by the story line – developed. One way Gilligan et al., (2003) offer to track the movement of the protagonist in a narrative involves tracing "I" statements and developing a sub-story based on those "I" statements. However, transcriptions of counselors shaping impressions of Debby precluded such statement from occurring. Therefore, the second stage of narrative analysis involved tracking the general plot developing in these transcriptions keeping in mind the central role Debby's maternal status played in shaping those larger plot lines. Further, this second stage of analysis involved turning an eye toward how Debby's maternal status may (or may not) operate in a dynamic interaction with her opening statements to produce differing plot lines between groups.

Story lines noticeably diverged on one central dimension between the two opening statement groups – certainty. Again, having already acknowledged the interpretive power Debby's maternal status provided for counselors, stories of Debby still followed a generally predictable pattern in both groups not including differences in certainty that Debby could handle all hurdles that may emerge during recovery.

The overarching story unfolded as follows: Counselors established quickly that Debby both had a problem with methamphetamine (given the substance abuse

counseling context this occurred regardless of presenting problem) and was willing to do what it would take to get her kids back. All interviews included at least one statement that Debby was motivated. Most counselors also came to know she was in a problematic relationship (obviously, this occurred more frequently in the DV presenting problem group). Blame for the loss of her children and/or her dysfunctional relationship was most often placed on drug addiction. Hence, Debby was perceived as a loving mother, motivated to get her children back but who fell into using a debilitating drug. The substance use has resulted in mutually abusive interactions with her husband and loss of her children. In inquiring about Debby's support outside of her husband, almost all counselors further developed the story to include Debby having love and support from her mother. Given the lack of evidence supporting this part of Debby's story, this last component seems directly tied to wanting mothers to love their children, a theme guiding interpretations of Debby as well. Perceptions of Debby's story most often also progressed to include a desire to reunite with her husband and, based on counselor advice, she acquired some tools to try to amend that relationship. "Motivated" re-emerged repeatedly as a word defining Debby's journey. Debby was portrayed a sad sort afflicted with an addiction that resulted in domestic dilemmas of which she wanted nothing more than to mend. Motivated by love for her children and love for her husband, Debby would do what it takes to made amends. The drug addiction took a back seat to relational problems. Recovery from substance dependence operated as a tool

toward her true goal – family. Debby would proceed to engage treatment, reunite with her children and husband, and live happily ever after.

While this story emerged in both groups when Debby offered domestic conflict as the reason she attended the assessment interview counselors overwhelmingly wove in less certainty about the "happily ever after." The DV group transcripts included 36 total "what if" questions or comments by counselors challenging Debby to consider possibilities that could result in less than ideal outcomes, with a particular emphasis on her husband. Three of nine DV group transcripts did not include any "what if" questions or comments. Those narratives were characterized by extreme and unrealistic optimism. Example "what if" statements include,

> "If he (Eric) is going to continue using, how do you see yourself..."

> "You already said you are going to get a job and stuff like that, but if your husband continues to use and is still around...you said he was a big influence on your using in the first place..."

> "So, if the meth were to go away do you think all the other problems would go away. So, before he (Eric) started using meth, you guys weren't having any problems?"

"Because your husband has been a big influence on you...of course you guys are a couple and married, so which is really normal, natural to be indluenced by each other at the same time, when he is going to be released you're saying he's going to quit as well."

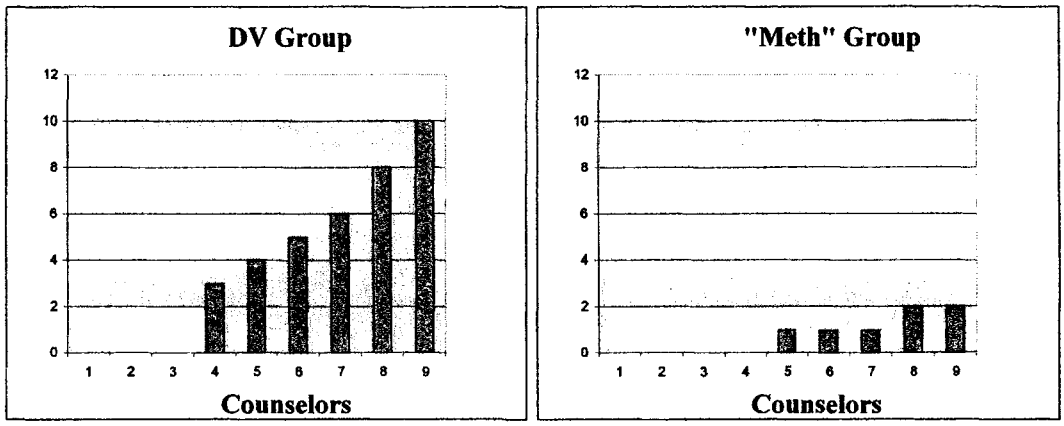
"It may be that you may be doing some counseling, he (Eric) may be doing counseling, or you may be doing counseling together. Because it could get worse without help and using meth and alcohol it could get worse."

"What's gonna happen if you won't get your kids back?"

When Debby offered that problems with meth brought her to the session, counselors asked only seven total "what if" questions. The "style" of question differed from the DV group as well. For example, one counselor asked, "If your husband comes back and starts using again is that a situation you can feel comfortable with?" This closed ended question characterized many of the questions in the transcripts from the methamphetamine group. As opposed to open ended questions such as "what's gonna happen" in the DV group, providing the option to answer questions about a topic Debby feels unrealistically optimistic about with a "yes" or "no" did not leave room for further exploration of possible problems. See Figure 5 for distribution of "what if" statements/questions by presenting problem group and counselors.

Figure 5

Number of "What if" Questions/Comments by Counselor Within Presenting Problem Group.



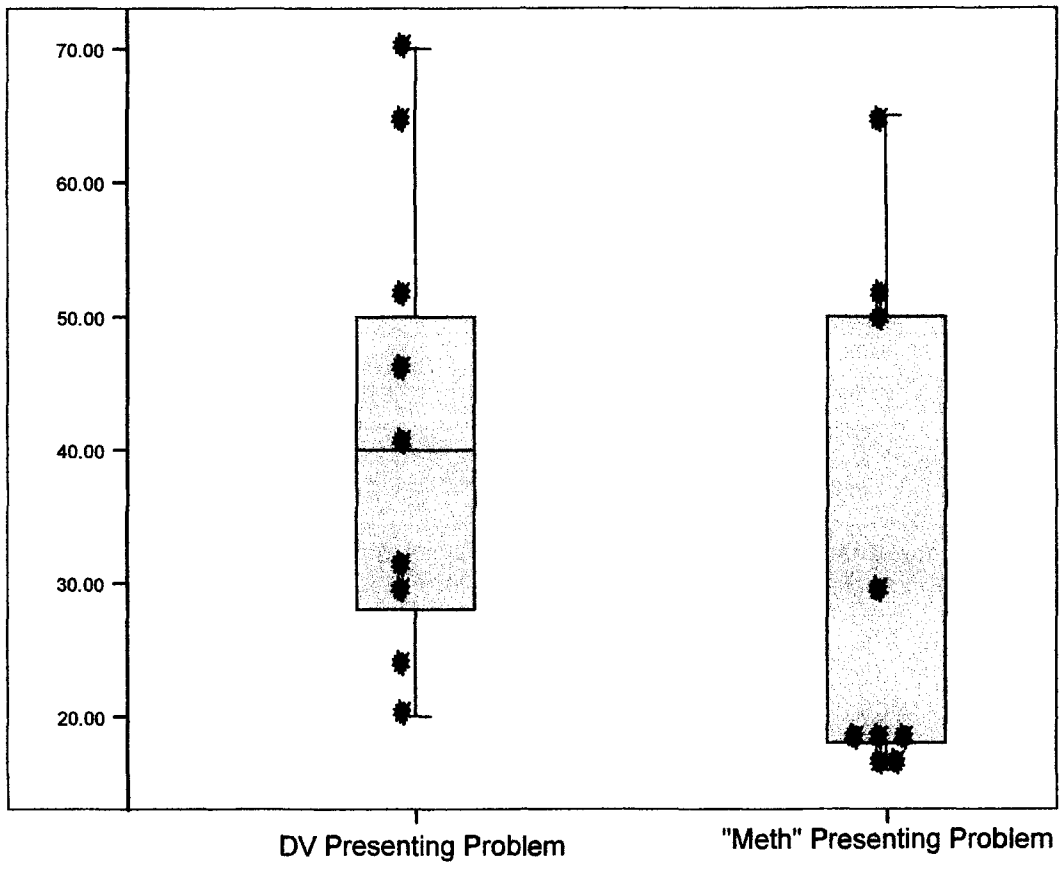
*The y-axis indicates the frequency of "what if" questions.

Quantitative indicators provided support for divergences in the DV group and the methamphetamine group as well. The median duration of interviews in the methamphetamine group was 18 minutes. Half the interviews took less than 18 minutes and half took more than 18 minutes. Mean number of minutes is not useful in this group due to an outlier. One counselor wanted to use the taped interview as support for possibly obtaining employment. This was implicated in that counselor's session taking 65 minutes, substantially longer than the other eight interviews. The mode interview length for the methamphetamine group was 18 minutes. Alternatively, the median duration of interviews in the DV group was 40 minutes, over double the median for the methamphetamine group. The mean duration of interviews in the DV group was 59.3 minutes. Reporting a mean duration for the

DV group becomes useful due to the even distribution of time spent interviewing Debby. See Figure 6 for a box plot illustration of data point distributions of interview length by presenting problem groups.

Figure 6

Box Plot: Data Point Distribution of Interview Length in Minutes by Presenting Problem Group.



Findings raised questions however, concerning what happened in the additional 20 + minutes counselors spent with Debby when she offered domestic conflict as a presenting problem. The transcripts pointed to time spent exploring

socially impinged possibilities with Debby that might jeopardize her recovery. Presenting with a story of social conflict may have opened up space to explore social level implications to decisions made for recovery.

Reading three. The third and fourth stages of reading narratives, according to Gilligan et al., (2003), involve connecting the multiple emergent themes to the research question guiding the analysis, drawing conclusions based on evidence gathered in the first two stages of analysis. Narrative analysis of these transcripts provided, above all other findings, information that three central characteristics – maternal status, DV presenting problem, and methamphetamine presenting problem – appeared to be dynamically interacting to produce divergent trends in certainty of Debby's outcome and level of divulgence in her story. Although a comparison group was not available, the narrative derived through transcripts of substance abuse counselors interviewing Debby provided evidence that central characteristics did inform interpretations of subsequent information and that those interpretations varied depending on additional and divergent central characteristics.

Chapter Eight

Phase Four: Analytic Method and Analytic Results

Phase Four: Analytic Method

Phase four synthesized key findings from the first three phases in order to demonstrate emergent patterns in each opening statement group. This included connecting key analytic outcomes of items on the post-interview questionnaires with emergent trends in ratings of counselor receptions to Debby by group, and, finally, extending those connections to results of narrative analyses. Including three phases of data analysis provided platforms for revisiting the theory guiding this dissertation. Phase one demonstrated how first impressions may interact in diagnostically relevant items in substance abuse counseling assessment interviews. However, the analytic framework of phase one precluded understanding if/how socially relevant presenting problems shaped colder versus warmer receptions to Debby, a task of phase two. Finally, through enlisting narrative analytic approaches to transcribed video taped assessment interviews, phase three offered a view of *how* counselors interpreted Debby's story. While all three phases contributed to assessing impression formation, taken together conceptually coherent patterns inform further answers to the research question "how do first impressions shape clinical interaction."

Phase Four: Analytic Results

Within the DV group maternal status and presenting problem appeared to have dynamically interacted to produce six themes across phases one, two and three

of data analysis, including, 1) predominate mental health diagnosis for co-occurring problems in the DV group and more emphasis on environmental circumstances in the methamphetamine group, 2) predominate placement in the preparation stage of change for both groups with "getting kids back" offered as the explanation for this more advanced stage of change in the DV group twice as frequently than in the methamphetamine group, 3) DV group cited Debby's husband as a barrier to recovery twice as frequently than the methamphetamine group, 4) methamphetamine group cited getting kids back as a treatment goal twice as frequently than the DV group and DV group reported mental health assistance; methamphetamine did not report mental health assistance as a treatment goal, 5) ratings of counselor receptions to Debby were predominately warm in the DV group with one cold rating versus 8 cold ratings in the methamphetamine group, 6) focus on mother role (and specifically maternal status) in both transcription groups, and 7) twice longer interviews for DV group, substantially more "what if" questions in DV group.

Table 13 illustrates analytic results organized by presenting problem group. Figure 7 summarizes key findings in phases one, two and three in order to establish thematic connections in results. Labels in Figure 7 reflect dominate themes by presenting problem group and are, therefore, not exhaustive. Figure 8 demonstrates two individual counselors' decisions – counselor 81 from the DV group, rated as having a warm reception to Debby and counselor 95 from the methamphetamine group, rated as having a cold reception to Debby. This illustration includes

examples in order to demonstrate how the quantitative illustrations of divergences by group unfolded during actual interviews. Counselors were chosen based on relatively unanimous warm or cold ratings in the DV and methamphetamine groups respectively. This provides a clear view of how the warm and cold receptions to Debby were associated with other key analytic themes. Following Figure 8 are narrative excerpts providing illustrations of divergent trends within phase four.

Table 13

Phase Four Results: Divergent Trends by Presenting Problem Group across Data Analytic Phases.

	DV Group	"Meth" Group
Phase One		
Detect Co-occurring Disorder/Problem?	**78%** of total group	**44%** of total group
Mental Health Diagnosis/Problem	**100%** 7 of 7 affirmative respondents	**75%** 3 of 4 affirmative respondents
Situational Diagnosis/Problem	**0%** 0 of 7 affirmative respondents	**50%** 2 of 4 affirmative respondents
Psychological Basis for Diagnosis/Problem (including no-co-occurring problem)	**41%** 7 of 17 total reasons **71%** 5 of 7 affirmative respondents	**8%** 1 of 13 total reasons **20%** 1 of 5 affirmative respondents
Situational Basis for Co-occurring Diagnois/Problem	**12%** 2 of 17 total reasons **29%** 2 of 7 affirmative respondents	**23%** 3 of 13 total reasons **40%** 2 of 5 affirmative respondents
Preparation Stage of Change?	**67%** of total group	**56%** of total group
Reason: "will do what it takes to get kids back"? Within Preparation Rating	**100%** of preparation ratings	**60%** of preparation ratings
Husband barrier to recovery?	**50%** 14 of 28 total statements **89%** 8 of 9 total respondents	**20%** 5 of 25 total statements **67%** 6 of 9 total respondents
"Get kids back" as Treatment Goal?	**44%** 4 of total group	**78%** 7 of total group
Mental Health Evaluation as Treatment Goal?	**33%** 3 of total group	**0%** 0 of total group

*Note: Warm and cold include any original ratings with the word "warm" or "cold" as part of their definition.

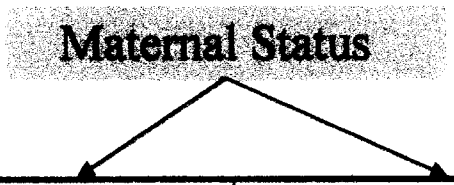
Table 13 Continued

Phase Four Results: Divergent Trends by Presenting Problem Group across Data Analytic Phases.

Phase Two	**DV Group**	**"Meth" Group**
WARM Counselor Reception Ratings?	**15** **IDs:** **150 (3x) ,39 (2x),22 (2x),81(2x),59(2x),165, 117,172,144**	**10** **IDs:** **115,36 (3x), 70(2x) 20, 52, 76, 95**
COLD Counselor Reception Ratings?	**1** ID: 150	**8** 170(2x), 20, 95(2x), 115, 140, 176
Phase Three	**DV Group**	**"Meth" Group**
Median Length of Interviews?	**40** **see Figure 6 for distribution**	**18** **see Figure 6 for distribution**
"What if" Questions in Interviews?	**36** **see Figure 5 for counselor distribution**	**7** **see Figure 5 for counselor distribution**

Figure 7

Phase Four: Integrated Findings from Phases One, Two and Three



Analytic Category	*DV Presenting Problem*	*"Meth" Presenting Problem*
Co-Occurring Disorder/Problem	Mental Health	Situational
Basis for Diagnosis/Problem	Psychological	Situational
Stage of Change	Preparation/Multiple	Preparation/Multiple
Basis for Stage of Change Placement	Maternal Status	Maternal Status
Barriers to Recovery	Husband/Family	Situational/Family
Treatment Goals	Multiple/Psych Evaluation	Maternal Status
Counselor Reception to Debby	Warm	Cold
Narrative Focus	Maternal Status	Maternal Status
Narrative Themes	Longer Interviews Less Certainty More "what ifs"	Shorter Interviews (1/2 DV) Less exploration – "what if" (19% of DV)

Figure 8

Phase Four Specific Counselor Illustrations

Maternal Status

Analytic Category	***DV Presenting Problem***	***"Meth" Presenting Problem***
Co-Occurring Disorder/Problem	Adjustment Disorder w/ Anxiety	None
Stage of Change	***Precontemplation*** "The client is willing to participate in treatments including individual counseling and attending NA meetings. She wants to stop using drugs in order to **get her kids back**, and her commitment to that seems very strong. However, her awareness of her addiction/dependence problem is low, and also low recognition of how her past drug problem can influence her future goal, 'to get kids back' and maintain a safe environment for them."	***Preparation*** "She showed to assessment & states that she is wanting & **willing to do what is needed for having** her old life back including **her kids.**"
Barriers to Recovery	**"Her love with her husband & hope** to keep family together can get in her way of recovery. Since her **husband's recovery commitment is uncertain**, and also **her tendency to be influenced by him and his behavior** (using drugs)."	**"Money, employment, low mood without kids, isolated, transportation."**
Counselor Reception to Debby	Warm, Warm (inferred), Warm	Cold, Cold/inferred, Cold Neutral
Narrative Focus	Maternal Status	Maternal Status
Narrative Themes	• Open Ended Questions • Exploration of Relationship • "What Ifs" • Less Certainty of Outcome	• Closed Ended Questions • Directive • Less subjectively driven

The following narrative excerpts were taken from Debby's interview with counselor 81. This counselor's reception to Debby was rated warm by all three participating blind raters. Items related to children are highlighted. "What if" questions are additionally set off with asterisks. Information in parentheses provide context for counselor quotations. See Appendix H for complete transcription of nodal points in this interview.

"So they took your husband away too...."

"So, basically you've been alone at home right now..."

"So, **you don't know where your kids are...that must be very, very hard for you...**"

"So, **sounds like you would really like to work on getting your kids back...so that's your priority right now...**"

"Kind of makes this pretty bad right now..."(that Debby is tired)

"You haven't used in five days, that sounds like an accomplishment..."

"So, he was the biggest..."(response to Debby saying Eric isn't around so it's easy to not do drugs)

**** "How do you think the situation will (work with) your goal, which is to get your kids back" (when Eric comes back)?****

"You can stay there?" (the trailer...assumption)

"Oh I see you have some support...**So, she's concerned about your life and her grandkids, which are your children**...that's great" (all about Debby's mom...all Debby stated was that she thinks mom would help if she knew Debby was in treatment)

"It sounds like you've been through a lot of stress at this point... how are you coping?"

"Sounds like **you really love your kids"** (Debby reiterated she would do what it takes to get them back...did not say anything about love).

** "Because your husband has been a big influence on you...of course you guys are a couple and married, so which is really normal,

natural to be influenced by each other at the same time when he is going to be released you're saying he's gong to quit as well?"**

** "What if he doesn't?"**

** "Maybe one out of 100 percent possibility but what if he comes out of jail and starts using again. **Which is important to you, to get your kids back** or to be with him?"**

** "Hopefully it's not gonna happen, but if it happens do you think you're ready to go somewhere and seek help as well, as a couple, you and your husband?"**

** "So, if that happens, I hope you will give me a call or call your case worker.

I'm just a little concerned about...cause what you're going through is a really really difficult situation especially with **how much you care about your kids** and they're gone now, although it does sound like you're doing a really good job getting back on your feet."**

"You doing okay with taking care of yourself, pretty much..."

The following narrative excerpts were taken from Debby's interview with counselor 95. This counselor's reception to Debby was rated cold by all three

participating blind raters. Items related to children are highlighted. No "what if" questions occurred in this interview. Information in parentheses provide context for counselor quotations. Also note that this interview contained no mental health related questions and illustrates a more closed ended, pragmatic approach to interviewing consistent with the methamphetamine group. See Appendix H for complete transcription of nodal points in this interview.

"I'm really sorry to hear that..."(**that her kids** were taken)

"And that's been with Eric" (that she's been doing meth for one year)

"I'm going to really highly **encourage you to get a hold of SCF** so that you can find out who your case worker is so **that you can visit with your kids.** I mean a week...**you must be going coo coo wondering about them**. I don't know if you're sleeping...or...so **you've been off of it (meth) since they got taken?**"
(response to Debby stating she doesn't know what's going on with her kids)

"I would **really encourage you to call them (SCF) ASAP** so that you can at least have even if it's a **supervised visit with your**

kids… you know just to see them…I'm sure that they want to see you too…that's very heart wrenching."

"I'm guessing you're unemployed."

"I'm guessing you're a binge, run, crash type of user."

"They've got a room in the trailer…"(in response to Debby saying the kids go in their room while she uses)

"Well this is an opportunity I think…um they may suggest it and encourage you to do it…**I'm not gonna paint a pretty picture here**. You're now in the system and having to **do a lot of hoops to jump through**. It's not fun, but **it's mandatory** that you go ahead and do these things **in order for you to get your children back**."

"In the last year with the meth use with you and Eric were there more fights?"

"So, this drug use has kind of infiltrated your life in a pretty significant way."

"Well, **she must know something now, I mean the kids are…**"(in response to Debby not knowing if her mom knows about drug use)

"Sounds like you've been sober, sober...kind of has slapped you cold ha?" (Debby hasn't used in a week)

"Did you like the fact that meth kept your weight down? And...like your bone structure was coming through and it wasn't very attractive..."

"So, **when they said there wasn't much food in the house...for the kids**, cause they're really growing and um..."(questions about Debby feeding the kids)

"He's learning to fend for himself very young ha..."(Debby's son)

"It's so pretty" (counselor laughs in response to Debby saying she doesn't like her smoker's cough)

"I know that **SCF will require parenting class** for you as well. You know if you were to take some initiative...to go ahead and contact certain agencies...but if you take initiative they're gonna look really highly on that..."

"It's kind of like a huge nightmare you woke up to. Like everything just flipped topsy turby on you. Did you ever think in your wildest dreams this would ever come?"

"Well we can always hope right, that that's gonna be the case. I lean toward, you know, supporting your request. I'm usually pretty accommodating. If outpatient...but I probably would say more of an intensive outpatient..."(information about it)

Integrated Review

In phase one the first predominate finding included counselors from the DV group unanimously reporting mental health diagnoses (e.g., depression) as co-occurring problems while the methamphetamine group reported some mental health diagnoses but more so, situational difficulties. Examining responses to what led counselors to diagnostic conclusions demonstrated a trend toward inferences into Debby's psychology in the DV group and situational difficulties in the methamphetamine group. Counselors from the DV group rated Debby quite similarly on "readiness to change." In analyzing *why* counselors from each group placed Debby in certain stage of change categories, the second substantial qualitative theme emerged – the predominate emphasis on Debby having lost her children as an interpretive lens regardless of the stage of change. Within the preparation category the additional theme included counselors from the DV group unanimously reporting Debby's children as a reason for placing her in that stage.

Counselors from the DV group recognized DV related barriers to Debby's recovery in substantial quantity compared to counselors from the methamphetamine group. In examining goals counselors asserted for Debby, an interesting trend emerged – counselors from the methamphetamine group asserted "getting her kids back" as a goal far more frequently than did counselors from the DV group. In looking at why counselors who placed Debby in different stages of change and associated hopefulness categories, the theme of the counselors from the DV group emphasizing Debby's psychology re-emerged.

Conclusions from phase one pointed to the DV group processing information on Debby in a more complex and similar manner than the methamphetamine group. Themes for the DV group included an emphasis on mental health and other factors internal to Debby in perception formation processes. Themes for the methamphetamine group included an emphasis on situational difficulties contributing to perceptions of Debby, including an emphasis on the client's desire to "get her kids back" – a theme that that emerged as central to perception formation all the way through to treatment goals.

Consistent trends characterized phase two. All three clinicians, albeit with some divergences due, in part, to differing rating criterion, tended to rate receptions to Debby from the DV group as warm. Alternatively, all three clinicians tended to rate receptions to Debby from the methamphetamine group as cold. These relationships substantiated the social relevance of DV and methamphetamine use as

well as the assertion that one set of circumstances appeared to impart warm receptions and the other impart cold receptions.

Narrative analysis in phase three expanded possibilities for understanding what operated as central characteristics for counselors and how those characteristics dynamically interacted with other central characteristics to produce different perceptions of Debby's story. Both sets of narrative included heightened emphasis on Debby's maternal status. This theme dominated the narratives to the point that information Debby presented with was, in many instances, re-interpreted as indicators of Debby's satisfactory relationship with her children. This arguably central characteristic operated in conjunction with presenting problems, however, to produce slightly different interpretations of counselor confidence or certainty in Debby's ability to follow through with treatment. Transcribed interviews of the DV group included substantially more "what if" questions and statements directed at Debby. Most of them centered on, "what if...when your husband gets out of jail." Presenting problems did appear to operate as central characteristics facilitating differential interpretations of subsequent information. However, Debby's maternal status operated as the principal central characteristic and the opening statements appeared to interact with that dominant characteristic to produce observable differences between groups.

Chapter Nine

Establishing Reliability and Validity of Qualitative Findings

The combination of quantitative, content analytic, and narrative analytic approaches in this proposal yielded rich, descriptive findings. However, both the processes of qualitative inquiry and its "products" fall outside of traditional definitions of reliability and validity. Therefore, the integrity of qualitative inquiry was established as follows.

Tindall (1994) asserts that qualitative research is grounded in the idea that "knowledge is constructed, as one version of reality, a representation rather than a reproduction." (p. 143) A central concern of establishing reliability in quantitative analyses includes the reproducibility of results. However, in instances such as the qualitative analyses presented in this dissertation, the goal was not to reproduce the results but rather to develop a thorough description of what occurred during these particular interviews. This study sought to obtain a deep and broad view of how the research question operates with one SP and multiple counselors in one particular study. Rather than establishing statistical reliability, this study also sought to demonstrate the "dependability" (Lincoln & Guba, 1985) of results. This includes adequately explaining the analysis process. The content of the descriptions provided in the methods and results allow other researchers to assess details of the results and determine how certain aspects of the findings might generalize to other settings.

Traditionally, validity relates to the believability or authenticity of results

(Ambert, Adler, Adler, & Detzner, 1995). Because qualitative research acknowledges that findings are related to researcher interpretations, validity becomes a matter of how carefully and systematically the researcher represents the findings (Tindall, 1994). Several steps were conducted to ensure criterion related to dependability and authenticity of results, including, 1) enlisting the blind raters of post-interview questionnaires in peer debriefing (Johnson, 1998; Hill, Thompson, & Williams, 1997), 2) close monitoring of data collection and analysis (Hill et al., 1997), and 3) use of low inference descriptors (Johnson, 1998).

Peer debriefing involves enlisting others with academic and/or professional knowledge related to a specific inquiry as a source for checks and balances. Those individuals provide commentary and critique in order to ensure interpretations of data do not fall outside reasonable boundaries given the intentions of the research project. In addition to rating the content of the post-interview questionnaires, the two clinicians with experience in evaluation were asked to also act as sources for peer debriefing. This excludes the Chair of the dissertation committee, as she provided a source for the next form of establishing validity of results. The two clinicians were provided the opportunity to read through and discuss assessments of how all the analyses fit together and relate to first impressions. One clinician participated in re-evaluating initial interpretations of the post-interview questionnaire and also posed questions or concerns regarding my overall assessments of the relationship between the data and interpretations. The clinician indicated approval of how ratings were integrated into the document.

Close monitoring of the data involves maintaining ongoing assessments of the data analytic process. Dr. Haaken engaged in multiple meetings and "check points" throughout the analysis process. Dr. Haaken had full access to post-interview questionnaires and consulted on outcomes for all phases of data analysis. Note: Dr. Haaken's blind ratings of the post-interview questionnaires occurred prior to her knowledge of how particular counselor ID's link to opening statements. Due to the informed consent options available to participating counselors, Dr. Haaken had access to examining nine of the 18 transcribed tapes as well. Dr. Haaken agreed that integrity to data sources was maintained throughout the analyses and results.

In order to satisfy using low inference descriptors (Johnson, 1998), language reported in the analysis closely matched participants' accounts. This included utilizing exact quotes from narrative portions of the post-interview questionnaire as well as from transcribed video-taped footage, providing confidence that participants words were not changed, only interpreted.

Part III

Chapter One: Discussion

Interpersonal perceptual processes are particularly salient in clinical interaction. Impressions of clients that clinicians form of clients result in diagnoses and treatment recommendations -- outcomes with lasting importance for client trajectories. Some clinical contexts include legal consequences of clinicians' impressions of clients. This study examined one such clinical arena, substance abuse counseling. Utilizing the technology of standardized patients, this study assessed the impression formation processes employed by substance abuse counselors during their interaction with a female client. The client's children had been taken away by the authorities and she had been mandated to a substance abuse assessment interview by the district attorney. Drawing on models of impression formation established by Solomon Asch (1946,1952), the study design incorporated alternating first impressions via presenting problems offered by the standardized patient. This choice emanated from Asch's theoretical premise that first impressions, in particular, may dynamically interact with subsequent information to establish perception trajectories. In order for first impressions to substantially impact impression formation they must be socially salient to the perceiver. Therefore, the SP strongly insinuated problems with domestic violence victimization, a social problem with associated discourse encouraging sympathetic responses to the client, in the first opening statement, "Me and my husband have been fighting a lot lately and this last time the police came and took my kids."

Alternatively, the SP stated she "has been having some pretty bad problems with meth" as the second opening statement. Violent victimization in a domestic setting tends to elicit more sympathetic responses than methamphetamine addiction. Public representations of methamphetamine users include behaviors such as child abuse, child neglect, robbery and perpetrating violence.

Conclusions from four phases of data analysis indicated that one role Debby occupied – mother – substantially shaped interpretations of subsequent information provided during interviews. More specifically, Debby's maternal "status" operated to supporting central characteristics as asserted by Asch (1946). The term status takes on different meanings depending on the theoretical orientation in which it is applied. Used here, status refers to the aspect of motherhood appearing most salient to counselors -- a mother whose children have been forcefully removed. This information skewed interpretations of Debby's story to the point that negative information of Debby's scenario (i.e., no electricity, no phone, four year old son changing two year old daughter's diapers) was recast in many instances as Debby having a positive relationship with her children. This severe interpretive error was not unanimous. Some counselors ascertained a more accurate assessment of Debby's maternal status. However, those counselors also relied on Debby's maternal status as an indication of her motivation toward recovery and an indication that counselors had reason to be quite hopeful about her recovery. Although maternal status operated as a central characteristic, it did so in conjunction with varied presenting problems. When Debby asserted domestic

conflict as a presenting problem it appeared to open up space for deeper exploration into Debby's psychology and overall recovery from substance use. Dual diagnoses tended toward mental health problems rather than situational difficulties. Emphasis still tended toward Debby's maternal status in the DV group. However, in assessing Debby's treatment goals, the DV group tended toward psychologically oriented assistance as opposed to emphasizing the return of Debby's children – a more frequently reported goal for the methamphetamine group. The DV group also included more domestically related barriers to Debby's recovery. These trends were associated with blind outside rater reports that counselors in the DV group had a warmer reception to Debby than counselors in the methamphetamine group. Narrative analysis revealed a tendency for the DV group to spend more time exploring possible "stumbling blocks" that may occur in the recovery process than did the methamphetamine group.

Thus far, the discussion of results has focused on how maternal status and presenting problems operated as central characteristics. However, drawing on role theories, this study asserted *expectations* associated with presenting problems would operate similar to Asch's (1946) "characteristics." Methamphetamine and domestic violence were selected because of their political salience as correspondingly colder and warmer social problems. The roles "domestic violence survivor," "victim of domestic violence," and "methamphetamine addict" became central through their implications. More than simply presenting complaints, these opening statements elicit a set of culturally loaded associations and attributes.

This study did not directly evaluate the expectancies of participating counselors. Although methods informing this study were not intended to directly assess whether or how expectations influenced impression formation, evidence in the analysis did point to possibilities. Analytic findings reflected an investment counselors held in the idea of Debby as a "good" mother, not simply a mother. "Good mother" is a role with associated expectations such as loving one's children, nurturing them and having a relatively positive relationship with them, all attributes assigned Debby regardless of evidence to the contrary. Behaviorally, comments Debby made eliciting maternal associations of "good" mothering included, "I'll do what it takes to get my kids back" or "whatever it takes...I just want my kids back." While these statements pointed to desire on Debby's part to act in accordance with role expectations, they did not provide any evidence that Debby was indeed an effective or loving mother.

The expectations associated with a good mother role also appeared to interact with expectations related to a victim of domestic violence. Counselors' overall failed to explore Debby's violent victimization. Counselors may have failed to hear or register that aspect of the interview. Alternatively, differing trends in the results suggested that DV did register in an unconscious way. Trends in the results suggested that this shaped counselor explorations in how they made use of the good mother category. For example, mental health diagnoses and psychological indicators in the DV group were interpretations of Debby's story, not actual scripted material. Pathologizing Debby in the DV group may have been a result of

counselors expecting her to desire, love and value her children while also negotiating that she would place the children in direct or indirect danger. Presenting problems and associated roles did appear implicated in perception formation processes similarly to the characteristics in Asch's studies. However, the story counselors constructed of Debby inferred characteristics that were not given in the script.

Divergent analytic trends by group supported the dynamic interaction of central characteristics. What of the dynamic interaction between Debby and counselors? How did social psychological processes between client and counselor shape clinical interactions? In framing how role theories contribute to understanding impression formation, the point was made that they allow for glimpses into how the perceiver is situated in interpersonal perceptual processes. Montgomery's role-person merger model (2000) provided a possibility for orienting the dyadic interactions between Debby and counselors. More specifically, the "fuzzy logic" theory offers that self-identity is a product of dynamic interaction between roles and expectations associated with roles. People associate particular appropriate behaviors with particular roles. In the case that individuals over-attribute a target person's behavior to one role, that role takes on particular importance for the target person. This in turn, supports a belief by the target person that the particular role and associated behaviors … truly do define more of the self, hence more appropriate behaviors. The "fuzzy" aspect to this theory involves multiple others and multiple aspects of self concept operating over time to produce

fluctuating social identity. For example, mapping both basic and broad aspects of Montgomery's (2000) theory onto these assessment interviews, analyses supported counselors over-attributing Debby's behaviors to her mother role. Because the expectations of the mother role appeared to manifest as the "good mother" reasonable postulations included a reinforcing effect resulted, facilitating increased statements related to appropriate good mothering behavior by counselors and increased statements asserting "doing whatever it will take to get her kids back" by Debby. The "part" counselors played in these interviews included reinforcing certain client behaviors associated with a good mother role.

Interestingly, given that these counselors were interacting with a *standardized* patient for the duration of a single interview, one might not expect such an accurate mapping onto Montgomery's (2000) broader theoretical model. The SP was restricted to particular responses upon counselor inquiry into her motivations and/or her children. On the one hand, one might expect that, if these counselors were interacting with a real client the reinforcing effect of the importance of maternal status could have been even more profound. Allowing behaviors associated with the client role to fluctuate may have produced even more profound directions for interpreting subsequent information. Alternatively, the SP factor may have increased the reinforcing effect. Debby had no options available to her in responding to repeated questions and comments by counselors about her children. The continued statements of desire to retrieve children may have

supported counselor over attributions to Debby's role as a good mother even further.

Turning the discussion away from process and structure and toward practical application, it becomes important to address how "positive" or "negative" the various findings appear in relation to practices in the substance abuse counseling field, or other clinical fields. Domestic violence advocates and people involved in spreading awareness of the dynamics of domestic violence would, most likely, be disappointed in the paucity of emphasis on Debby's safety in the assessment interviews. Additionally, counselors tended to accept Debby's assertion that "she hits him too" as indicating domestic violence was not worth exploring in any detail. Expectations included substantial emphasis on DV in both diagnoses and related discussion. Nonetheless, the different trends in analyses presented here, point to the power that domestic violence carries in shifting perceptual processes. The emergent trends warrant further exploration of *how* DV and methamphetamine addiction influence clinical interactions.

Recall that contemporary models for understanding the dynamics of domestic violence are gleaned from radical feminist origins. Unlike liberal or socialist feminisms, radical feminism is rooted in firm beliefs that patriarchy and the level of power it affords men are responsible for social problems such as domestic violence. The "power and control" framework (Pence & Paymar, 1993) dominates the DV field as a guide for understanding why men batter, including resultant problems for women if men are granted heightened levels of power in

society. Illustrations of the power and control model tend toward general accessibility. A "power and control wheel" offers visual representation of the forms that abuses of power and control may take, changing to accommodate particular communities. Although specific training backgrounds in DV were not obtained for counselors, the addictions treatment field is currently addressing the co-occurring nature of the problem en mass. Why didn't counselors access knowledge of the dynamics of domestic violence available through this model? Results from this study pointed to possible incongruities between the power and control model and substance abuse counselors' expectations associated with domestic violence.

Domestic violence was under explored as a separate problem from substance abuse in all but one interview out of eighteen. If the only available framework taught to clinicians involves steadfast statements of unified sources for male abusive behavior, little room exists for exploring the problem outside the contained power and control framework. The title "substance abuse counselor" automatically reflects a necessary divergence in focus that clinicians must engage when trying to explain dynamics of DV other than power and control. Drawing the status constructs available in role theory, the power and control model all but eliminates the behaviors associated with a "victim" status. According to Aquino and Lamertz (2004) "statuses designate the parts people play in a social system" (p.1025). The power and control model disallows parts women, in particular, play in violent domestic relationships. Substance abuse counselors' job emphasizes noting the contribution of chemical use in all facets of a person's existence. That

actuality may be responsible for a disconnect between predominant thinking on DV and its application in these substance abuse counseling assessment interviews. Counselor impressions of Debby as a victim of domestic violence quite likely included recognizing at least some part Debby plays in her violent domestic partnership given available knowledge on the effects of methamphetamine, substantiating a need for complimentary models of DV and substance use rather than one best model that may or may not resonate for practitioners in differing fields.

Interestingly, reinserting Debby into an *active* victim status did not produce direct naming of DV as a co-occurring problem. Orienting DV into perceptions of Debby for substance abuse counselors included an emphasis on mental health rather than on either partner's volitional intentions. Domestic violence was explored then through a mental health lens rather than a power and control lens. Feminist informed interpretations of mental health diagnoses in the DV group would include concern that counselors pathologized Debby. Feminist based domestic violence education tools like the power and control model (Pence & Paymar, 1993) intentionally de-emphasize "the part" women "play" in explaining ongoing violent interpersonal interactions. The concern reflects a long history of emphasis on "why woman stay" in violent relationships and an intentional shift toward why men batter. One immediate rebuttal to concerns that diagnosing mental health problems pathologizes women who are in violent relationships includes the fact that DV was only one aspect of Debby, and returning to the emphasis that

these were not DV counseling sessions but substance abuse counseling sessions. Therefore, the counselors were not pathologizing a victim of domestic violence but rather a methamphetamine user involved in DV, allowing for explorations of real mental health possibilities for Debby which may have been missed if the full interpretation of her situation was that she was at the complete mercy of her husband's control. In sum, while on the one hand, counselors missed the severity of Debby's DV problems including safety concerns, the information *in conjunction* with other key aspects of Debby facilitated a deeper inspection into Debby's psychology and resultant diagnoses. Unfortunately, mental health problems were not written into Debby's role. Why then, regardless of a positive or negative loading on mental health diagnoses did they occur in the first place?

Neutral diagnoses such as depression deemphasize the complexity and moral judgments that may operate in discussions of "why she stays." Exploring possibilities for depression or substance induced mood disorder shift attention away from DV terrain, a clinical topic that could include questions that feel like "prying" into a person's private affairs beyond substances. Within the mental health lens clinicians, nonetheless, inquired with "what if" questions intended to explore Debby's assessment of possibilities upon her husband's return from prison, another topic more familiar and less murky than domestic violence. Inquiries into Debby's assessment of future possibilities fit appropriately with concerns of her assessment of reality in general. If DV, as a presenting problem, did establish a direction for interpreting additional information, yet counselors were either consciously or

unconsciously shifting the direct topic of DV to more familiar terrain, questioning Debby's assessment of future realities was conceptually congruent with diagnosing her with reality distorting disorders.

What of counselor distortions in utilizing Debby's desire to "get her kids back" to explain stages of change? Maternal status and respective presenting problems operated as central characteristics, dynamically interacting resulting in altered interpretations of multiple peripheral characteristics. In particular, Debby's desire to get her kids back justified counselors' varied assessments of her stage of change. Additionally, the response served as both a positive (i.e., motivated) indicator and a negative (i.e., only externally motivated) indicator. Divergent presenting problems informed divergent interpretations of Debby's maternal goal as positive and negative. Clinicians from the DV group tended to include Debby retrieving her children as an indication of increased motivation. In order to reflect on this finding, a review of key themes from the four phases of analysis becomes useful. First, the DV group emphasized mental health. Second, the DV group reported Debby retrieving her children *less frequently* as a treatment goal than the methamphetamine group even though they recognized her desire for children as a positive indicator of motivation. Third, the narrative analysis revealed that the methamphetamine group spent less time with Debby and engaged in more closed-ended questions and less exploration of concerns. Conclusion: The methamphetamine group may not have explored the *meaning* of Debby's maternal status as much as the DV group. The DV presenting problem included more

complexity than simply "I've been having problems with meth." However, that complexity did not include a direct statement indicative of recognizing substance problems.

Establishing client recognition of substance related problems is a key goal for substance abuse counselors. Therefore, participating clinicians in this study who were exposed to the DV presenting problem may have surmised that Debby was less motivated than those who heard the methamphetamine presenting problem. If, initially, counselors don't assess the client as recognizing their substance problems, they may seek signs of motivation during the interview. It may be that pursuing signs of Debby's motivation facilitated counselors from the DV group to ascertain that Debby does emphatically want her kids back and interpreted that as a sign of motivation. They also, however, balanced that positive motivating factor with more practical treatment goals focused more on the mental health component. Alternatively, the methamphetamine group hears initially that Debby was at the interview because she knew she had a drug problem and wanted to change – phrases both indicating that she was motivated. In debriefing counselors following interview sessions, several of them made comments indicating that her recognition of a drug problem placed her in a "breath of fresh air" category for counselors who often have to work to establish that recognition in clients. The methamphetamine group had reason, then, for conducting shorter interviews. They were interacting with a client who *appeared* to be an "open and shut" case. Further, any exploration beyond factual questions related to use may have included a search for hints that

Debby is *not* motivated, given her promising presenting problem statement. Hence, more negative interpretations of her desire to get her kids back resulting from a desire to find lack of motivation accompanied by less in depth exploration of Debby's scenario.

Substance abuse counselors were not the only clinicians to utilize Debby's maternal status divergently. Two of the blind raters' receptions to Debby made use of Debby's maternal status discrepantly in explaining criterion for warm vs. cold receptions. Comments from the first rater's warm assessments included items such as, "states positive traits of client – honesty, determination, love for her children, willing to follow directions... despite low awareness of addiction clinician perceives clients "wants" her kids...addresses client's self esteem and self confidence and desire as clinician to support client's goal (to get kids back)...points to children as assets in recovery, client values kids." Whereas post-rating responses to the process by the second clinician indicated that her initial inclination was to rate any post-interview questionnaire that included getting Debby's kids back as a priority treatment goal as cold. The first clinician's comments point to an emphasis on substance abuse counselors ascertaining Debby's "love" for her children and the "value" Debby places on her children as a sign of a warm reception. Using words that hold more subjective than objective value to explain warm ratings that occurred more frequently in the DV group intersected with the more subjective mental health diagnoses that occurred in those groups as well. Viewed this way, clinician one and clinician two were reflecting similar thoughts on Debby's desire

to retrieve her children. The second clinician elaborated her rating criterion by stating that including getting kids back as a priority goal indicates a lack of attentiveness and depth of exploration into Debby's scenario – concepts associated with a cold reception. Both clinicians viewed the children as indicative of a warm reception if care was taken by the substance abuse counselor to make use of the information in a way consistent with developing, what the third rater and chair of the dissertation committee referred to as "a therapeutic alliance."

Results of the blind ratings generally substantiated premises guiding this study that DV is associated with more sympathetic (i.e., warm) responses and methamphetamine addiction is associated with more distancing (i.e., cold) responses. Warm ratings predominately were assigned to those post-interview questionnaires informed by a DV presenting problem and cold to colder ratings went to those with a methamphetamine presenting problem. However, although the numbers of questionnaires rated warm, cold, etc. were similar, raters did not always agree on which questionnaires fell into particular categories. For example, counselor ID 76 was rated ambivalent, warm and cold. Rather than lending doubt to Asch's (1946) theory, the discrepancies in ratings for individual counselor's receptions to Debby actually substantiate the key premise that even dynamic interactions demonstrate relatively predictable outcomes. Regardless of individual criterion and subjectivity, aggregate outcomes nonetheless indicate that, when socially salient attributes imparting generally warm or generally cold receptions to a person were offered as central characteristics, regardless of *which specific* aspects

of the person were interpreted, the overall result was the same – more warm receptions related to a problem eliciting sympathy and more cold receptions to a problem eliciting distance.

In setting up expectations for warm and cold receptions to Debby, the media account of Hedda Neussbaum and media attention toward methamphetamine served to substantiate the point that even child abuse is interpreted differently if a woman presents as a victim of domestic violence versus a methamphetamine addict. The former tends to elicit responses that the woman is not responsible for the child abuse due to her own victimization. The latter elicits responses that the woman "feeds only her addiction." Similar to Hedda Neussbaum, Debby's story operated at the boundary between these two positions. Although Debby's script included many similarities to situations described in media examples of meth users (i.e., no food for children, one young child taking care of the other child, neglect, and dilapidated living conditions), she asserted her plight similar to Neussbaum's. With adequate questioning, counselors learned that Debby blamed her drug use on her husband and that she did not believe she was abused even in light of disputes resulting in neighbors calling the police. The power of this story line, especially with domestic conflict as the presenting problem, resulted in the overwhelming belief that Debby was a good mother in a bad situation. The media excerpts establishing methamphetamine addiction as imparting a decidedly cold impression isolated the drug use from other social factors impinging on parents' lives. By creating an "other" – those people who use meth – it is easier to cast an intensely

critical eye toward associated child abusing behaviors. The cold ratings of counselors' receptions along with shorter, closed ended interviews substantiate the power of the meth story line, even in the context of domestic violence. Alternatively, similar to Neussbaum, emergent trends from this analysis substantiated how inviting others into a story of experience appeared to open up space for multiple and more nuanced interpretations. "Me and my husband have been fighting a lot lately and this last time the police came and took my kids" laid ground work for exploring multiple aspects of Debby's experience, one of which was domestic violence. Alternatively, "I've been having some pretty bad problems with meth lately" offered the optional response of "okay then let's make it better," without necessarily engaging multiple layers of Debby's experience, a trend made visible in analyzing transcribed narrative of nodal points in the interviews.

The narrative analysis conducted in this study allowed for a look at *processes* counselors engaged while formulating overall impressions of this client. Similarities, particularly centering on Debby's maternal status, predominated and appeared to strongly influence often errant interpretations of subsequent information. Yet, the length of the interviews, the open ended vs. closed style of the interviews as well as the content counselors emphasized differed. The DV group spent more time, asking more open ended questions and explored possible ways Debby's domestic scenario could impede on her recovery. As stated previously, stating a presenting problem that includes some complexity, specifically related to DV, and leaving client motivation up to the counselor to assess seemed to open the

door to wanting to understand more of the story, including Debby's subjective experiences. Alternatively, although Debby's story was the same regardless of which counselor she saw, presenting with a problem directly amenable to what counselors want to hear was associated with closed, short and less exploratory story lines counselors created for Debby.

Results of this study indicate that, for the DV group, Debby Patterson was cast as a mother who was sad as a result of losing her children, in a bad relationship, possibly mentally ill but equipped to effectively manage her recovery process and in need of psychiatric assistance. In the methamphetamine group, Debby Patterson was portrayed as a mother whose children had been forcefully removed, whose cards had been stacked against her, was in a bad relationship and needed to get her kids back and reunite her family. The Debby Patterson designed for this research was a mother whose children had been rightfully removed from an environment that was unsafe, unclean, and mentally, if not physically abusive to her children. Her marriage was characterized by increased physical assaults by her husband in the last two months. Debby wanted to get clean but was designed to portray someone over-compliant and at a very early stage of change. She needed in-patient treatment, housing upon release, and disengagement from her husband. Her focus on her children without additional insight into why she was seeking treatment was intended to be a signifier of her lack of readiness to change. She was not stable enough to have her children returned to her. Which presenting problem seemed to facilitate a closer proximity of the real Debby Patterson? Both groups emphasized

aspects of Debby that seemed to derail retrieving the appropriate information necessary to form a more accurate impression. However, in the methamphetamine group, the emphasis on reuniting the family, primarily the children with their mother, most substantially indicates a more shallow, unformulated, and distant impression of Debby.

This study demonstrated multiple ways socially salient information came together in a complex interaction producing divergent trends in person perception processes. First impressions appeared to matter, but primarily in interaction with the overarching central characteristic, maternal status. Knowledge of pre-existing categories people occupy and associated expectations and stereotypes may dominate perception formation processes albeit with differing trajectories depending on first impressions. The ability to discern trends in perception processes between the two presenting problem groups in settings reflecting real human interaction re-affirms Asch's (1946) theory that key characteristics operate in a dynamic interaction. Further, although complex dynamic processes inform impression formation that does not make the phenomenon completely random. Individual perceptions of socially salient personal attributes may establish somewhat predictable patterns and outcomes. Particularly in clinical contexts, this information demonstrates the need to attune counselors in the training stages of the unconscious power seemingly typical or benign information may wield in influencing their perception processes and, therefore, their treatment plans.

Chapter Two

Limitations

From a traditional positivistic perspective on studying psychological phenomena, the primary limitation of this dissertation is the design. While a quasi-experimental design allows for a more controlled view of a phenomenon than strict observation alone, it still leaves multiple questions left unanswered about exactly how alternate factors other than the manipulated variable might influence outcomes (Cook & Campbell, 1979). Specifically, in this project where the goal was to examine interpersonal interactions as they relate to first impressions and utilizing standardized patients, the least "controlled" elements were the individual differences in each substance abuse counselor. These concerns became most problematic when trying to demonstrate that one thing caused another. SP technology appears particularly amenable to addressing theoretical questions such as those posed in this dissertation. However, approaching questions of causation would necessitate incorporating supplementary designs and repeated use of SP studies in order to control for competing explanations to the findings presented here and draw comparisons.

The NIDA study procedure also included instructing counselors prior to participation that a specific assessment tool would not be provided and that they could bring their own if they wish. Therefore, some counselors brought assessment tools to guide their interviews and some did not. The decision to not include our own tool and to let the counselor decide whether to use a tool was made in order to

allow for the sessions to be as realistic for *each* counselor as possible. The consequence for studying impression formation was the introduction of variation in how "free" the counselors were to take the interview in the direction they wished versus follow a specific format. This may have altered the natural dynamic progression of interpersonal interactions in cases when the counselor brought their own assessment tool, thus altering overall impression formation.

Counselors were instructed at the beginning of each session that the primary goal of the study was to assess the authenticity of the SPs. Further, they were being video-taped, an experience more or less uncomfortable for different counselors. These two artificialities could have influenced the focus of attention for the counselors to the point that impressions of the client were altered.

A key theoretical question unresolved in this study concerns central vs. peripheral characteristics. According to Asch (1946), peripheral characteristics, in particular, can take on central qualities in different people and different contexts. This brings up the question, "Are the presenting problems central or peripheral characteristics?" Maternal status appeared to occupy the central characteristic definition adequately. One perspective emphasized in this study included presenting problems as additional central characteristics acting in a dynamic interaction with maternal status to produce differing overall impressions. However, future studies would need to further establish DV and methamphetamine specifically as central characteristic by placing them in the context of differing attributes of Debby. Removing maternal status allows a fuller view of how the

presenting problems operate alone. However, particular care must be taken in not inadvertently incorporating a different central characteristic.

Chapter Three

Implications

A key finding of this study was the centrality maternal status maintained in substance abuse counselors' interpretations of almost every aspect of the standardized patient, Debby Patterson. This attribute in conjunction with the intentionally divergent socially salient presenting problems appeared to inform differing trends and outcomes. Although controlling Debby's presenting problem provided comparison between counselor group processes and outcomes, caution must be taken to not overstate exactly *what* was dynamically interacting with *what* to produce emergent trends. Future research utilizing the same actor with the same script and the same presenting problems yet altering her maternal status would allow for comparative analyses of the three phases conducted in this study. Differing trends in perception formation processes from those identified in this study would lend support to the centrality maternal status maintains in shaping impressions of women.

Additional possibilities for central characteristics informing observed perception processes and outcomes include Debby's gender, race, and level of attractiveness. The actor trained to portray Debby was a white woman who fell into the conventional category of attractive. Research demonstrates trends in clinical interactions with women perceived as attractive. Conducting a study in which the same actor portrayed Debby the same way with the same script yet controlling for maternal status may yield similar impression formation processes and outcomes as

this study. Such findings would point to possibilities that being female automatically elicits some sympathy and using methamphetamine takes away from that base level of sympathetic response. Or, training an African American SP to engage the exact same process as this study and comparing differences may point to racial stereotypes and prejudices that account for differences.

In order to accurately re-create an actual clinical assessment interview for the NIDA study, written introductions indicating how the client came to the session were provided to counselors. A brief written description of the client included information on the SP's maternal status. This artifact of simulating the actual clinical process proved to be a rich source of unexpected influence on the counselors' judgments and interpretations of the interview. However, a systematic assessment of these effects including omitting or changing written descriptions could clarify whether it was the information provided (i.e., maternal status), the initial presentation of the information, or that the information was written that proved most influential.

The quasi-experimental design implemented in this study provided advantages, including, 1) contributing a new approach to research examining Asch's (1946, 1952) theories on impression formation and 2) contributing a new line of inquiry in the ongoing proliferation of research utilizing standardized patients. Including extensive qualitative analyses of the quasi-experimental design allowed for a rich view of these dynamic interactions as they really occurred. Examining the unmanipulated and "uncontrolled" aspects of the interactions

between counselor and client (e.g., specific demographic groupings of the counselors) through additional analyses beyond this research project may yield findings worth pursuing in future research.

As previously explored, Asch (1946) asserted the importance of studying impression formation processes in interpersonal interactions. Dynamic systems theoretical models require examining social psychological processes as they really work. Methodologically, that task invariably involves complexity. Controlling for individuality is not possible and also not realistic. The quasi-experimental design implemented in this dissertation, and particularly, the use of standardized patients allowed for controlling key elements of interpersonal exchanges in order to study constructs such as first impression. The design and tool also, however, allowed maintaining integrity to real life. Ironically, the issue of control both increased and decreased generalizability when utilizing standardized patients. On the one hand, control within an experimental context is seminal to making claims of what variable informed changes in other variables, a crucial question when examining impression formation. On the other hand, over-controlling and manipulating otherwise dynamic interpersonal interactions decreases their authenticity and therefore, generalizability. In sum, making use of limitations associated with this study as a guide, future studies dedicated solely to understanding how first impressions may implicate varying outcomes in a clinical context becomes possible. Future work utilizing standardized patients seems prudent for advancing inquiries into how impression formation works beyond the lab.

Assisting people with substance related problems is not relegated specifically to addictions counseling. Family practitioners increasingly address substance abuse with patients. Such interactions are substantially shorter than the assessment interviews conducted for this study. Literature indicates strong primacy effects in shorter interpersonal exchanges. Results from this study indicated first impressions carry substantial importance in longer interviews as well. Family practitioners may be unaware of how presenting problems influence clinical interaction. Investigating first impressions in medical contexts could contribute to family practice and ongoing theoretical elaborations on perception formation.

Analytic themes that emerged in the DV group support taking steps to understand how the intersection of substance dependence and DV are negotiated in clinical settings beyond substance abuse counseling. The predominate power and control model used to understand the dynamics of DV did not operate as an interpretive lens for substance abuse counselors. However, DV did appear implicated in other interpretations of Debby's story, interpretations that diverged from mainstream notions of men wielding socially sanctioned power over women. There are several implications to this line of analysis. For example, future clinical interventions might benefit from research focused more closely on use of the power and control model, including investigating whether practitioners with specific training on the model integrate key concepts. If it appears that certain presenting problems create difficulty in integrating the power and control model into DV

intervention, implications include examining ways modifications to the model may increase chances for exploring the problem in multiple clinical contexts.

Use of standardized patients in clinical settings has vastly increased over the past decade as have studies investigating their utility and limitations. The NIDA study that provided the context for this dissertation demonstrated that SPs can authentically portray substance abuse counseling clients. Most research using SPs has focused on their overall clinical validity and reliability as training and evaluation tools in clinical interactions. However, research has not focused on actual processes in interpersonal clinical interaction. The unique contribution of SPs as a methodological mechanism is that they offer a way to investigate the interpersonal aspects of clinical practice. This dissertation pursued a currently unexplored use of SP technology by focusing on social psychological interpersonal *processes* that guide outcomes of clinical evaluation and assessment. This line of inquiry contributes to social psychology, improving and expanding the use of standardized patients and assisting in bridging the gap between research and practice.

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Appendix A: Post-Interview Questionnaire

Standardized Patients as Drug Abuse Treatment Clients
Post-Interview Questionnaire

Thank you for your participation in this research project. The following questions are about **the case you just saw**. Please answer them to the best of your ability. You may choose to skip any question for any reason. All information provided will be kept confidential.

Diagnosis(es)

1. Does this client have one or more problems with substances?

   Yes No

2. If yes, what label(s)/diagnosis(es) would you use to describe the problem(s)?

_____

_____

_____

_____

_____

3. Whether or not you believe this client has one or more problems with substances, what led you to this conclusion?

_____

_____

_____

_____

_____

4. Is this client suffering from one or more co-occurring problem(s)/disorder(s)?

Yes No

5. If yes, what labels/diagnosis(es) would you use to describe the problem(s)?

_____

_____

_____

_____

_____

6. Whether or not you believe this client is suffering from one or more co-occurring disorder(s), what led you to this conclusion?

_____

_____

_____

_____

_____

7. For this question, you will need to refer to the Global Assessment Scale (a copy of the scale is on page 10).

Highest GAF past year: _____

Not enough information to know about the GAF: _____

I don't know what a GAF is: _____

For numbers 8 through 14 please circle the appropriate answer.

8. What is this client's risk for suicide?

Very High	Somewhat High	Somewhat Low	Very Low

9. What is this client's risk of hurting other people?

Very High	Somewhat High	Somewhat Low	Very Low

10. Is this patient currently in physical danger?

Yes No

11. How much do you agree with using the DSM-IV ***as a tool for diagnosing substance-related*** problems?

Strongly Agree	Agree	Disagree	Strongly Disagree

12. What is your level of confidence ***with your use of*** the DSM-IV for diagnosing ***substance-related*** problems?

Very Confident	Somewhat Confident	Somewhat Uncertain	Very Uncertain

13. How much do you agree with using the DSM-IV TR ***as a tool for diagnosing mental health*-related** problems?

Strongly Agree	Agree	Disagree	Strongly Disagree

14. What is your level of confidence ***with your use of*** the DSM-IV TR for diagnosing ***mental health-related*** problems?

Very Confident	Somewhat Confident	Somewhat Uncertain	Very Uncertain

For numbers 15 through 21, please rate the client on each of the following American Society for Addictions Medicine (ASAM) crosswalk dimensions.

(Check the box next to the appropriate level of treatment.)

15. **Dimension 1: Intoxication and/or Withdrawal Potential**

☐ Level .5 (Early Intervention)	☐ Level I (0-8 hrs week)	☐ Level II.1 (9-19 hrs week)
☐ Level II.5 (20+ hrs week)	☐ Level III.1 (5+ hrs & supervised living)	☐ Level III.3 (Med. Intensity Residential)
☐ Level III.5 (high intensity residential)	☐ Level III.7 (Med. Monitored residential)	☐ Level IV (Med. Monitored inpatient)

16. **Dimension 2: Biomedical Conditions**

☐ Level .5 (Early Intervention)	☐ Level I (0-8 hrs week)	☐ Level II.1 (9-19 hrs week)
☐ Level II.5 (20+ hrs week)	☐ Level III.1 (5+ hrs & supervised living)	☐ Level III.3 (Med. Intensity Residential)
☐ Level III.5 (high intensity residential)	☐ Level III.7 (Med. Monitored residential)	☐ Level IV (Med. Monitored inpatient)

17. Dimension 3: Emotional, Behavioral or Cognitive Conditions and Complications

☐ Level .5 (Early Intervention)	☐ Level I (0-8 hrs week)	☐ Level II.1 (9-19 hrs week)
☐ Level II.5 (20+ hrs week)	☐ Level III.1 (5+ hrs & supervised living)	☐ Level III.3 (Med. Intensity Residential)
☐ Level III.5 (high intensity residential)	☐ Level III.7 (Med. Monitored residential)	☐ Level IV (Med. Monitored inpatient)

18. Dimension 4: Readiness to Change

☐ Level .5 (Early Intervention)	☐ Level I (0-8 hrs week)	☐ Level II.1 (9-19 hrs week)
☐ Level II.5 (20+ hrs week)	☐ Level III.1 (5+ hrs & supervised living)	☐ Level III.3 (Med. Intensity Residential)
☐ Level III.5 (high intensity residential)	☐ Level III.7 (Med. Monitored residential)	☐ Level IV (Med. Monitored inpatient)

19. Dimension 5: Relapse, Continued Use and/or Continued Problem Potential

☐ Level .5 (Early Intervention)	☐ Level I (0-8 hrs week)	☐ Level II.1 (9-19 hrs week)
☐ Level II.5 (20+ hrs week)	☐ Level III.1 (5+ hrs & supervised living)	☐ Level III.3 (Med. Intensity Residential)
☐ Level III.5 (high intensity residential)	☐ Level III.7 (Med. Monitored residential)	☐ Level IV (Med. Monitored inpatient)

20. Dimension 6: Recovery Environment

☐ Level .5 (Early Intervention)	☐ Level I (0-8 hrs week)	☐ Level II.1 (9-19 hrs week)
☐ Level II.5 (20+ hrs week)	☐ Level III.1 (5+ hrs & supervised living)	☐ Level III.3 (Med. Intensity Residential)
☐ Level III.5 (high intensity residential)	☐ Level III.7 (Med. Monitored residential)	☐ Level IV (Med. Monitored inpatient)

21. **Overall placement for this client:**

□ Level .5 (Early Intervention)	□ Level I (0-8 hrs week)	□ Level II.1 (9-19 hrs week)
□ Level II.5 (20+ hrs week)	□ Level III.1 (5+ hrs & supervised living)	□ Level III.3 (Med. Intensity Residential)
□ Level III.5 (high intensity residential)	□ Level III.7 (Med. Monitored residential)	□ Level IV (Med. Monitored inpatient)

22. How much do you agree with using the ASAM crosswalk dimensions ***as a tool for assessing a patient's necessary level of care?***

Strongly Agree	Agree	Disagree	Strongly Disagree

23. What is your level of confidence ***with your use of*** the ASAM crosswalk dimensions?

Very Confident	Somewhat Confident	Somewhat Uncertain	Very Uncertain

24. Where is this client at in the ***Transtheoretical Model of Change Process*** (Prochaska & DiClemente, 1983)?

A) Precontemplation
B) Contemplation
C) Preparation
D) Action
E) Maintenance
F) I don't know what the ***Transtheoretical Model of Change Process*** is.

25. What led you to this conclusion?

_____

_____

_____

_____

_____

26. How much do you agree with using the Transtheoretical Model of Change Process as ***tool for understanding a patient's placement in the change process?***

Strongly Agree	Agree	Disagree	Strongly Disagree

27. What is your level of confidence ***with using*** the Transtheoretical Model of Change Process?

Very Confident	Somewhat Confident	Somewhat Uncertain	Very Uncertain

28. Given this client's overall clinical picture, what are his/her barriers to recovery?

_____

_____

_____

_____

_____

29. What is/are the treatment goal(s) for this client?

_____

_____

_____

_____

_____

30. Please list, in order of priority, the necessary steps that would be included in achieving your treatment goal(s) with "1" being the highest and "5" being lowest.

(Highest Priority) 1.

2.

3.

4.

(Lowest Priority) 5.

31. How hopeful do you feel about this client's chances of recovery (i.e., their prognosis)?

Very Hopeful	Hopeful	Unhopeful	Very Unhopeful

32. What led you to this conclusion?

_____

_____

_____

_____

_____

The following questions are about the **performance of the actor you just saw as well as the authenticity of the situation.**

33. Did you have enough time with the standardized patient to feel confident in your assessment of his/her condition?

Yes No

34. If not, how much time would have been sufficient for carrying out an authentic interview?

_____ minutes

35. How helpful to you as a professional was the overall process of interviewing the SP, filling out pre and post interview questionnaires, and communicating with the researchers?

Very Helpful	Helpful	Neutral	Unhelpful	Very Unhelpful

Please circle the number indicating your level of agreement for each of the following statements about the person performing as your client (also known as a standardized patient (SP)).	**Strongly Agree**	**Agree**	**Neutral**		**Strongly Disagree**
The SP appeared authentic.	1	2	3	4	5
The SP could be a real patient.	1	2	3	4	5
The SP was clearly role-playing.	1	2	3	4	5
The SP appeared to withhold information unnecessarily.	1	2	3	4	5
The SP stayed in his/her role the entire time.	1	2	3	4	5
The SP simulated physical complaints unrealistically.	1	2	3	4	5
The SP's appearance fits the role.	1	2	3	4	5
The SP answered questions in a natural manner.	1	2	3	4	5
The SP simulated psychological complaints realistically.	1	2	3	4	5

* Font adjusted for formatting purposes.

Please provide any additional comments regarding this experience, (e.g., level of comfort in participating, level of difficulty communicating with the standardized patient, suggestions for future use of standardized patients in this context, etc.) below.

Thank you again for participating in this research project. Your input as professionals and students in the addictions field is invaluable.

Appendix B: Global Assessment of Functioning Scale

The GAF is a 100-point tool rating overall psychological, social and occupational functioning of people over 18 years of age and older. It excludes physical and environmental impairment.

The GAF is included in the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision (DSM-IV-TR) in the section on multi-axial assessments.

91-100	Superior functioning in a wide rage of activities, life's problems never seem to get out of hand, is sought out by others because of his or her many qualities. No symptoms.
90-81	Absent or minimal symptoms, good functioning in all areas, interested and involved in a wide range or activities, socially effective, generally satisfied with life, no more than everyday problems or concerns.
80-71	If symptoms are present they are transient and expectable reactions to psychosocial stresses; no more than slight impairment in social, occupational, or school functioning
70-61	Some mild symptoms OR some difficulty in social, occupational, or school functioning, but generally functioning pretty well, has some meaningful interpersonal relationships.
60-51	Moderate symptoms OR any moderate difficulty in social, occupational, or school functioning.
50-41	Serious symptoms OR any serious impairment in social, occupational, or school functioning.
40-31	Some impairment in reality testing or communication OR major impairment in several areas, such as work or school, family relations, judgment, thinking, or mood.
30-21	Behavior is considered influenced by delusions or hallucinations OR serious impairment in communications or judgment OR inability to function in all areas.
20-11	Some danger or hurting self or others OR occasionally fails to maintain minimal personal hygiene OR gross impairment in communication.
10-1	Persistent danger of severely hurting self or others OR persistent inability to maintain minimum personal hygiene OR serious suicidal act with clear expectation of death.

Appendix C: Content Analysis Debby One

Debby (OS 1 – Fighting)

Item 3: Whether or not you believe this client has one or more problems with substances, what led you to this conclusion? (all counselors reported a problem with substances)

Her report of use (81) (172) (150) (144) (117)
Relationship problems...general...due to meth (59) (39) (165) (150)
Legal involvement (39) (165) (150)
Increased tolerance...increased use...substances (59) (39) (22)
Experiencing withdrawal (59) (39) (22)
Unsuccessful attempts to quit...meth (59) (39)
Employment problems (22) (165)
Kids taken away (22)
Possible Parenting problems (165)
Using social circle (165)
Problems with household tasks (39)
Giving up other activities due to use (39)
Dental problems (165)
Weight loss (165)
Smoker's cough (165)
DSM criteria (150)
Use in hazardous situations (150)

Item 6: Whether or not you believe this client is suffering from one or more co-occurring disorder(s), what led you to this conclusion?

No co-occurring disorder
Further assessment needed (39) (165)
Rule out depression after withdrawal (39) (165)
Frequency & amount of use does not warrant other diagnoses (59)

Mood disorder
Slow speech (22)
Poor self image (22)
Lack of social networks (22)

Substance Induced Mood Disorder
Depression following withdrawal only (150)

Depression
Reports of feeling bad...low mood (172)
Reports of low mood after coming down off cocaine (117)
Reports of being a poor mom (172)
Reported fighting w/ boyfriend (117)
Client report (144)
Client demeanor (144)

Adjustment disorder with anxiety
Two major changes in life...husband's arrest, children removed (81)
Withdrawal from meth contributes to fear of
future...nervousness...worry...jitteriness (81)

Item 25: What led you to this conclusion? (commenting on response to client's stage of change)

Precontemplation
Wants kids back (81)
Awareness of effects past may have on future (including good parenting) low (81)
Willing to participate in any treatment (81)
Awareness of addiction/dependence low (81)

Contemplation
Ambivalent toward treatment (39)
"Do whatever it takes to get kids back" (indication of ambivalence) (39)
Showed up for assessment (144)
Aware of consequences of use (39)
Considering abstinence (39)
Open to discussing needing help/negligence (144)

Preparation
Motivated by kids (59) (22) (172) (165) (150) (117)
Admits to having problem (59) (150) (117)
Needs skills for action stage (59) (150)
Abstinent for 5 days (22) (150)
Willing to start treatment (172) (117)
Open to change (22)
Has made changes (22)
Successful resistance to relapse (22)
Precontemplation stage for smoking (165)
Precontemplation stage for underlying marital/DV issues (165)

Item 28: Given this client's overall clinical picture, what are his/her barriers to recovery?

Hopeful-Precontemplation
Love for husband (81)
Husband's recovery uncertain (81)
Influenced by husband (81)
Desire to keep family together (81)

Very hopeful-Contemplation
Domestic violence charges (39)
Legal issues (39)
Housing (39)
Transportation (39)
Employment (39)
Lack of support (39)

Hopeful-Contemplation
Depressive disorder (144)
Co-dependency (144)

Hopeful-Preparation
None (172)
Husband still using (165)
Husband still abusive (165)
Continued involvement with husband (117)
Support (165)
Employment (165)
Toileting issues w/ daughter (165)
Financial problems (165)
Open (117)
Motivated (117)
Needs medical care (117)
May be staying clean only for legal obligations (117)

Very hopeful-Preparation
Husband uses and deals (59) (150)
Living environment (59) (150)
Husband's release from prison (59)
Social environment...husband's continued use (22)
Husband primary support (150)
Lack of support (59)
Feels like between mom and husband (59)

Needs life skills (22)
Employment (22)

Item 29: What is/are the treatment goal(s) for this client?

Get kids back (81) (59) (172) (150)
Abstinence (81) (59) (165) (150)
Employment (39) (172) (165) (150)
Parenting classes (39) (165) (117)
Psychiatric assessment (39) (144) (117)
Develop non-using social support (22) (172) (165)
Discover triggers (22) (117)
Relapse prevention (39) (117)
Family therapy (39) (172)
Couples therapy (39) (144)
Self-esteem (81)
Self-confidence (81)
Her needs (81)
Increase motivation (39)
Talk to husband (59)
Develop relationship with husband (165)
Leave husband if he won't do treatment (165)
Contact support options (59)
12-step meeting (59)
DHS requirements (39)
Drug & alcohol education (39)
Learn problem solving strategies (22)
GED (150)
Complete legal obligations (117)

Item 30: Please list, in order of priority, the necessary steps that would be included in achieving your treatment goal(s) with "1" being the highest and "5" being lowest.

1. Residential treatment (or general treatment) (172) (165) (144)
   Gain support (81) (59)
   Safety...ensure husband is not a threat (39)
   Identify positive aspects of abstinence (22)
   Identify requirements from caseworker (150)
   Abstinence (117)

2. Identify relapse patterns & influences (150) (117)
   Address self-esteem, self-confidence, her needs, happiness (81)
   Remove substances from house (59)
   Housing (39)
   Women's 12-step groups (22)
   Family therapy (172)
   Couples counseling (165)
   Mental health counseling (144)

3. Relapse prevention (172) (150)
   Explore relationship with drugs and other people (81)
   12-step meetings (59)
   Out patient treatment (22)
   Motivation enhancement (39)
   Parenting classes (165)
   Couples counseling (144)
   Medical issues (117)

4. Employment (172) (165) (150)
   Accept self and let go (81)
   Plan to stay clean when husband returns (59)
   Psychiatric assessment (39)
   Parenting classes (144)
   Complete legal obligations (117)

5. Employment (59) (144)
   Explore family history, patterns of relationships (81)
   DHS requirements (39)
   Reunite w/ family (172)
   Support system (165)
   GED (150)
   Mental health evaluation (117)

Item 32: What led you to this conclusion? (commenting on response to how hopeful the counselor is about Debby's recovery)

Hopeful-Precontemplation
Values children (81)
With resources can get children (81)

Very hopeful-Contemplation
Low duration of drug history (39)
Awareness of consequences (39)
Willing to go through treatment (39)
Mother will support (39)
Attachment to children (39)

Hopeful-Contemplation
Insight into problems (144)
Low duration of drug history (144)
However, treatment availability always a factor (144)

Very hopeful-Preparation
Motivated by valuing children (59) (22) (172) (150)
Has support (childcare included)...mom...aunt...(59) (22) (172)
Acknowledges neglect of children (150)
Counselor is always hopeful (22)
Honesty (59)
Determination (59)
Mother will take children in (59)
Open to suggestions (59)
Counselor anticipates follow through on treatment plan (59)
Admits to problem (172)
Fear around arrest (172)

Hopeful-Preparation
Highly motivated (165) (117)
Short duration of drug use (117)
Open to new ideas (165)
Yet, lack of effort to try to quit substances (165)
Naïve to difficulties of maintaining abstinence (165)

Hopeful-Precontemplation
Values children (81)
With resources can get children (81)

Appendix D: Content Analysis Debby Two

Debby (OS 2 – meth)

Item 3: Whether or not you believe this client has one or more problems with substances, what led you to this conclusion? (all counselors reported a problem with substances)

Her report of use (95) (76) (70) (170) (115) (140)
Increased tolerance to substances (70) (52) (20)
Neglecting children (52) (36) (20)
Job loss (52) (36) (20)
Increased use of substances (36) (20)
Early use of substances (70) (36)
Legal involvement (20) (76)
Domestic disputes w/ husband (52) (36)
The impact on her life (95)
Amount of use (52)
Neglecting bills (52)
Family history (36)
Possible childhood trauma (36)

Item 6: Whether or not you believe this client is suffering from one or more co-occurring disorder(s), what led you to this conclusion?

No co-occurring disorder
Client report (70) (170)
Responding reasonably to a difficult situation (52)

Multiple circumstance problems (e.g., unemployed, needs GED, etc.)
Problems in living (36)
Self-esteem problems (36)
Lack of education (36)
Low job skills (36)
Lack of support (36)
Lack of parenting skills (36)

Substance Induced Mood Disorder
Client report (115)
Depressed when using (20)

Depression
Flat affect (140)
Tired (140)
Running nose (140)

Parental abuse victim
Her report (76)
Hesitant to discuss step-dad (76)

Co-dependent
Partner introduced her to meth (76)
Partner support of meth & alcohol (76)

Item 25: What led you to this conclusion? (commenting on response to client's stage of change)

Precontemplation
She showed up for assessment (36) (140)
Entirely external motivation (36)
Required by DA to attend assessment (36)
Thoughts are about getting kids back (140)
Kids are her motivation (140)
Wants to be a good mom (36)
Pleasant and cooperative (36)

Contemplation
Wants kids back (115)
Will do whatever it takes (115)

Preparation
Wants kids back (95) (70) (20)
Will do whatever it takes...(95) (76)
No drug use for one week (70) (20)
She showed up for assessment (95)
Wants old life back (95)
Open to suggestions (76)
Willing to comply with required steps (70)
Aware meth use is responsible for loss of children (70)
Wants to quit substances (52)
Admits to problem w/ substances (52)
Knows what she needs to do (52)
Goal – Rehab (70)
Goal – job (70)
Goal – GED (70)
No current plan of action (20)

Action
Client report (170)

Item 28: Given this client's overall clinical picture, what are his/her barriers to recovery?

Pre-contemplation
Unemployment/Money (36) (140)
Husband's continued use (140)
Husband's in prison (140)
Lack of support...needs children...needs husband (36)
Needs parenting skills (36)
Never experienced another way to live (36)
Housing (36)
Needs medical care (36)
Her mood (140)

Contemplation
Support (115)
Living Environment (115)
Fighting with partner (115)
Using patterns (115)

Preparation
Husband continuing to use...general (70) (52) (20)
Lack of support...(76) (20)
Employment (95) (76)
Low mood without kids (95)
Single parent...for now (76)
Lack of parenting skills (70)
Economically dependent on husband (20)
Money (95)
Isolated (95)
Transportation (95)
Housing (76)
Lack of life interests or goals (20)

Action
Husband's continued use (170)

Item 29: What is/are the treatment goal(s) for this client?

SCF requirements...get kids back (95) (76) (70) (52) (36) (170) (140) (36)
Employment (95) (76) (52) (170) (140)
Abstinence (70) (52) (140)
Gaining support...aunt...mother (not always including aunt and mom) (95) (52) (20)
Couples counseling...address family issues (170) (115)
Identify what chemical does for her...address substance use (76)(170)
12 step meetings (95) (20)
Get husband back (36)
Parenting classes (115)
Be proactive in treatment (95)
Contact case worker (95)
Housing (76)
Pay bills (52)
In patient treatment (20)
Out patient treatment (20)
Increase sense of self (20)
Alcohol and drug education (115)
DV education (115)
Living skills (115)
Self-esteem building (115)

Item 30: Please list, in order of priority, the necessary steps that would be included in achieving your treatment goal(s) with "1" being the highest and "5" being lowest.

1. Contact SCF & caseworker (95) (76)
   Alcohol and drug education...address substance abuse (170) (115)
   Abstinence (70)
   Contact mom (52)
   Secure housing...for self and children (36)
   In patient treatment (20)
   Mental health evaluation (140)

2. Intensive outpatient treatment/treatment general (70) (36) (140)
   Gaining support...aunt...mother (95) (76)
   Abstinence (52)
   12-step meetings (20)
   Address family issues (170)
   Living skills/self esteem (115)

3. Employment (95) (76) (70) (52) (170)
   Satisfy DA & DHS (36)
   Out patient treatment (20)
   DV education (115)
   Parenting classes (140)

4. Contact low income providers (76)
   Compliant with court orders (70)
   Pay bills (52)
   Reunite family w/ supervision (36)
   Support system (20)
   Parenting classes (115)
   12-step meetings (140)

5. Treatment schedule (76)
   GED (70)
   Get kids back (52)
   Family medical care (36)
   Esteem issues (20)
   Family counseling w/ kids (115)
   Employment (140)

Item 32: What led you to this conclusion? (commenting on response to how hopeful the counselor is about Debby's recovery)

Very hopeful-Precontemplation
Short duration of drug use (140)
Yet, lifestyle must change...husband selling drugs (140)

Hopeful-Precontemplation
Have to be hopeful (36)
Debby is naïve (36)
Open to getting better (36)
Wants to be a better mom (36)
Not "a train wreck" (36)

Hopeful-Contemplation
Admitted drug use progressed (115)

Very hopeful-Preparation
High motivation (76)
Intelligent (76)
Sincere desire to change (70)
Desire to get kids back (70)
Motivated by involvement of law enforcement...(70)

Hopeful-Preparation
Wants kids back (52) (20)
Motivated today (95)
Admits to problem w/ substances (52)
Has support…mom…aunt (52)
Yet, in abusive relationship (52)
Yet, poor recovery environment (20)

Hopeful-Action
Admits to problem w/ substances (170)
Level of motivation (170)

Appendix E: Content Analysis Debby Combined

Debby Combined

Item 3: Whether or not you believe this client has one or more problems with substances, what led you to this conclusion? (all counselors reported a problem with substances)

Her report of use (95) (81) (76) (172) (150) (144) (117) (70) (170) (115) (140)
Increased tolerance (70) (52) (20) (59) (39) (22)
Employment problems (52) (36) (20) (22) (165)
Legal involvement (39) (165) (150) (76) (20)
Relationship problems...general...due to meth (59) (39) (165) (150)
Neglecting children (52) (36) (20)
Experiencing withdrawal (59) (39) (22)
Domestic disputes with husband (52) (36)
Unsuccessful attempts to quit meth (59) (39)
Increased use of substance (36) (20)
Early use of substances (70) (36)
The impact on her life (95)
Kids taken away (22)
Amount of use (52)
Neglecting bills (52)
Family history (36)
Possible childhood trauma (36)
Problems with household tasks (39)
Giving up other activities due to use (39)
Dental problems (165)
Possible parenting problems (165)
Drug using social circle (165)
Weight loss (165)
Smoker's cough (165)
DSM criteria (150)
Use in hazardous situations (150)

Item 6: Whether or not you believe this client is suffering from one or more co-occurring disorder(s), what led you to this conclusion?

No co-occurring disorder
Client report (70) (170)
Rule out depression after withdrawal (39) (165)
Further assessment needed (39) (165)
Frequency & amount of use does not warrant other diagnoses (59)
Responding reasonably to a difficult situation (52)

Adjustment disorder with anxiety
Two major changes in life...husband's arrest, children removed (81)
Withdrawal from meth contributes to fear of
future...nervousness...worry...jitteriness (81)

Multiple circumstance problems (e.g., unemployed, needs GED, etc.)
Problems in living (36)
Self-esteem problems (36)
Lack of education (36)
Low job skills (36)
Lack of support (36)
Lack of parenting skills (36)

Substance Induced Mood Disorder
Client report (115)
Depressed when using (20)
Depression following withdrawal only (150)

Mood disorder
Slow speech (22)
Poor self image (22)
Lack of social networks (22)

Depression
Client report (144)
Flat affect (140)
Tired (140)
Running nose (140)
Reports of being a poor mom (172)
Reports of feeling bad...low mood (172)
Reports of low mood after coming down off cocaine (117)
Client demeanor (144)
Reported fighting w/ boyfriend (117)

Parental abuse victim
Her report (76)
Hesitant to discuss step-dad (76)

Co-dependent
Partner introduced her to meth (76)
Partner support of meth & alcohol (76)

Item 25: What led you to this conclusion? (commenting on response to client's stage of change)

Precontemplation
She showed up for assessment (36) (140)
Wants kids back (81)
Thoughts are about getting kids back (140)
Kids are her motivation (140)
Entirely external motivation (36)
Wants to be a good mom (36)
Willing to participate in any treatment (81)
Awareness of addiction/dependence low (81)
Awareness of effects past may have on future (including good parenting) low (81)
Required by DA to attend assessment (36)
Pleasant and cooperative (36)

Contemplation
"Do whatever it takes to get kids back" (indication of ambivalence) (39) (115)
Showed up for assessment (144)
Wants kids back (115)
Aware of consequences of use (39)
Considering abstinence (39)
Open to discussing needing help/negligence (144)
Ambivalent toward treatment (39)

Preparation
Motivated by kids (59) (22) (172) (165) (150) (117) (95)
Admits to having problem (59) (150) (117) (52)
Abstinent for 5 days (22) (150) (70) (20)
Willing to comply with required steps (70) (172) (117)
Needs skills for action stage (59) (150)
She showed up for assessment (95)
Aware meth use is responsible for loss of children (70)
Wants old life back (95)
Wants to quit substances (52)
Knows what she needs to do (52)
Open to suggestions (76)
Open to change (22)
Goal – Rehab (70)
Goal – job (70)
Goal – GED (70)
Has made changes (22)
Successful resistance to relapse (22)
No current plan of action (20)
Precontemplation stage for smoking (165)
Precontemplation stage for underlying marital/DV issues (165)

Action
Client report (170)

Item 28: Given this client's overall clinical picture, what are his/her barriers to recovery?

Precontemplation
Unemployment/Money (36) (140)
Love for husband (81)
Husband's recovery uncertain (81)
Influenced by husband (81)
Husband's continued use (140)
Husband's in prison (140)
Lack of support...needs children...needs husband (36)
Desire to keep family together (81)
Her mood (140)
Never experienced another way to live (36)
Housing (36)
Needs parenting skills (36)
Needs medical care (36)

Contemplation
Support (115) (39)
Fighting with partner (115)
Domestic violence charges (39)
Co-dependency (144)
Living Environment (115)
Using patterns (115)
Housing (39)
Transportation (39)
Legal issues (39)
Employment (39)
Depressive disorder (144)

Preparation
Husband continuing to use...general (70) (52) (20) (165) (59) (150) (22)
Lack of support...(76) (20) (165) (59)
Employment (95) (165) (22)
Living environment (59) (150)
Money (95) (165)
Husband still abusive (165)
Economically dependent on husband (20)
Continued involvement with husband (117)
Husband's release from prison (59)
Husband primary support (150)
Feels like between mom and husband (59)
Single parent...for now (76)
Low mood without kids (95)
Isolated (95)
Transportation (95)
Housing (76)
Lack of parenting skills (70)
Lack of life interests or goals (20)
Toileting issues w/ daughter (165)
Maybe staying clean only for legal obligations (117)
Open (117)
Motivated (117)
Needs medical care (117)
Needs life skills (22)
None (172)

Action
Husband's continued use (170)

Item 28: What is/are the treatment goal(s) for this client?

SCF requirements...get kids back (95) (76) (70) (52) (36) (170) (140) (81) (59) (172) (81) (150) (95) (39) (117)
Employment (95) (76) (52) (170) (140) (39) (172) (165) (150)
Abstinence (70) (52) (140) (81)
Gaining support...aunt...mother (not always including aunt and mom) (95) (52) (20) (59)
Parenting classes (39) (165) (117) (115)
Couples counseling...address family issues (170) (115) (39) (144)
Develop non-using social support (22) (172) (165)
12 step meetings (95) (20) (59)
Psychiatric assessment (39) (144) (117)
Discover triggers (22) (117)
Self-esteem (81) (115)
Identify what chemical does for her...address substance use (76)(170)
Family therapy (39) (172)
Alcohol and drug education (115) (39)
Relapse prevention (39) (117)
Be proactive in treatment (95)
Self-confidence (81)
Her needs (81)
Satisfy DA (36)
Get husband back (36)
Talk to husband (59)
Develop relationship with husband (165)
Leave husband if he won't do treatment (165)
Housing (76)
Pay bills (52)
In patient treatment (20)
Out patient treatment (20)
Increase sense of self (20)
DV education (115)
Living skills (115)
Increase motivation (39)
Learn problem solving strategies (22)
GED (150)

Item 30: Please list, in order of priority, the necessary steps that would be included in achieving your treatment goal(s) with "1" being the highest and "5" being lowest.

1. Residential treatment (or general treatment) (172) (165) (144) (20)
   Alcohol and drug education...address substance abuse (170) (115)
   Contact SCF & caseworker (95) (150)
   Abstinence (70) (117)
   Gain support (81)
   Contact mom (52)
   Secure housing...for self and children (36)
   Mental health evaluation (140)
   Safety...ensure husband is not a threat (39)
   Identify positive aspects of abstinence (22)

2. Intensive outpatient treatment/treatment general (70) (36) (140)
   Identify relapse patterns & influences (150) (117)
   Address self-esteem, self-confidence, her needs, happiness (81) (115)
   12-step meetings (20) (22)
   Gaining support...aunt...mother (95)
   Abstinence (52)
   Address family issues (170)
   Remove substances from house (59)
   Housing (39)
   Family therapy (172)
   Couples counseling (165)
   Mental health counseling (144)

3. Relapse prevention (172) (150)
   Out patient treatment (20) (22)
   Parenting classes (140) (165)
   Employment (95)
   Explore relationship with drugs and other people (81)
   Satisfy DA & DHS (36)
   DV education (115)
   12-step meetings (59)
   Motivation enhancement (39)
   Couples counseling (144)
   Medical issues (117)

4. Employment (172) (165) (150)
   Parenting classes (115) (144)
   Compliant with court orders (70) (117)
   Accept self and let go (81)
   Contact low income providers (76)
   Pay bills (52)
   Reunite family w/ supervision (36)
   Support system (20)
   12-step meetings (140)
   Plan to stay clean when husband returns (59)
   Psychiatric assessment (39)

5. Employment (59) (144) (140)
   Explore family history, patterns of relationships (81)
   Treatment schedule (76)
   GED (70)
   Get kids back (52)
   Family medical care (36)
   Esteem issues (20)
   Family counseling w/ kids (115)
   DHS requirements (39)
   Reunite w/ family (172)
   Support system (165)
   GED (150)
   Mental health evaluation (117)

Item 32: What led you to this conclusion? (commenting on response to how hopeful the counselor is about Debby's recovery)

Very hopeful-Precontemplation
Short duration of drug use (140)
Yet, lifestyle must change...husband selling drugs (140)

Hopeful-Precontemplation
Values children (81)
With resources can get children (81)
Have to be hopeful (36)
Debby is naïve (36)
Open to getting better (36)
Wants to be a better mom (36)
Not "a train wreck" (36)

Very hopeful-Contemplation
Low duration of drug history (39)
Awareness of consequences (39)
Willing to go through treatment (39)
Mother will support (39)
Attachment to children (39)

Hopeful-Contemplation
Admitted drug use progressed (115)
Insight into problems (144)
Low duration of drug history (144)
However, treatment availability always a factor (144)

Very hopeful-Preparation
Motivated by valuing children (59) (22) (172) (150)
Has support (childcare included)...mom...aunt...(59) (22) (172)
High motivation (76)
Intelligent (76)
Sincere desire to change (70)
Desire to get kids back (70)
Motivated by involvement of law enforcement...(70)
Counselor is always hopeful (22)
Honesty (59)
Determination (59)
Acknowledges neglect of children (150)
Mother will take children in (59)
Open to suggestions (59)
Counselor anticipates follow through on treatment plan (59)
Admits to problem (172)
Fear around arrest (172)

Hopeful-Preparation
Motivated today (95)
Wants kids back (52) (20)
Admits to problem w/ substances (52)
Has support...mom...aunt (52)
Yet, in abusive relationship (52)
Yet, poor recovery environment (20)
Short duration of drug use (117)
Highly motivated (165) (117)
Open to new ideas (165)
Yet, lack of effort to try to quit substances (165)
Naïve to difficulties of maintaining abstinence (165)

Hopeful-Action
Admits to problem w/ substances (170), Level of motivation (170)

Appendix F: Chi-Square & T-Test Summary Phase One

Frequency Counts and Chi Square

Questionnaire Item	Total n	DV n	Meth n	DV group	Meth group	X^2	*df*	P Value
Is this client suffering from one or more co-occurring problem(s)/disorder(s)?	17	8	9	Yes (n=7) No (n=2)	Yes (n=4) No (n=5)	2.10	1	.147
If yes, what labels/diagnosis(es) would you use to describe the problem?	12	7	5	Mental Health (n=7) Situational (n=0)	Mental Health (n=3) Situational (n=2)	3.36	1	.067
Is this patient currently in physical danger?	18	9	9	Yes (n=0) No (n=9)	Yes (n=2) No (n=7)	2.25	1	.134
What is/are the treatment goal(s) for this client?	18	8	9	Get kids back (n=4)	Get kids back (n=7)	2.10	1	.147
Rater #1: Warm or Cold	11	9	9	Warm (n=5) Cold (n=0)	Warm (n=2) Cold (=4)	5.24	1	*<.05
Rater #2: Warm or Cold	10	9	9	Warm (n=5) Cold (n=0)	Warm (n=4) Cold (n=1)	1.11	1	.292
Rater #2: Inferred: Warm or Cold	14	9	9	Warm (n=7) Cold (n=1)	Warm (n=4) Cold (n=2)	.88	1	.38
Rater #3: Warm or Cold	13	6	7	Warm (n=5) Cold (n=1)	Warm (n=4) Cold (n=3)	1.04	1	.31

Independent Sample t-tests

Questionnaire Item	*t*	*df*	P value	Standardized Effect Size
(Client's) highest Global Assessment of Functioning score (in the) past year.	.000	16	1.00	0.00
What is this client's risk of hurting other people?	-1.60	16	.13	*.75
Dimension 4: Readiness to Change	-0.12	16	.46	-.03
Dimension 5: Relapse, Continued Use and/or Continued Problem Potential	0.55	16	.59	.26
Dimension 6: Recovery Environment	0.40	16	.70	.18
Where is the client at in the Transtheoretical Model of Change Process?	-0.27	16	.79	.15
How hopeful do you feel about this client's chances of recovery?	0.00	16	1.00	0.00

Appendix G: Instructions to Raters

Dear_____,

Thank you so much for participating in this data analysis process. Enclosed you will find 18 "post-interview questionnaires." These documents include diagnostic related questions that substance abuse counselors completed following an assessment type interview they conducted with a standardized patient. As I mentioned previously, I am interested in how alternating opening statements provided by the "fake" patient may have established "warm," "cold," "neutral"or"ambivalent" receptions to the client by the clinician. As such, the instructions for the analytic process are as follows:

1) Read each outcome measure as if it is a case report of a client. This includes paying attention to both quantitative and narrative information on the client provided by the counselor on specific items.

2) Disregard any items that you feel less than equipped to assess. For example, counselors were asked to rate the standardized patient on the American Society for Addictions Medicine crosswalk. If this is unfamiliar please disregard. Please indicate items that are unclear, however, by marking them as such on the document.

3) Indicate on the form provided at the end of the document whether you would consider the reception to the client by the counselor as either warm, cold, neutral or ambivalent. Although warm and cold need little description, neutral refers to a reception that appears neither warm nor cold. Ambivalent refers to a reception that appears both warm and cold, or undecided.

Note: These questionnaires are completely confidential, identifiable only by code. Please do not detach the rating sheet from the questionnaire, as they are matched by those specific codes.

4) Please feel free to include comments particularly if there are responses in the post-interview questionnaire that seemed to strike you as pertinent in your decision making process.

5) You can contact me at the following options for questions and when you have completed the analyses: Home: ----------, Cell: ----------, Email: ----------

Thanks again.
Sincerely.....

Appendix H: Video Tape Transcription

Counselor ID: 20
OS: Two (meth)
18 Minutes
Student

I'm so sorry Debby…(that police took the kids away).

That's great…(that she hasn't use in five days)

Staying away from other people that use then…(inferring how she has stayed clean)

Sounds like a real difficult situation (that Eric is in jail)

So, you saw a change in your pattern of use in the last couple months or so…

And then a couple month ago when Eric started dealing… every two or three days…

And, you're generally using together…

You notice any real changes in the last months…(withdrawal)

Why part-time? (response to Debby seeking only part-time employment)

You sound pretty determined to stop the meth and five days, that's pretty significant.

So, before the meth…(drug questions)

Pretty much isolated circumstances (using extacy a couple of times)

I'm curious Debby, how you think, you know when Eric gets out of jail, how that's going to affect your ability to stay clean…

So, you think he will stop too…

And, so you've been a stay at home mom since the kids were born, or….

So, kind of just cause it was there (Debby is trying to explain her meth use being tied to Eric)

Well that seems odd that you saw that it was causing you bad things in your life but you kept on doing it…

Oh, Eric…okay.

Because I think what the DA's gonna want to see is your working on abstinence from the meth in particular, probably the pot is not something that would be wise to use either.

You don't like alcohol too much…

Pretty much squared (can't understand next word) there ha? (comment on meth being her favorite drug)

I'm curious what you like so much about meth. Cause you really do seem to like it a lot. There seems to be that part of you anyway…

Did you ever feel like you were depressed before you started using the meth…

But you probably feel that way when you're coming down from it ha?

Well that's pretty impressive (that Debby has never and wouldn't hit her kids)

So, Tyler's gonna be in school next year ha? (counselor trying to get Debby to talk about parenting)

Really that's pretty intense (that mom won't talk to Debby right now)

Oh, that little (response to Debby's sister's age)

Pretty nice guy…(Debby's step-dad)

Okay so mom's pretty much always been there for you….

There seems to be some emotion there…(Debby commented that when Mom met Lenny they moved here)

Lenny's been an asshole…

Doesn't sounds like a nice guy…

So that had to have been kind of difficult for you with him in the house...(Lenny...not much divulged yet though)

As close as you're gonna get with a twelve or thirteen year old. It's not always possible is it? (Debby says she's not that close to her sister)

And, you mentioned earlier that you were looking for part-time work...

Is that why you're not at Ross anymore (Debby said her boss was and asshole, the counselor giggles after making this statement).

Get your kids back. Pretty much be a mom and get your kids back. I can see that's pretty important to you. Session ends.

Appendix H: Video Tape Transcription

Counselor ID: 22
OS: One (fighting)
25 Minutes
Student/No Work Experience

Opening statement not accurate … said "I'm here so I can get them back"

Next statement…the appropriate opening statement.

You don't feel tired, you don't feel jumpy…(when you're high)

Wow! That's awesome. Congratulations. That's the longest you've been clean? (Debby states she's been clean one week)

So, you know you can at least do it that long, you've done it before (I think stay clean). Right on, congratulations.

Do you use it sometimes to counterbalance the meth? (pot)

Has his (Eric) being gone helped you stay clean the last five days?

So, it sounds like your kids are a really important motivating factor for you to stop using. At least they have been for five days.

Wow, it's gotta be hard to be with the kids all day. They pretty well behaved? That makes it easier.

So, you used meth five days ago…

Let me make sure I have understood you correctly here. you haven't used in five days. Which, by the way, is awesome. It's been longer than that since the pot. While this has been going on sometimes you take Tylenol PM. And that's just to help you sleep. And you're drinking four to five nights a week maybe six or seven beers a night.

I know sometimes with DHS if the other person in the house is still using or whatever that's a condition of it (getting kids back)

I'm sure you've heard about people going to AA to try to get clean…

Let's say you get your kids back and you're looking for a job (how is she going to stay clean)

Sounds like this has been a pretty big motivator, pretty big wake up. That's hard. It's hard to be separated from your kids.

What if you look for a job somewhere they use a drug screen?
Even when you're high you don't want to hurt someone else? (prying about Debby saying she doesn't have thoughts of hurting herself or others)

So, when they said the kids had been neglected what were they talking about?

So, if the house was dirty and they found gear, what do you think they're going to ask for you to keep your kids if those were signs of neglect.

Does that seem like it's possible for you? Sound like it's doable? (keeping house under control)

So, if there's a recommendation that you do some ongoing meetings and counseling and whatever else, you'll have someone to baby-sit for you?

It's gonna be hard to kind of disconnect from them. (her druggy friends)

And if Eric's still in jail. You don't know how long he's going to be there. How are you going to hang in there by yourself while he's gone?

...gotten in fights, been late to work, or been sick, had to go to the hospital (options counselor gives for bad things that may have happened due to drugs)

Oh, were you good? What was your best position? Nice. I played a couple years in Connecticut and couldn't serve over the net so I'm impressed. (Debby said she served well).

What's gonna happen if you won't get your kids back?

Well, thank you very much. I appreciate you being here and I appreciate you talking.

Well thank you very much Debby I appreciate your time. Good luck.

Appendix H: Video Tape Transcription

Counselor ID: 36
OS: Two (meth)
65 Minutes

Note: Her opening statement was ignored and he went into introducing who he is. The next major statement was opening statement one.

Lucky number 13, ha? (jovially stated) (in response to her birth date)

Do you have any fears about what might happen here?

That must be very distressing (with your kids and all).

Was he arrested for domestic violence, or drugs or ....

Hopefully this will be as painless as possible

First time (police intervention) ... a lot of bad things happen the first time.

I think mom's judge themselves in terms of mom's perhaps more than what happened before... so, do you think if you weren't using you would be a better mom? (in response to her saying she is a shitty mom)

Well, my brain doesn't always work so well either so we might get along here. (in response to her comment on withdrawal).

That'd be kind of scary wouldn't it, to not remember what we're doing? (in response to her having hit a wall and not remembered it)

And you said you actually have been drinking less than you used to.

No problems in school, minor in possession or anything like that?

Let's move to the meth, because that seems to be what got you here, unfortunately. (consistent with opening statement)

So, you haven't used yet. It must have made quite an impression on you. And you're still kind of anxious? You know it takes a while to calm down, that's just the way it is (in response to her stating her last use was one week ago at the time of her husband's arrest)

And when you were on meth you probably had some personality changes (fighting).

So, you kind of don't always have control over your use.

It's (meth) interfered with your being a mom.

So he (Tyler) takes care of his little sister?

And, the reason you're not currently working? It may be kind of obvious because you're a mom but ....

There are perhaps some other drugs in your life?

So, sometimes your kids, well more than sometimes, your kids are around people who use drugs.

Well, you must have had some sort of check up two or three years ago when you were pregnant.

A lot of women don't (drink while pregnant) women can be pretty strong that way. (she couldn't remember if she did and this was his response.)

Maybe you can get some dental work done. There can be some advantages of being in the criminal justice system you know. Hard way to get there ....

No heart problems, no asthma ...

So, you never really knew your dad ...

Well that's too bad sometimes grandparents are good to have around. (in response to her not knowing hers)

Oh good you're a healthy person. Lucky too. (no major medical history)

I'm guessing you and your husband are sexually active. Some people find when they use meth that they are sexually fired up. (he didn't preface why he asked this)

Hmm. Healthy person.

And you appear to be neither underweight or overweight.

I think you said other than birth control you don't take any medications.

Trailer??? Okay.... (in response to where they live)

One and only (happy face), yeah!!! (in response to asking if she had other partners)

He must have some charm if he's a salesman, well you were in sales .... (probing about Lenny, her step dad)

There's a big age difference there ...(??)

You said about thirteen is when you staring using alcohol.

How could I forget that, that's everyone's favorite (he's referring to forgetting to ask about pot).

Weekend stuff? (pot as a teenager)

Well I guess if you had you would have known it (got high the first time she smoked pot).

You say that your mom drinks some ... how old is your mom anyway... sounds young to me.

We just don't know (about dad and his use)

Hopefully that will turn around (her and Eric not having jobs)

That's pretty hard (being alone a lot as a teenager)

You said you have no relationship with your father ... your mother?

Kind of on your case. Yeah sometimes grandparents stick there nose in a little too much. (her mom expressing concern)

How bad was the fight...it got the attention of the neighbors and all.

That's possible too (getting GED).

Oh I guess there's a reason to call it average ... most of us are (after she said she got c's and b's in highschool)

You need the money for… yeah, taking care of your kids. (asked why she wanted a job she didn't refer to kids)

That's right being on a volleyball team so that's kind of a social thing … some exercise.

So, like with the volleyball you're an active person. (she said she learns best by doing)

And you probably have not been in the military, that's a safe bet.

Well, yeah people would get on your case (she said her boss was an asshole)

Yeah, it's hard to cope when your like that.

So, it sounds like at least alcohol has affected your employment.

How are you doing so far with this stuff?

Are you fairly comfortable?

When the police came to your house, you were arrested, is that right.

Well, sometimes cooling off isn't so bad when things get out of hand.

So, this is kind of your first brush with the law…kind of a big whack…the law, bust up the family … whoa

I guess drugs have affected your involvement in the legal system.

So you have both, now, if you didn't get arrested why did the DA get involved.

You know I have trouble remembering whether it's CSD, DHS it's just a bunch of letters and uh…. (she couldn't remember)

I'm guessing that's what you want … to get your family back together.

I thought you might want to get in touch and find out what's going on (with CSD)

… perhaps to pay for some of the drugs or … that's tough isn't it when you have to sell your car just to get by?

So, neither you or Eric are on unemployment?

You know, that's usually why people get fired is for being late. They don't do us any favors do they? (she said Eric got fired from a recent job for being late)

Yeah, that's a huge one … that and Eric lost his job.

Well, that sure occurs to me, who wouldn't be (depressed when coming down).

I understand you're a little anxious right now, you're sort of sitting there picking away…have you been anxious in the past?

So, you would take the Tylenol pm …. So you have some trouble sleeping.

Kind of lonely isn't it … (Debby just expressed what makes her mad)

Boy, that's kind of a problem to have to choose between your husband and your mom. I'm sorry to hear that. (she mentioned that Eric and mom don't get along)

Well, I guess you can take care of yourself (she said she fights back with Eric)

Well, not much (fighting with Eric in highschool) what's not much?

Changes in eating and sleeping habits? I guess with meth that's a given.

You know that's one of the strongest motivations going (getting kids back), so you just hang in there.

I think you said you'd seen Lenny hit your mom or something, so you were exposed to that.

Well, he was touching you.

I'm sorry she didn't believe you, because mom's need to protect their children.

When Lenny was trying to cop a feel …

So, you didn't feel safe did you?

No kidding, wow, Eric really is the one and only isn't he? (she said she was 17 when she lost her virginity.)

I hope they didn't break down the door... that can be pretty... dragging your kids off, dragging you off, dragging your husband off...a lot of trauma (Debby mentioned the police broke down the door)

Well, I guess meth does that for you. (keeps you awake)

Well, I guess that's safe enough (playing cards with mom, not gambling)

You have a nice voice (after a really long pause)

You said you've had some problems with sleeping

When you're on the meth less eating now more eating

Well, good for you (he asked if she ate something green occaisionally)

And, you know who you are, where you are, what time it is.

That's a bad one these days (meth)

Well that sounds like a safe place for you (in a ball in a dark room when crashing)

I'm sure your kids would like to have you more there.

So, your kind of in a tight spot, but I think there are ways to get out of it, you know this is all about you having a better life and having your kids back and your husband back and working ... being more like normal folks.

Well, you've had the though, you know and the journey begins up here with the thought. Where your mind goes maybe the feet will follow.

Maybe the drugs kind of hindered your carrying these things out.

I think you said there are other people in your life concerned about your drug use, your mom picks on you, or even Eric who uses it also.

Well, that's one reason .. ha ha ha ...(could not understand what prompted this)

You said you have a couple drinks sometimes. How much does Eric drink?

You have a lot of time on your hands. He drinks beer that's like a six pack.

Works for me, whatever's on sale (when she says she drinks whatever is cheap)

Yeah, I think so .. and it's good you make that connection ... you want your kids back. I'm sure they want you back too. (she said she's 10 in wanting to change)

Well, that's in the middle there (she said 7 or 8 for confidence in changing).

Yeah, well a lot to be said for working we kind of organize around it, get paid for it, that's good too.

And you've not had any prior treatment.

Well, sometimes things go better when your brand new. It can be kind of scary but take things in and move ahead.

In the next six months doing what you're getting your kids back doing what you're doing, what will be the most difficult

I guess so, that's a good reason to have a job (not having one stresses her out)

Yeah, that and maybe treat you better. (Eric should)

Yeah, this is kind of off the page here, but some people find it beneficial to have some parental training. Few of us know as much as we would like to about raising kids. We kind of learn as we go. It's helpful to have some guidance on that one. Being a parent not an easy job. It's the hardest job and most important one around.

Sounds like that's not a problem (coffee)

No big deal (she doesn't drink more coffee now)

It might be easier if you get some friends that don't (use) that can be one of the advantages of being in treatment

And, your probably not in a gang. So, no gang connections to the drugs.

Well, having a dream is not so bad. (she expressed not having any) And perhaps you'll learn from your kids. Sometimes kids want to do things and parents have a lot of fun doing them also.

Just like most Americans Heinz 57. (he asked her national back ground)

So, you're comfortable being Anglo. So far, that's what most of us are.

Well, a lot of people find a lot of comfort in that. It kind of like having a good parent available to us at times (being Christian)

What comes to mind is you have kids and you probably celebrate Christmas. (in getting her to talk about rituals)

Maybe that's something between the DA and CSD DHS or whatever can figure out a plan because certainly if you're all going to get back together as a family you need a place to live.

Maybe uh, in some way, strange as it seems, the DA can be an ally. They would rather the kids went with you in a safe place.

With you and Eric using sounds like maybe some uproar at home. Not regular meals and …

It's really helpful if you and Eric work together on getting the family back on track.

I would guess she would want to. So, you would feel okay in asking her. That's real good cause we need people in our corner a lot of the time. (mom may help)

Well, long as this is, it seems that we have motored on through this.

I can't say what you do next. I need to send some sort of a judgment to the DA.

They may give you some options. They may be kind of mandatory options, but… (the DA) I think your goal is, if I hear you right is to get your kids back, for you and Eric to be back together again, somebody's working again, and living as a family. I think between the DHS and the DA they will have some choices for you and they may not be all bad.

You know that was exactly the thought that was going through my mind. (he asked what Debby thinks he would say to the DA as a counselor. She said that she wants to get her kids back)That's a very positive motivation. That's certainly what I would like to see for you and Eric and your kids. My guess is that's what DHS wants also. And the DA I would imagine is busy enough.

My suggestion to you would that you need some treatment. We gotta learn how to do things. We don't get off drugs just by stopping. We have to substitute something that's positive. And that takes time. That takes some good influences. It seems to be that more recently that you have not had the best influences in your life. People who use drugs and alcohol are not on a good path often.

Well, I hope there are going to be some good examples. It's really about is not stopping the drugs and alcohol it's about having a better life. And if you don't drink and use for a while it sure does help.

So, my guess is. You say you haven't used in a week. Your healthy, never had a seizure. My guess is you don't need in patient. Don't need to go to someplace for a week or tow. What you will need is intensive outpatient treatment. That could be two or three times a week. They will also ask you to go to some twelve step programs.

Well, you've got an open mind. What I want to say to you. I would encourage you to go to particularly meetings where they have women groups because women are very supportive of each other. Men are like bears in caves. They stare and grunt. Women take care of one another. You may have to ask for some help. But I'd like to think they would be there for you. You are also going to need a place to live for you and your kids. I don't know what to say about that. Maybe DHS, maybe your mom, how is Lenny acting lately... is he still kind of weird? You don't feel comfortable around him.

Well you might want to share some of your experiences (about Lenny) with Lisa. In that sense even thought there's a big difference between you, you could be a big sister.

I'll be sending a report off to the DA.

You feel okay about going, be safe out there.

Thank you very much for coming Debby. You take care.

Appendix H: Video Tape Transcription

Counselor ID: 39
OS: One (fighting)
50 Minutes

He starts stating that if there is child abuse or abuse to her he needs to tell people.

He also states that she doesn't have to answer anything she doesn't want to.

So, there was some kind of altercation between you and your husband.

And, your children are in custody right now …

So, you're saying that there was a fight and the police came and they took your kids away…

So, you started using at 23 and a month ago you started using it real regular…

Do you get depressed…feel like the world is just a big black place? (trying to gauge her withdrawal)

You say you also use alcohol and beer …

You say crack cocaine when it's around …

You first use meth at age 23, the very first time you used…

Hmm that must have been embarrassing… a lot of people have that experience the first time they drink. (she said she puked all over herself the first time)

Well, I mean let's talk the last year or so … (trying to see if she needs more alcohol to get drunk than before)

I'm a little confused because you said your husband drinks a lot …

So, he was pretty drunk that night (trying to figure out arrest … she says no, he was high and then expands on the opening statement)

I'm sorry you lost your kids I can't imagine what that would be like. That's gotta be really hard. It's gotta hurt a lot. (she cries)

If you wan to take a break sometime feel free. If you want to get up, smoke a cigarette, whatever…

Tell me more about the crack use … (asks about husband)

That must have been hard on you guys when he didn't work…
I'm confused … why was he showing up late?

Just be hung over and not able to do his job very well (feeding what her husband was like at work)

So, you've been married for six years, so you got married when you were 18 (marriage questions)

I've noticed that you say you didn't start doing meth and cocaine until the last year or so (looking for instigator)

Husband and DV questions for a while

You say when he comes down from speed he's not easy to be around … *(more DV questions)*

Protective custody … *(repeating where kids are)*

Sure… (in response to her saying she doesn't like needles … he's trying to educate her on the consequences of her husband doing it)

So, it gives you more energy (she was describing what meth did for her)

Sure … (she says kids are gone as a consequence of doing drugs)

Some people don't think they do (have problems with drugs)

That sounds like that was your wake up call … like this is really serious now (her kids getting taken away)

So, you didn't really see a lot of what you know to be consequences (of her mom or step-dad's drinking)

So, there's things the kids have told her just things that have happened that would cause her to think there's a problem (she stated why mom is distant now)

…but you're not quite sure (if jail will wake up eric)

So um, sometimes when people grow up in homes where there's boyfriend's and stepfathers and their girls their thing happen between the mom's boyfriend and the children … uh…anything ever happen like that with you…

That's pretty creepy (that Lenny – step dad -- played "grab ass" with her)

You don't think very highly of Lenny …

That's gotta be hard to see your mom go through that (Lenny hit her occasionally)

You seem pretty down right now…

Sure… (she said she hasn't used in 7 days, she feels like crap)

So, you're saying fine before you started using meth (sleeping)

Sure … (after her saying she will do whatever to get kids back)

Think your mom might need some help too?

Eric would probably be interested in that ….

So, you'd say to yourself "I'm never doing this again" and next thing you know there you are again almost like you don't even have control over it sometimes … yep …

Okay. Just let me tell you a little bit about what we do here … counseling … what it's like. Cause you say you've never gone through this before…even when you were a kid?...what we do mostly is group counseling, okay, I'm not sure if you're what you would call an alcoholic or addict or whatever but it looks like drugs have caused you a lot of problems and might be good for you to learn from other people how they got off of it and help you get on with your life … and that's what we're here to help you do … we don't kick people out for using so if you have a relapse we're not going to throw you out of the program or …any of those things… I do hope you'll learn to be honest with us about it because it's the best way people can get clean and sober … if they tell us what's going on in their lives… it's got a lot of shame attached to it, if you relapse, but just know that's what we're here for, that's what we do and we're here to help you …as far as DHS goes we can communicate with them if you want to. It's entirely up to you. Um, we would what we normally do is they ask us for a report once a month wanting to know your UA results. Do you know what a UA is? Urinalysis. That's one of the things we do in treatment. People who are mandated, it has to be observed by somebody. We have a female

clinician come in the room with you, they're not watching the evacuation process or anything. They're just there to make sure everything is on the up and up. It's a legal requirement. If it was to go to court and it wasn't completely observed it's not admissible as a legal document. It will work in your favor really, the more clean UA's the better it makes you look. So we do UAs here. Group counseling individual counseling. What we take a look at is the motivation for not using anymore and try to shore that up a little bit. I know you seem pretty motivated to come in and you know you have a problem and are thinking about it. I just want to encourage you, that's a good place to start. I'm glad you came in now and it seems like your looking at it from a realistic perspective. That's a good sign. It doesn't feel like it but … so, what we normally do is …

She's gonna help you with the two months back rent … (returned to question about housing)

That's gotta be a big burden on you right now. What we do…first we figure out if you need to be in treatment or not, then we decide what level of treatment you're supposed to be in … and um... I think with all that you've got going on in your life right now, coming to treatment everyday is probably not a realistic thing for you… how about every other day…it's gonna be like three times a week. The groups are usually two hours all together there's also individual counseling. I usually like to meet with people once a week just to get to know them just for the first month or so.

You know for sure she'll help you (mom as transportation)

There are resources available. Your DHS worker can help you get a bus pass or whatever

I think what we need to do first is figure out exactly what your mom is going to help you with.

Now this level of treatment can change it can go up or down any time during treatment. It's up to you and your level of drug use, your number of relapses, your environment. The worst case scenario is a residential program. We don't kick people out of treatment. We just increase your level of care. If you find that it becomes just too much to handle with all the pressures on you, residential treatment is recommended. I think the first thing you need to do is call your mom, find out what she's willing to help you out with … housing stuff like that… then we can assess further what kind of barriers you have to get in here. But we'll put you in groups to start with then individual counseling. I definitely think drug use has been a major barrier to you living your life like you want to. I think that if we come at this thinking that it's going to do something for you, you can get a lot out of it. I

know it's hard when people are telling you what to do and everything. I don't like doing stuff when people tell me what to do. I can't imagine what it would be like in this situation. But this could be an opportunity for you, possibly, I know it doesn't seem like it. The state has a lot of resources for you. So, I hope you'll be able to see that as a resource and not just an adversary. I've seen a lot of others in your situation who took that belief and it took them a lot longer to get their kids back. It was really difficult for them. Cause all they did was fight, fight. I can understand their desire to do that but it really works against them a lot of times.

You say you've been depressed the last week ...

I don't really have any more questions to ask you at this point. I thought we'd just um now is when we normally do the urinalysis, schedule the first appointment and group session.

You all right?

I'll give you a card and you can call me as soon as you find out what your mom can do.

Thanks for coming in today.

Appendix H: Video Tape Transcription

Counselor ID: 52
OS: Two (meth)
18 Minutes
Student

Yeah, you tired?

Yeah, that's hard...(losing the kids).

Was it your friends or family (the way she got beer as a teenager)

Ohhh (sad expression to Debby saying she was called "Ralph" for throwing up after drinking as a teenager).

But not during the day...(inferring when Debby doesn't drink)

So, you're kind of like self-medicating yourself to get rid of the high feelings...(the beer)

So, your husband is making it and dealing it...(Debby has just said only dealing it)

So, he drinks alcohol too...

So, you plan on being with him (Eric when he gets out of jail)

I'm just curious for your kids...

And so then he probably won't be in jail for very long is that right...

And your goal it sounds like is to get your kids back...

So, you see that as a problem... (using meth)

So, you would like to get clean off meth and alcohol and be there for your kids, basically (Debby just indicated she doesn't see alcohol as a problem, miscommunication)

So, it's mainly just to cope with your husband or...(doing meth)

Yeah, so you don't like that...(doing drugs to be with her husband)

And drinking is just to calm those feelings…(being high)

So, you'd like to do something like that again (work at Ross)

So, it looks like you actually have a lot of good things going for you…you want to get a job, you want to have your kids, you want to get clean of everything…I mean that sounds awesome…I think you have great goals…
So, you only use when your husband's there to give it to you…

When you guys were getting a complaint for noise was that for yelling or anything…

(DV questions)

It sounds like a tuff situation to have kids and stay clean while he's in this place where he's using drugs and selling meth.

I think that you've got these great goals and it sounds like you want to work towards them.

So, you would like to work on getting your kids back. It's the number one goal.

(safety of kids question)

Sounds like your other goal is to get a job.

If your husband comes back and starts using again is that a situation you can feel comfortable with.

I'm sure…(in response to Debby saying he loves his kids)

Because I was just wondering if you wanted to create a plan in case that did happen…in case.

So, you've got your mom…(Debby says she thinks mom would help)

So, those are the two people you think you could turn to outside of any group thing you get set up with.

So, your goal is to get your kids back…

Do you wan to get yourself settled first? (before getting a job)

Let's make a list of some things you think need to happen to get your kids back.

So, you're going to stop using meth and alcohol, get a job, catch up on bills and those are the three things you think...okay great.

Mmhhm I bet she would be (Debby's mom, happy if she knew Debby was getting help)

So, you want to tell her that you have been using meth...

So, you want to tell her what's been going on...

So, you want to tell her about this last year...

And that's pretty much it...well good. I think it would be helpful to continue coming to counseling and maybe get a support group. Just you don't feel alone with everything. And, with handling not having your husband there and not having your kids right now. And it sounds like you've got some good people that you can turn to, to have support outside just your husband even...

I think that you're going to do great...

Appendix H: Video Tape Transcription

Counselor ID: 59
OS: One (fighting)
40 Minutes

So, you have children…

Two year old girl and four year old boy

The police came and took your kids…

So, you found yourself in court…

So, was this meth yours?

…how I can help you to get your kids back…cause that's ultimately your goal right? (introducing why the counselor will be asking questions)

You said you used…do you think it is a problem?

So, you use it like for two or three days and then you recover for the rest of the week and then you go back…

So, pretty much like at the end of your use at the two to three days you use it…(beer)

So, this is just kind of to mellow you out…(pot)

It seems like that's the primary thing you're doing…(meth…asking if she's tried to stop)

So, does he like bring it around or are there arguments that happen…(inferring why Eric is a trigger for her using)

So, you've been out of jail for the last five days, is that it…

That kind of goes together with amphetamines…(inferring answer to why she smokes cigarettes)

And the methamphetamines is a recent thing or…(inferring time-line)

Other than the things you're going through physically, the withdrawals and coughing...your pretty healthy...

In your home is it your children, your husband and you...

So, you've been around here a long time (in Portland)

How about when you were little, was she around then...(mom)

Is there any kind of connection between your step dad coming into the picture and you...(using)

And is that the time when you found your...(when step-dad came around counselor infers that, that is when Debby saw the least of her mom)

Pretty healthy emotionally...happy...(inferring mental health)

You're a stay at home mom... (Debby said she doesn't work)

Did you have financial difficulties or did you have some savings? (because Eric is unemployed)

You have a lot of people coming in and out of the house then...yeah that's difficult ha? (response to Eric is dealing)

How long is your husband going to be in jail...you don't know... (inferring answer)

So, tell me about that relationship with your mom and the things that are going on between her and your husband, that must be really difficult...

Does that put you in the middle between them ...(Eric and mom)

Your daughter, she was talking to your daughter...(inquiring about Debby's mom finding out info. from her mom)

If he is not willing to get well and he's gonna continue using, how do you see yourself...

So, do you think he is going to be willing to go to counseling as well...

So, it's something you both can be involved in and work towards...(counseling)

And you've only been using for about a year, right, so how did it all start?

And the next thing you know you're here. (cause they fought)

So, your husband was the one who really started to use it more and more and you just kind of...in order to get along with him...

So, let's say you were to go home and your husband came home and he would pull out the stuff, probably now you don't have it...but he would probably bring it home or something, lets say that he would... not that he would... but I'm just saying that if he were to bring it home and he was to use it right in front of you how would you feel about it...would it pull you a lot....(more of questioning what she would do)

So you can maybe gain some skills of how to cope with that if it happens...(why Debby would go to NA meetings)

The reason I'm suggesting that is because I think it would be really beneficial, it's your decision, but to gain some skills that you can use when these kind of situations arise. Lets say your husband does bring it... he stays home and you still don't have the children there yet to resist using would be pretty difficult especially because no one is there to watch you and see you doing that and you could kind of...you know, just one time.. so gaining these skills would be a good things...

How would he feel about it if he came home and all the beer is gone and all the stuff you guys stashed is gone...

I want to assume that your husband is just as ready as you are, that would be wonderful. But lets just say, for the sake of argument, you find that when he comes home he's just not ready to give up the life style...(questions about how strong she is for resisting)

So, for the sake of argument lets say that you guys get clean for a few months and you get your children back and then you find out that your husband has been using without you knowing about that...how would you, for example, lets talk about setting up some alternative plans if that were to happen...your mom, would she be willing for you to come home with the children if you needed to... how about you, would you be willing to go with your children and allow your husband to get the help that he needs...

Right...(Debby keeps insisting that Eric love the kids too)

So, when you go home, let me just ask you this, in case there's stuff you find maybe, when you go home are you willing to clean out your house of all the drugs

and all the different things that are in there so that when your husband comes home you are ready to begin.

And, you're talking with your husband I presume...

So, would you be willing to the next time you talk to him talk about your recovery and his recovery and see where he's at for that...

These would be a couple of things that would be good to begin that way you know where your husband is at so that you can begin your treatment with some kind of direction. It seems to me you're very connected to your husband, which is a good thing, you should be you're his wife. But also when you're both using it can be a really difficult thing because you're so connected to stop because you don't really have control over the other person's decisions. So that way it will prepare you a little bit for when he comes out, okay?

I think what I would like to do, if it's okay with you is meet with you a couple more times before we start formal treatment...

How do you feel about contacting your mom when you get out of here and talking to her a little bit and maybe going to visit her so you can have some support.

How would your mom be with you being honest about everything that happened?

(lot's of support questions)

Between now and our next meeting can you at least contact her and at least attempt to talk to your mom... see how that goes...seems like you said Linda would be a little bit more open and be a bit easier to talk to her...(family support members)

How comfortable would you be with saying, you know what this is not a good time, I want you to go away...(if "druggy" friends come around)

So, in the evenings would be a good time to attend those meetings. That way it will keep you busy so you don't have to think so much about what's going on... it will help you..

How do you think you're doing spiritually? Have you ever attended church? Do you have any kind of awareness of your spirituality?

So, it's not something that you grew up with. Like AA meetings and NA meetings they're twelve step meetings were based on, there's a lot of spiritual things that are addressed, which are good things...so when you go to that meeting and if you don't

feel comfortable with that, we'll explore some more options. I thing you'll enjoy it, there's a lot of great people that go there that you'll be able to connect with. I also want to suggest to you that if the first meeting is not one you like, go check out another one, becasu they all are very different. It's like going to someone's house and they are all different. So, if you go to one and you don't feel comfortable go to another one maybe go and check out a few of them before you make a decision about which one is home. Because I know sometimes go "oh no this is not for me" and they have not really gone and found the one where they belong.

It's kind of just a thing that happened because friends were bringing it over and... (asks a trauma in childhood question at the very end)

Well, just so you know to encourage you I feel that you are on the right track. You love your children. You love your husband. I've seen it over and over again that people like you come into treatment and when you're really wanting to get well that they get their children back. So, I just really wanted to encourage you on that. And this is a really good time for you to explore yourself and where you're at and explore a new life a new beginning. And I really encourage you to talk to your husband with where he's at with his decisions about getting into treatment and we can talk about that next time as well.

Appendix H: Video Tape Transcription

Counselor ID: 70
OS: Two (meth)
16 Minutes

Ok so their in custody right now (kids)

And someone said ... a neighbor called.

You haven't seen them yet.

They have pretty good foster care to take care of kids. They take pretty good care of them. They have a good system set up. You'll be able to arrange visits them.

Ok. So that seems to be your problem that brought this about. (the fight and kids)

So, they were thinking that the kids were neglected.

So, you continued to drink beer since you were twelve.

Good ... Good (in response to not using in a week).

Ok. Very good (in response to her stating a goal of getting her kids back)

Well, I applaud you for not using for a week. Has that been difficult for you?

That's a good move not having used and that's a good move toward getting your children back. So you're on the right track. OK

OK good. (no self-harm thoughts)

So, umm, you said you and your husband had been arguing that night. Do you want some water? If you change your mind let me know.

So, you are determined to get your kids back and that's .... (abrupt switch from discussing Eric)

I'm thinking ... what did you have in mind ... other than this is the first step?

Good ... very good... sounds like you've given this some thought ... you know what's coming up... you recognize you have a problem ...and are willing to take

steps to correct that for your kids and get your life and go on with your life... looking for a solid job and your getting your GED

At this point ... (more questions)

The good news about something like this happening is that it will put you in a place where you can get the help you need so that you can continue parenting. So, I'm gonna um. It makes sense... the kids are in custody ... umm ...

I'm thinking probably intensive outpatient treatment at this point would be good for you.

That means there would be three or four meetings a week with a counselor and groups um... and you would be able to live at home you have to be in a facility ... and the only option I'm looking at too is if Eric gets out and is still wanting to use...give it some thought ... there are precautions you can take... there are restraining orders you can get to protect yourself...because if he comes around and is using it could jeopardize your program... I hear you're aware of that and hopefully this will be enough for him too to want to make some changes. At this point I'm going to recommend intensive outpatient... how do you feel about that? I'm thinking that would also give you a chance to get going with your GED and look for a job and do some of the steps that DHS are probably gonna require also and give you time to visit your kids too.

(ending the interview)

What you say here will stay here unless I get a signed release from you to release info. or opinions or diagnosis to anybody you want to have that. I just want you to know this is all confidential. I'll get in touch with Holly and get you going with an appointment. I think you're doing okay and I think that now that you're a week out from doing meth and you said you're feeling a little better today and it should be getting better and better because it works out of your system in a few days and so there are community meetings you might also want to get in touch with because a lot of the additions is what you're telling yourself about drugs. So you might want to get into a community group like twelve step or there's smart recovery there's several groups out there and I'll give you some information about them ....because just the support is really helpful for long term and initially and so I'll encourage you to check into community resources and we'll get you an appointment...just as soon as we can to get you into outpatient.

Okay well we'll get you an appointment. Well good luck to you and I admire your courage for tackling this.

Appendix H: Video Tape Transcription

Counselor ID: 76
OS: Two (meth)
18 Minutes

Good (in response to a week clean)

Well that's one of the best motivators you could have really (wanting your kids back)

Everything else was just experimental here and there (kind of question more a statement in response to Debby's asserting trying crack)

Sounds like this is kind of … so how you've been doing with the kids during that time… do they get on your nerves more … are they easier to handle?

That'll be a big part of it, it really will. You know I'm sure you've talked about people with drug problems before. They always say it makes a difference if people really want to do stuff. That will make a difference. (her wanting to get better)

Probably right, especially with you guys together (Debby says her and Eric's going to probably need help). You know usually the courts want to take a look at both parents you know, see how their doing in the long run. It sounds like short term is a little more relevant to you.

A lot of times they don't want to place kids in a foster home. They want to keep them with the family.

All right well what I can to with that too if you like is I can have you sign a release and then I can talk to the courts and see what they have in mind to….

It's been a week, gotta place to stay so here's a vital question for treatment. We don't want to leave you homeless and try to do stuff either…you thinking maybe going into residential for a while might be a good idea …would it would be cheaper in the long run to just throw your stuff in storage and get a job, that kind of stuff

Well, you know people have different ideas what might be best. Usually we have to start on what you think might be best too.

Here's the options that you've got it sounds like at this time. TBI has an inpatient program. Alpha house has an inpatient program. We have a residential program but it's more … we deal primarily with homeless women but you're not homeless. We

do have treatment services here also that you can get for free. Do you have any insurance anything like that … okay so we're looking at what's available basically for pretty inexpensive.

Well it sounds like. You haven't been involved with it a whole heck of a lot of time. Sounds like most of your …

You wanna wait for a minute on that until you get a little more stabilized (quitting smoking)… just quit ha, cold turkey (amazed that Debby did that before).

Well, incredibly motivated, and that sometimes will have a big difference in what happens in treatment and things like that and of course look at those kinds of things too, how motivated you are and that won't be an issue … high motivation.

Sounds like you would qualify for umm. If you're housing is stable we can look at outpatient. If its not we need to look at inpatient just for your safety.

Sounds like maybe a job might be high on your priority too.

Well, good news. Because you've been clean for a week you can pass a drug test. I have some referrals I can give you for employment. You know get you started on that. I'll give you some names of some agencies I've been working with that are pretty positive about getting people jobs.

You scared of seven elevens? Plaid pantries? They're a little scary sometimes.

The other thing I'm thinking we're going to need to check on is if you need to be taking classes, parenting classes, other than drug and alcohol treatment it sounds like there may be some other things they want.

It's awful hard if you have to be going to work and you have be going to class at the same time.

Well, it looks like your totally outpatient … looks like a real good fit for this point in time. We'll try that first. If you start having problems staying clean…or I'm thinking Eric's friends may come hang out or check back…see how Eric's doing…and you know how that sometimes works… you know they come over…"hey get you out of your troubles" and give you a little line here…so you may have some of those problems with people coming around.

Very insightful (she says Eric's friends are not her friends anymore)… Very insightful (again).

You are already starting to get a grasp on a little more things I think. A week doesn't sound like much time but...

Drink tons and tons of water and if at all possible get some fruits and vegetables it will help with the detox process. Try to get some sleep, I know you're probably not sleeping that well at his point in time you're worried about your children. That's very natural at this point in time.

Okay. Well, why don't I set you up then ... I'll set you up for your first group for this Sunday and I'll talk to the DA and tell them that you arrived for your assessment and your'e perfectly willing to do what it takes. We'll see what it takes for you to be with the kids.

Now, talking to mom...this is probably one of the most critical questions. Because right now it seems like mom's going to be ... you're going to be really dependent on her financially and possibly for custody of the kids.

Asks Debby to make choice of who calls mom.

Sets up practical contact issues.

If one of the guys comes over or gals comes over and you catch yourself being tempted what do you wanna do about it ...

You really get the feeling like you want to use...got this overwhelming urge...there are thirty NA meetings a day in the Portland area (*give her bus tickets*) and I'll set

Is this all too much for you or ...

Okay, well I just don't want to overwhelm you right off the get go.

One of the things that also may be helpful for you is to sit down maybe a pad and piece of paper and make a list of stuff you want to work on ... I have found...women who do sessions ... I'll probably be your counselor...

You want me to write some of this stuff down or are you okay with it?

There you go...you got it...well you know sometimes that's the way to do it, one day at a time.

Thank you for coming in today and I'll look forward to hearing from you again. Good luck to you.

Appendix H: Video Tape Transcription

Counselor ID: 81
OS: One (fighting)
30 Minutes

That sounds really difficult...(response to opening statement)

So they took your husband away too...

So, basically you've been alone at home right now...

So they took you away as well....

So, you don't know where your kids are...that must be very, very hard for you...

So, sounds like you would really like to work on getting your kids back...so that's your priority right now...

So, you're looking for a job...

Kind of makes this pretty bad right now...(that Debby is tired)

That's good...yeah that's a start!!!!! (that she hasn't used in five days)

You haven't used in five days, that sounds like an accomplishment...

So, he was the biggest...(response to Debby saying Eric isn't around so it's easy to not do drugs)

So, you said he's in jail right now...(question about his return)

How do you think the situation will (work with) your goal, which is to get your kids back (Eric coming back)

You can stay there...(inferring answer about housing...the trailer)

Oh I see so you have some support...(Debby says mom would help if she knew Debby was getting help.

So, she's concerned about your life and her grandkids, which are your children...that's great.

Given what you're going through right now, that's pretty typical that you're having troubles sleeping.

And that's the only thing you ever use...(inferred answered)

So, that was the first time you ever tried any kind of drug ... (one year ago with meth)

So, you don't usually drink...

And that helps you to calm down...(drinking beer)

Just cold turkey...(how she quit)

It sounds like you've been through a lot of stress at this point...how are you coping?

So, you have someone to talk to and what you need to do to get your kids back...(referring to the DA)

Sounds like you really love your kids (Debby reiterated she's do whatever to get kids back)

So, it does sound like your husband is the reason why you started using meth and drug you down into the drug environment. It doesn't sound like he was always look like that hu?

Sounds to me like he's a big motivation.

His stress is influencing you to ...and eventually now your kids are taken away from you...

Sounds like you're working hard on that...(Debby says she needs to get a job)

Because your husband has been a big influence on you... of course you guys are a couple and married, so which is really normal, natural to be influenced by each other at the same time when he is going to be released you're saying he's going to quit as well.

You believe him you care about his (something) as well.

What if he doesn't?

He will (counselor repeats Debby)

Maybe one out of 100 percent possibility but what if he comes out of the jail and starts using again. Which is important to you to get your kids back or to be with him.

Hopefully it's not gonna happen, but if it happens do you think you're ready to go somewhere and seek the help as well, as a couple, you and your husband…

So, if that happens, I hope you will give me a call or call your case worker. I'm sure you have a case worker as well.

You're coming here to counseling…(responds for Debby that she is doing this as part of current recovery)

That's not your thing hu? (church)

I've heard your mom sounds like very supportive to you and your kids just to get back into…

So, there are two people. (mom and aunt as support)

And you haven't had any medical problem or anything… pretty healthy.

(recommends NA meetings, five of them, until she finds one that feels like home, and other people feeling the same thing)

You'll find a meeting like that and once you find it it's just really you can just get a lot of support from those people.

No not much, you're doing okay…(Debby nods head no to whether she's going through withdrawal right now)

But now you're just feeling…

It sounds like your kids, just thinking about your kids just keeps you going…even though you're feeling like shit.

So, the length gradually got shorter and the amount gone up…

In the last five days is the longest you haven't used it…

Sounds like you're going just the right direction…

If you're case worker can recommend you, and take care of the bill and everything can you see a doctor and see if they can help you ease it down.

I have to write a report to the case worker and see if it's possible for them to arrange that for you.

It sounds like you're going in the right direction and you're doing the best you can do and you deserve the best support possible during this difficult time...to get your kids back.

It kind of sounds like a crisis. Sounds like you guys have been fine two years ago and just all of a sudden this kind of a thing happened...

What let you let him influence you (to use the drug)

So, it kind of start snowballing ... the time you woke up and your kids were kind of gone...gosh what happened...

It's kind of natural...(Debby says drugs were always there and that's why (plus Eric stuff) she didn't quit before.

So, that's sounds like the same thing you it just started happening to you and feel you'll be strong enough just not to use...

I'm just a little concerned about...cause what you're going through is a really really difficult situation especially with how much you care about your kids and they're gone now, although it does sound like you're doing a really good job just getting back on your feet.

You doing okay with taking care of yourself, pretty much...

Just very much wanted to get your kids back...it sounds like you're pretty determined...

Before we see you again next week do you think you could attend one or two NA meeting...

Appendix H: Video Tape Transcription

Counselor ID: 95
OS: Two (meth)
53 Minutes

I'm really sorry to hear that...(that her kids were taken)

And that's been with Eric (that she's been doing meth for a year)

That's really scary (that this is the first time she's been in trouble)

You've got, uh, nothin...(response to Debby not having insurance)

I'm going to really highly encourage you to get a hold of SCF so that you can find out who your case worker is so that you can visit with your kids. I mean a week...you must be going coo coo wondering about them. I don't know if you're sleeping...or...so you've been off of it (meth) since they got taken? (response to Debby stating she doesn't know what's going on with her kids)

I would really encourage you to call them ASAP so that you can at least have even if it's a supervised visit with your kids... you know just to see them...I'm sure that they want to see you too...that's very heart wrenching.

I'm guessing you're unemployed.

I'm guessin you're a binge, run, crash type of user.

So, the drug use was really effecting your job.

When you're using the meth, like I said I'm guessing binge run crash, you kind of...you do it, you're up four days at a time and then you...

They've got a room in the trailer (in response to Debby saying the kids go in their room while she uses)

I bet you do...(miss her kids)

Well this is an opportunity I think...um they may suggest it and encourage you to do it...I'm not gonna paint a pretty picture here. You're now in the system and having to do a lot of hoops to jump through. It's not fun, but it's mandatory that you go ahead and do these things in order for you to get your children back.

And you never met your father so I'm guessing you grew up with…(inquires about mom's partner)

Well that's not nice (that step dad hit mom) and I'm sure it's not very good for you to see.

You got married to him awfully young and you're young now and you married at 18, you said he has outstanding warrants so I'm guessing he's in trouble with the law (she then inquires about Debby and Eric's relationship)

I'm just curious. Were you doing anything else together before the meth came into the picture, a lot of drinking, or cocaine, or…

So, you didn't do this much as a teenager? (use)

In the last year with the meth use with you and Eric were there more fights?

So, this drug use has kind of infiltrated your life in a pretty significant way.

Well, she must know something now, I mean the kids are…(in response to Debby not knowing if her mom knows about drug use)

I'm gonna also direct you, the case worker can help you with food stamps, the case worker can help you with insurance, getting your electricity turned on…

So, you have a relationship with her and you might be able to give her a ring…(Eric's aunt)

So, you do have a few resources out there for you to …kind of call in on and say "hey."

Sounds like you've been sober, sober…kind of has slapped you cold ha? (Debby hasn't used in a week)

And you don't know much about your biological father…

And he's never tried to get in touch with you…and there hasn't been any child support…so he's just been a dead beat dad…(Debby's dad)

So, it was just you and your mom growing up in Arkansas…you think she did okay…she worked hard… like held down a couple jobs at a time…so she's a cashier

Were you alone a lot after school and all that, going home... latch key and all that...

Lenny didn't come over and move on in quicker and all that...so he was obviously willing to move out here...so he has a good job...

So, you don't know if grandma and grandpa, you don't know much of your extended family. Okay. I was just curious if there's some sort of hereditary gean in your family that might be part of you...

So, um you never got in trouble with the law, growing up in Arkansas, or you never felt like your mom wasn't there for you...in your childhood... there was no abuse going on...physical, emotional, sexual abuse....

So, alcohol, you never really cared for it. You just do about two beers a day...

I'm just curious how you guys are supporting at all the household (questions about what Eric does for a living)

Oh, he's been selling...

That's uh pretty scary, you know having people come over where you live and wantin to get the drug...

So that's how you guys were able to maintain at minimum a roof over your head...

Did you like the fact that meth kept your weight down? And...like your bone structure was coming through and it wasn't very attractive...

Gorging...(counselor laughs)...you know I've known people to eat a lot of sweets, like ice cream and yogurt, cause all that calcium in it that helps...(this is in response to Debby saying she has been eating a lot this week.

It's so pretty (counselor laughs in response to Debby saying she doesn't like her smoker's cough).

So, when they said there wasn't much food in the house...for the kids, cause they're really growing and um...(questions about Debby feeding the kids)

He's learning to fend for himself very young ha...(Debby's son)

I don't know if you know a lot about it, often times people do know some things about treatment (names the kinds of treatment)

So, you guys would get into some domestic violence…you think maybe you were provoking…(Debby says the violence goes both ways and that it's not as bad as it sounds)

Do you see yourself getting your life together and being a healthy mom for these kids and having them back in your life?

So, you think that you can be a really good mother to your kids…

So, prior to this last year, you felt like you were doing a great job…

I know that SCF will require parenting class for you as well. You know if you were to take some initiative…to go ahead and contact certain agencies…but if you take initiative they're gonna look really highly on that…

So, you don't your grandma, mom's mom…

So, you want to find a job…

You know if get a drug test right now, you know there will be marijuana in your system…so, you either might want to be up front with them, or you might want to wait.

That is also part of what I'm going to ask of you today, here, I just want to make sure you're on the up and up with me. I'll know that marijuana is in your system so I won't be surprised or anything of that nature… you said you've been real clean and sober over the last week so that's what I will expect.

You did!! (quit smoking for a month)

Do you know the average time it takes to quit smoking is seven. Quitting cigarettes is like quitting heroin. They're both the hardest drugs to quit. If you're interested in quitting I can assist you with that, if it's, sometimes people don't want to end all vices right away because it's overwhelming and you have so much stress that you're going through.

So, I'm going to request you take a drug test for me today. There's a place out there called methamphetamine anonymous. I don't know how you feel about the drug. Do you feel like you may relapse and go back to it? (asks about environment)

It's kind of like a huge nightmare you woke up to. Like everything just flipped topsy turby on you. Did you ever think in your wildest dreams this would ever come?

And when he used, did you just go ahead and use…

So, the experience is there for you to go back, get a job…

Is there anything else I can help you with today, now. Cause I can get you a whole lot of stuff right now, like um, it would be positive for you to get involved with a few things here…to get the wheels in motion and gets your kids back (counselor offers a place to get cheap clothes, a number for parenting classes)

I'm not sure if you want to try this, but it might be part of your outpatient requirement, but methamphetamine anonymous or some kind of narcotics anonymous. If nothing else just to check them out and see if you can relate to it at all. At least there will be people there like yourself and they can give you some sort of direction and help.

This is my thinking okay…you've used marijuana and you're pretty addicted to nicotine, and pretty addicted to methamphetamine. But right now you've determined and kind of what we call preparing yourself to do away with meth. The major concern I have is Eric coming out of jail and coming back and wanting to get back into it. That would be my major concern…

He's been a real good father up until the meth (response to Debby saying this will scare Eric too and that he loves the kids too)

Well we can always hope right, that that's gonna be the case. I lean toward, you know, supporting your request. I'm usually pretty accommodating. If outpatient…but I probably would say more of an intensive outpatient…(information about it)

And I can get you set up in that NA and we can get you goin next week. I'd like you to make some phone calls today before you leave. Id like you to call DHS and see if you can't get a hold of who your case worker might be and maybe make a personal visit with them. So that you can get… and know what they need and that sort of thing…find out where your kids are at… they are probably dieing to see them.

All is not lost, there's lots of hope here. You just need to persevere and bite the bullet.

Cause you'll want them to know you came here today right? (the counselor laughs)

You got a lot of things to do…I don't want to overwhelm you…

Appendix H: Video Tape Transcription

Counselor ID: 115
OS: Two (meth)
30 Minutes

I understand your kids have been taken away and that can be temporary (*has not asked an open ended question yet).*

Five + minutes in before the open ended question.

She used both opening statements, albeit the meth one first.

So, you've been using about the last year.

But, you would say your drug use has progressed in the last six months …

Those are beautiful names … those are great names (her kids)

So, those are good things, those work in your favor (not being in trouble with the law before)

So, now the two of you got to fighting it got loud, it got out of hand, the neighbors called the police … (then where were the kids during this)

So, you spent one night in jail…ok

So, smokers cough in the morning…your'e not expecting

So you do feel like there's a problem (with meth)

So, you've been clean for a week

So, alcohol …so…cigarettes maybe at 13…(drug history)

You used cocaine 6 months ago. 23 first usage (meth)

So you used cocaine for the first time since you've been 24.

Let me just go over a few things with you for a moment. I want to make sure I have the right information.

So, you're 24. You've been married for six years. Is this your first marriage? Um, your husband is currently in jail. He's been in there the last week since the incident occurred. He was taken to jail for a failure to appear for a second DUI is that right? And, then he had a little bit of speed. Okay so they took him into custody. You spent one night just to cool down and they let you out. You have two kids. A four year old his name is Tyler and then Hope is two, that's your daughter. And then you guys were arguing and bickering and the neighbors called the cops. You have been cleaned up for the last week, no meth no alcohol. Very good. And you said to me you realize …maybe the last six months the drug usage has really progressed and become a problem…you guys are living on state assistant…he get unemployment?

So, a couple months ago was the last time you worked. So, you've worked at like Ross, um beauty supply store … like Sallies? Target…I love target.

Part-time because of the kids.

Is there any domestic violence going on in your marriage? *(included because the first time a blatant question was asked in relation to this)*

So, there is domestic violence on both parts.

You seem a little depressed. Or are you just tired and exhausted from getting the drugs out of your system?

So, let me just go over the drug history part I want to make sure I have the right information. So, as far as health concerns you said … other than a smokers cough in the morning…that's pretty much it so that's good. You started using alcohol between ages 12 and 13, first usage. Nicotine at 13 and then you started smoking marijuana and then you tried ecstasy at 16. And then at age 23 first usage of meth and then age 24 you tried cocaine. And then between the ages 16 and 23 you've been just like what, drinking and smoking week off and on throughout the years…

…because of the drug usage (offered as reason relationship with mom is bad)

One sister … she's younger.

So, you haven't had any contact (with dad)

One sister … how old is your baby sister.., oh good age, she's ten

Okay…okay *(not happy…in response to Debby stating she hasn't been taking that good of care of kids…this appears to be a seminal point in the interview where the*

clinician becomes more removed for some time and starts taking over the discussion and not asking questions.)

So, let me just give you a brief scenario of what I see. Clearly there is an issue with a drug issue. There's no doubt about that. And, as I'm like the go between person, Im like in between you and DHS and the judge. So, they look to me to make a referral. And, give them my suggestions and my thoughts on what might help you. Because you have two small kids...Hope is two and Tyler is four ... you have the opportunity to go into a residential treatment center with your kids... we can make that happen. I guess the other thing I'm concerned about too is your husband. Because it really needs to be a package deal and I know that family is important ... tell me a little bit about that.

Okay so, again back to where I was before I asked you what does family mean to you... I am going to recommend to do residential treatment with your kids because that is an opportunity for you. And I guess the goal now or the priority is to figure out which one you'll go to. There's a couple treatment centers just for women who will take you and your kids. I'm going to try to find you a placement. So, my recommendation to you is to complete the program. It can be anywhere from three to six months. During that time you'll get some parenting skills. You get some uh... what is it called. Well, of course you'll work on your hygiene. But I was thinking of some living skills for house cleaning for cooking for time management to prepare meals do baths have set bedtimes and that kind of thing. And more importantly, you get to work on you and do a little soul searching about who you are. I think maybe an anti-depressant will help with your depression. Because I'm sure if you've been using meth on a regular basis and coming down you might need something to help with a little balance. So, I would suggest maybe like Prozac, I'm not a doctor or anything but just from some of the drugs I've done some research on. You could probably start with 10 mg of Prozac and then go up to 20 mg for a while to see if that helps curb you just a little. And that way with you going into treatment you will be able to keep getting some assistant. It will help you get some clothes for your kids some clothes for you. They can get a little schooling. They can be in an environment with other kids where they can be them. It's difficult for them to be them when they're in an environment where people are using. It's abusive and it's destructive.

We'll need to set up a visit (with kids). Because once we can get you a placement into residential treatment you will be reunited with your babies so they can be reunited with you as well. I think you need to call the judge and let them know you will be placed in a treatment center. And the treatment center will be able to take your kids as well. In the mean time you need to not drink or use. I'll give you a ... have you ever been to a twelve step meeting... okay, so that will be new for you...I'll give you a meeting slip. I don't expect you to do that right now because,

again, this is all new to you. I want you to try and sit patient until we can you a bed and treatment. Again, I'm ....okay give me that number (contact number).

So, today is Wednesday I should be able to get you into a bed by Friday, but if not Friday then Monday at the latest. And so I will call and leave you messages and I'll give you a card so you can contact me. And I'm gonna try and find out who is the DHS representative so I can contact them so we can get your kids reunited with you and you three can start the treatment process.

And that's a healthy feeling (she's afraid for her kids and wants to see them). Keep your head up and try not to drink and use in the meantime. Think you can do that? Okay, take care of yourself.

Appendix H: Video Tape Transcription

Counselor ID: 117
OS: One (fighting)
46 Minutes

So, it looks like you were mandated here to take an assessment today by the district attorney.

Maybe unkept...(answering for Debby about how her house looked that would have made the DA think there was neglect)

Nothing big...social gatherings and...never by yourself and...(responding for Debby about how often she used pot and drink)

Looking to see if there's a generational...no problems there...with drinking or health issues. So, you said ecstasy at 16 and you started up speed a year ago.

Good, Good. (that Debby thinks she has a problem)

Wow, Good! (that Debby hasn't used for a week)

Good, good, sounds like good motivation then (Debby says she's willing to do whatever)

When your husband was with her ... just like her (confusing...the latter is about step-dad's drinking)

That would be a great distance to develop a relationship (14 years difference between Debby and her sister)

Oh...okay (surprised, mom and Lenny been together a long time)

Okay, sounds like there's no contact with the grandparents then...

Mmm (sounded like "bummer" when Debby said Lenny was touchy feely with her)

So, no trouble with the law in the past...good.

So, both of you are not working currently.

Oh, very recently (couldn't discern the rest...Debby had stated she has been unemployed for a month)

Not such a fun situation (Debby said her boss was an asshole and that's why she got fired)

Oh good, yeah (Debby was working at a Beauty supply store)

You ever felt like your drug use might have been to a place where … (unclear again…it was about drugs around kids)

Would you like to eventually get back to work?

Ok. Yeah. Sounds about right (that her last TB test was two years ago when she was pregnant)

Good. (Debby answered yes, that her kids were pretty healthy right now)

Ever around the kids, or…(using meth)

Is there a certain room you go into… and the kids might be left in another room…

Yeah, you pretty close to your kids, yeah, it's pretty hard isn't it. Sometimes we all have to get to that rock bottom moment to realize, have it hit home to us…

Good, Good (Debby says she has a problem but will do anything to get kids)

Meth withdrawal can do that…(Debby says she feels depressed when coming down)

With speed you're obviously not shooting it up or anything…

So it's been a while (since she saw a doctor … pregnancy with Hope)

Those are two things that I would definitely look into. Check out your liver. Check out your nose. Then smoking obviously both with the speed and the cigarettes. Find a way to cut down on smoking. I always tell my clients, if you can't quit smoking, at least find ways to cut down. The other thing about smoking it can lead to needing vitamin intake. So it's important to maybe take a multi-vitamin to supplement that.

Your face and your arms look amazing to me …being on meth…

So you guys don't get out too often, you both stay home a lot…(in response to Debby saying Eric is not a very social person)

So, there was never a time when you had to exchange drugs for sex or anything… oh good.

So, you do believe in that concept of a higher power or…good, okay.

From what you've told me with a drug history. It looks like it might not hurt to do some outpatient. I don't know that you need residential. Of course I'll have a better idea once I get a chance to

Are you nervous about anything or, how are you feeling?
Would you say you have an overall good relationship with your kids?

Did they ever sense any trouble between Mom and Dad?

Do they have any sense that you use drugs?

Has he ever asked you about it?

Yeah. (In response to Debby saying Tyler told her mom that they never paid any attention to them.)

So, you would say overall, that they're happy pretty balanced kids…

That's two year olds for you…(Hope is into everything)

Good. (That what is keeping Debby clean is thinking about her kids)

You know also, if by chance, you find yourself going into withdrawal there's detox too…help you get it out of your system.

It sounds like you've gone through the worst of it.

I guess we'll cross that bridge when we come to it… ha ha ha (detox if she needs it)

Instilling routine or structure/discipline back into your life… we lose a lot of that with day to day… drugs…residential brings a lot of that back to our lives…there's a lot of down time too, it's not like it's constant treatment… the first two weeks are a black out period, no contact with your kids or husband…if your kids are five years or younger they can come in with you…

Thank you for your time. So, hang in there. Alright, good.

Appendix H: Video Tape Transcription

Counselor ID: 140
OS: Two (meth)
16 Minutes
Student

Debby gives history first, name, age, from South, married for…years, then clear opening statement.

So, you have a few hoops to jump to get your babies back (after further prodding Debby restates that her kids were taken – it is in the description counselor's receive prior to meeting her).

Let's see what we can do to make that happen.

Has Eric ever hit you or hurt you or make you feel afraid (included because an odd jump

Just normal fighting…

It's not like domestic violence you figure because you hit him back…

I want to warn you as well that it is now a Class C felony to have any kind of violence in front of children, I just want to caution you there…

No judgment call here, but how long have you been using…

Six months ago…

What do you think is going on six months ago that's different than before?

So, he was cut back on salary and you started using quite a bit more after that, and selling…

Did you have to start after this, after the salary got cut back, and you started more, I mean there's more access so there's more use…

Yeah…I'm a stranger to the game (laughing from counselor)

And the lack of job, okay what's going on that Eric got cut back, coming back six months ago, something happened….

What's going on with Eric is he an alcoholic?

I'm just trying to pin point something six months ago, you mentioned Eric went down part time with his work because you had an argument. So, he's having some stressors, there's something going on with him as well. You start keeping in pace, more access, more use...and it snowballed pretty quick, so whatever is going on it's been six months....

Some pot and meth...

Snort or smoke okay...

Do you see yourself shooting up? does he try to get you to do it sometimes?

It's been about six months...

Okay, so where's Eric at is he in jail still?

Okay, so you're still waiting for him. Of course, that's why you're here.

And, child endangerment...

So, since you're...this is a little out scope but just let me...if you're going this custody...I'd like to get you into some treatment, residential...if you're at home, I don't know how that is, housing, whatever you can afford, to not accrue that expense...

Like a 45 day treatment with some outpatient afterward...

There's also medication. So it's merely just doing what's good for you, getting you clean...you're pretty well detoxed after five days but you've got a lot of stuff going on I'd like to see you have some support around...before it spirals out of control. Right now you're at a place where you can get your babies back with some hard work and some support...

You're pretty hopeful...

I'm telling you right now that with this charge and if you're convicted you're going to be doing treatment anyway...

How's Eric doing in jail?

It's definitely not your responsibility. I know there are twelve step programs in prison. And see if he'll check 'em out. See if you guys can talk about that stuff. It's a lot to bite off but, some people say it's even like brain washing...but even if you can get some of the baggage, some of the wreckage, and some of the good things come about because of it, it could be a blessing in disguise. You know these babies need both their mommy and their daddy. They need them well and they need them healthy or their not emotionally available...are you okay? (Debby shows emotion)

Let's call your mom, you said you had your mom, yeah? ...we'll see what she thinks about taking care of your home while your away...get your mom to sign a release so I can talk to her...you've got a lot of people paying attention. You'll find that when you're trying to help yourself other people will be helpful as well. If there's anything else I can do for you please don't hesitate to call.

Appendix H: Video Tape Transcription

Counselor ID: 144
OS: One (fighting)
71 Minutes

When you say fighting, you talking physical-verbal? (*first question so included*)

You met your husband in high school, got married, had children? (*statement and question, he was surprised)*

I know retail you have a lot of interaction with people (*he's leaning toward thinking she considers this one of her better qualities based on this inference*)

Cause I know your children tend to active (*trying to see if she matches as an active person)*

So, you've always had your children and now this is a new thing for you and it is painful as a mother.

You seem like somebody who you know, maybe, I don't know what your husband is going to do, as far as your concerned, for the four year old and a two year old their needing their mother, so hopefully that can happen (getting her kids back).

Actually they probably could have it in jail (drugs), I don't know, but the assumption is he probably would be clean, but uh, if your going to be getting some help in treatment and you plan to stay with your husband it probably makes sense that he would try to get some help too.

Hope that this experience… (scares the husband like it did Debby)

You know you have such pretty teeth, you know what happens over a period of time … cause I know that meth use kind of hurts your teeth. If you've been around people who've used a long time, one of the way it affects them is it eats away the bone marrow…you might want to give that some thought, because I know that, well a whole lot of reasons, one is you want to be able to chew your food, and the other is if your going to be dealing with the public your going to want to have your dentures in order, that's one of the things that long time meth use, but there's other things that happens, before we get through here I get a chance to tell you some of those things. But there's probably already things you know about meth use. So, hopefully and this actually has become what they call an epidemic. So your husband and you … it would be useful to get as much information as you can. And

if you have any questions be sure to ask me. If I don't know, I'll just say I don't know and try to get you that information.

What I'm trying to say, if they say, okay you need to do some inpatient treatment does that mean you would be able to keep your trailer, or ....

Because that actually could happen. They could say okay in order for you to get your children back you need a 90 day treatment program. Then you could have visits with them and then you get them back. It could happen. Because there are children who have been neglected as a result of their parents or parent using meth. It's notorious for that. People become focused on use of meth. And you have to as a parent you have to focus on your kids because they need attention around the clock. So, I just wanted to bring that up.

But you haven't at this point in time... *(called the DA to find out what's going on with the kids)*

Why did you frown up when I mentioned a needle? That's just something that's totally out of the picture...(he seems surprised)

But you currently smoke cigarettes...(just commentary on use but bothered to repeat this)

I imagine you were trying to look adult or something...that's how it happens for a lot of us. (smoking)

It's if it's five dollars a day, a year ahead, that's 1500 dollars (cost of smoking cigarettes). Imagine that your rent, or not your rent but your payment on your trailer is a lot less than that. Not to say that I don't know that it's hard, I know. Nicotine does a funny thing to the brain, you know, it circulates and kind of tricks the brain. A lot of substances/drugs circulate once and they're gone. But not nicotine, so even when you're not smoking, you still have it in you. That's why some people can quit for weeks at a time and then they're back smoking. (asks if she wants to participate in smoking cessation program)

If you're smoking cigarettes I imagine when you're using meth you smoke more.

13 was a big year for you (response to her trying things for the first time then)

So, you were married at 18...

So, you plan to make this area your home... (as opposed to move back to Arkansas)

Oh, you think you'd be a good counselor? Ha Ha (he says this in response to Debby stating that counseling is one area she needs help with … it was not a malicious response, more just lightening things up)

Where would you be, an average student…(his guess)

People are often times multi-talented, they can do more than one thing … (in response to her not stating many interests)

Well at some point your probably gonna have to take a look at that (Eric's use or not use post-prison). Being individuals he may decide… or maybe his addiction is farther along than yours…that's a little unusual (that Eric started using at the same time she did)
Oh is that right? (that they had classes together – he seems interested in this)

He's a good father would you say? He could be much better though right? I'm saying because of your usage, it costs money, you didn't get it free did you, he was selling it, was he making it, because sometimes people will rent or buy trailers and that's where they use to … some of them blown up too…(he laughs)…you don't want your trailer blowin up? (he laughs).

Wow, you guys are going through some stuff here.

The way it used to be… (before they used)

So he was using while he was working for almost a year…

You used at home? So, if you were smoking that means the fumes were in the trailer right? How large a trailer was it? Oh, a stationary one. So, it has a bathroom, you have a hook up to a sewer line and stuff. How many bedrooms? So, your children had one and you had one (bedroom). When you smoked (meth) would you confine it to your bedroom or, so that means the kids couldn't come in there when you were smoking. So, that means they were on their own for a lot of the time… what about your cigarettes? Did you smoke those only in the bedroom or…cause they're now starting to bring out information about second hand smoke. Some children are allergic to a lot of different substance including nicotine smoke, or whatever it is…tar…

What I'm thinking about is if you wanted to quit this (meth) hypothetically. I don't know that you're there yet. One of the things that helps is if you have a network of people who you know you can call on and talk to you know that is a big part of

them keeping themselves together. So if don't have a network of friends who don't use it could be very hard for you…

Okay your mom, your aunt (can maybe help her)

Well life brings with it a certain amount of issues, concerns, challenges, problems. So, many people say that one of the things that helps them is they have a spiritual basis. Not necessarily connected to organized religion. Something that is a resource to them… (questions her spirituality as a strength)

Okay let's take Eric out of the picture for a moment. And, you can't talk over you problems with your children, they're not the educated listening ear that you need. So, you're by yourself (questions more about resources)

Camping…

No nature pictures…(in trailer)

Just trying to determine. We all have some strengths, we have our weaknesses. Just trying to find out what kind of resources including those within you that you can reach and get. And, that's what my questions are about…you're not really part of organized religion. You do say that the last week you've been praying…

So, uh, you know what a UA is…urinalysis. Or, they have actually they have a lot of different tests to see what levels the substances are in your system, you could pass one right now? Would you be willing to that? Usually a person they make excuses or something, so hopefully your clean now (he's not convinces of her week clean)

I'm gonna ask you to be honest here, I'm assuming you have been all the time. But I'm noticing that you're not looking up a lot, you're looking down a lot. And I know that because you don't have your children it has to be a downer. But have you ever had the idea that you might be suffering from depression? (she says the usual only the last week)

½ gram??? (he's not believing the amount)

Lot's of questions about crashing

Counselor blows air through is lips in a "oh boy" kind of way when Debby says that she and Eric never went to preschool so they figured they didn't need to put Tyler in preschool. Then he asks about a baby sitter. He seems somewhat exasperated about the neglect of children at this point.

I want to just go back to this depression a little bit. You're saying you rarely get depressed. (she says except when she's coming down) But you come down every time you use. You have to come down, you can't stay up, so you go through that depression...okay you're up here ...and you come back down here but you don't stop here, now you're down here, so, what do you do, how long does it take to get back to normal?

He's confronting about how often she's depressed due to coming down.

So, you're depressed almost half the time! I mean crashing. And like I said, you know, with you not having the eye contact and you've been clean now a week, you may have some depression, ongoing. It's something that you may want to ask somebody about. Or get some information about yourself. You know, they have ads on tv now saying this a symptom, this is a symptom...

He connects the fight to crashing

He's under pressure then...and that means what...that means he's saying he wants work... can't work...he's not gonna work...(in response to Debby saying they fight about work)

Well, then you were...(he's confused about her being in jail one night but not "being arrested.")

Okay so, you knew they were in custody of children services or what have you... (when they took her to jail)

Cause you know they do have a problem with ID theft and a lot of it is being fueled by meth use. So a person who has a drivers license is a value to somebody who's cashing checks and doing all sort of things so you're fortunate you've been able to keep your license. Well, you could probably getting a driving job somewhere.

Questions about joint and separate activities again

NO PETS? (reaction to her saying no pets)

I know that's a strange question. Some people have a difficulty, you know knowing, you have to get them involved in activities before they know they're having fun.

Sounds like your life is pretty much centered around meth use.

You like volleyball? Well, that's fun. I like volley ball too.

Uh? I see (she says she plays board games with kids)

I know you want a job, you want to quit using, you want the same thing for Eric, but what do you see in your future?

So, you want to get out of the trailer and go into a house...

So, you think two is enough (kids)

So, you imagine you and Eric being together as a healthy family, not using, getting a house, children in school, at some point, you mentioned grand children...

I'm kind of like the goal setting model. I teach a goal setting group. And I know a lot of times it takes really small steps to get where you really want to go. So, let's say in a year, you may still be in the trailer but you could be working. He may be back working ...

Ten years...(her timeline for house)

Well, I'm sure if he's in jail for a week he's been seen (reaction to Debby not knowing if Eric has been seen by a judge)

But, they found it (the small amount of drugs)

Well, you might want to check on that because, well, your planning a future, but it may be that he has to do some jail time first...you know, so you won't be... well, to lessen the impact, maybe just check into that, because I don't know far, how far, treatment is available for him or you at this point. But they may require some jail time they may require some treatment for him So, uh, that should be included as a possibility...I would be hesitant to say... you know you may want to plan for the next six months or a year without him in your life... I know in a lot of ways your dependent on him in some respects it may even be co-dependency. You know where what you do is dependent on him. And not being able to talk to him he may have that same kind of frame of mind. In some ways it's probably good in some ways it's not so healthy. You know, as a mother there's certain things you'll have to do, as a parent, whoever's dealing with the children has a big job...you know and it's kind of like independent of another person, because you have actually deal with your immediate future without him. I don't know the circumstances but I'm just trying to prepare you for something you may have to look into. And also if you're going to be getting counseling the only way a person can help them is if you let them know what areas you need help in. That may be an area where, besides the

drugs and alcohol, you need what they call co-dependency counseling. Where you know the goal is to strengthen you in the relationship so you could be a better partner, but you wouldn't be so intertwined in his wellbeing. Because ultimately we are responsible for our own well-being. I don't mean to overwhelm you with that. I'm just saying so that you'll be able to mention that or if someone else brings that to your attention, you'll be aware that you can get help. And you know, you mentioned the domestic violence, and you may be able to get help in that area too, both of you. It may be that you may be doing some counseling, he may be doing counseling, or you may be doing counseling together. Because it could get worse without help and using meth and alcohol it could get worse. So, I'm bringing that to your attention so that you may be able to get a chance to talk to someone else. Or if I do my assessment and at some point I'm sure you'll have access to that assessment that would be one of the things I would say, that there's a possibility you need some co-dependency counseling, drug and alcohol treatment. I don't know, it may be that you would do well with outpatient treatment. Outpatient means that would report somewhere ... if you learn about the disease model of addiction...you would be educated about drugs... you would get coping skills, you would be encouraged to develop a support group... you know people that you could call on .... You might be encouraged to get some other support members and if your spirituality is a resource for you... build on that... pray more...not just when you're in trouble...or commune with nature...take some walks... play some volleyball...get involved with some things, build a life...that is healthy. And you have children to think of... Anyway, those are the kinds of things I would be putting down as a plan....

(I paraphrased near the end)

Do you have any questions... do you feel like I'm a nosy guy. You can tell me.

Well, I'm sure they want their mom back. I'm sure that every day they think about you. I'm sure they miss you as much or more than they miss you. And as a mother I know that's a primary concern for you. Keeping yourself together is important. I see some positives. I see that even without any formal training that you've been able to secure jobs doing retail and it could be that you have tremendous people skills but that they may of smeared off the forefront as a result of drinking or smoking or whatever. That you may be able to reclaim that. Or look around and see what you really enjoy doing. I got this off the internet it talks about if there's something you like doing employment wise or business wise, you never have to work another day in your life. The key is finding what you like to do and some people have been fortunate to find that. So, it's not about retirement, they're gonna do whatever they can do as long as they can do it. It's not about the level of pay. Because it's almost like getting paid for doing something you love anyway, so it's like free money. And it's healthy for your mental outlook, and even your

spiritual...it helps you ... they've shown that stress is a killer... you're aware of that I'm sure... and the lifestlyle you live going up and down...you're going to have health problems... not to say that...if you were not using meth you wouldn't still have health problems.. but the things you bring on yourself... to the extent that you can you should work on them... some people can't...but I believe you can if you want to... once you identify some certain areas... find a way to do it... there are people who have suggestions... some people don't even have your ....you communicate very well.. a person seeing you would be hard pressed to say you're an addict...they would be hard pressed to say that...you and your husband have addiction problems...they (the State), they're job is to find out what's best for the children...they don't have a choice... you have a choice... I know sometimes it;s hard to be honest especially with a complete stranger...

You have been honest with me haven't you? That's a first step, that's a first step. Just by you showing up is a positive. A lot of times even when children are in jeopardy people don't show up to these things. They have to be tracked down. I don't know if you know anybody who's had to go through this, many of them don't get their children back. They don't follow through. At least you've shown up to this assessment. That's a positive. Hopefully, you might be somebody ... can ultimately be a good mother, can have kids back, can be a support for your husband...and you say he's a good father...you've been together for a while, that's a positive...a lot of people can't make it that long married or not, so that's a positive.

That's a good attitude. And they (the State) won't be asking you do anything that's hurtful. They will be asking you to things that have been shown to help. So it's in your best interest to be open to suggestions, to be consistent with following through with suggestions, and one more suggestion is that you would try to get a number or call and show interest in getting the children back, because they want that, they want you to show interest in that...

Did you catch the bus to get here, ride a bicycle, a surf board, what do they call those little scooter things, skateboards...you're in that age category aren't you...(all of this with laughter)

Nice to meet you... Hopefully um, Ill see you again, I'll see you walking down the street with your children beside you...

NOTESThis whole interview vacillated back and forth between questions/statements about Debby and Eric. Equal weight seemed to be paid to both their situations and them together.

Appendix H: Video Tape Transcription

Counselor ID: 150
OS: One (fighting)
28 Minutes

I bet that's really hard (response to opening statement)

I imagine (it's hard)

So there was no electricity but you did have food and you did have shelter (recapping Debby's reaction to claims of child neglect)

So getting your kids back is definitely important

You've been using methamphetamines then…

So basically you got more supplies and that's when you started using more often… it's just around (response to hearing Eric has been dealing in last six months)

That's great, glad to hear that (that Eric isn't cooking meth just getting it from others)

It's just kind of something you picked up without thinking about it before hand. (Debby said she does it sometimes without even knowing it) So it sounds like you've really felt like that you should stop and that you have been having trouble cutting down, controlling use of it …

So it takes up quite a bit of time just trying to back up on your feet (in response to coming down)

So you'd spend a lot of time in bed when you were recovering ha?

Which is hard cause he's in jail (reaction to Eric being Debby's primary emotional support)

So, it sounds like there are some people out there to help you out with this.

It sounds like you're really ready to quit this. That's great. That'll make it a little easier on you. I bet you already know it's going to be pretty hard for though.

You're still in some withdrawal stuff. Some of it does get easier.

So this is a lot worse for you than the last two weeks was (Debby had quit for two weeks a long time ago. The counselor says this in response to her increased use this time trying to quit)

It's just something you experimented with and started using (in response to how Debby started using)

So right now what I'm getting is that some of your main goals are obviously to get your children back obviously stop your use of methamphetamines.

So maybe that's a goal for you (to get GED)

These are really great Debby, really.

You have some really amazing goals here Debby. This is really great. And um just going through all this and being able to come here and do this it's really great. I think we have some really good places to start on this.

Developing these activities is really important because it's what keeps us out of trouble gives us back some enjoyment in our lives. (Debby said used to play volleyball and play with kids)

Being with people is really important to you (Debby said she liked being with Eric)

So right now the plan is to really try to develop some skills for staying away from methamphetamines. That's probably the main goal for coming here to try to get your kids back. Being involved in treatment and following through with that.

I'm really impressed by your dedication. It's going to carry you really far. Thanks for coming in today Debby.

Appendix H: Video Tape Transcription

Counselor ID: 165
OS: One (fighting)
64 Minutes

He was coming down off drugs…

He hadn't hurt you before like that…but there had been times when he did hit you…(Debby said Eric broke her wrist once)

So, money's probably kind of tight right now…

And that was from using drugs (Eric being late to work)

How about you…you've been staying home with the kids… is that what's been going on?

You said that you didn't come to work with a hang over, but had you been drinking or taking any drugs the night before?

Okay, so you were doing some speed.

Weekends when you were working but now you're doing it about every other day…a few days a week.

You also mentioned beer…

When was the last time you had a beer? was that like one week ago too?

You also mentioned marijuana…

Can't do the needle thing…

One of the things you've mentioned a few times, just what we've been talking about here, you'd say "when Eric's around." So, it seems like you use more when Eric is around.

Was he on meth too…

Okay, so prior to a year ago you hadn't used it at all. So, your first use was only a year ago.

So, you drank with the intention of...So, it wasn't something where you just sat there and drank a beer...communed with your friends.

Was that for partying with your friends (smoking pot)

The crack, it doesn't sound like you've used very much of it...
Were trying to blend in, be cool...Some girls smoke tobacco as a way to manage their weight...The reason I ask that is because it gives me some idea of some other issues you may be having.

So, Eric smokes cigarettes...So, Eric smokes cigarettes, and he does meth and crack...beer...he smokes marijuana too.

So, the two of you are doing most of these drugs together...

So, it wasn't a big part of...it didn't impact your relationship before...

So, he did beer and marijuana from before...

So, one year older than you (response to Debby giving Eric's age)

You've expressed an interest in wanting to stop smoking cigarettes...

I'm gonna write that down, kay? (that she will do whatever it takes to get kids back)

Okay, so your kids are really important to you...

Is he in jail now because he hit you...

How would you feel about him if he were...(driving with the kids while he was intoxicated)

Okay, so I kind of have your history with drugs and alcohol here...(asks questions about family)

Okay so she was kind of a partier (Debby's mom)

Okay so as far as you know, however she was before she had you, she didn't continue with that...(Debby's mom)

Your pretty healthy then...

So, as far as you know, the doctor wasn't concerned about the health of your bones...(following up on Eric breaking her wrist)

So, you're feeling pretty confident in that...or at least in your desire (to quit meth)

Okay, so maybe some new techniques for working with Hope (discussing parenting classes)

So, you feel like a stable place to live...

So, you have your mom as a support person...

So, you think that she also suspected that you guys were doing drugs...so it's not a secret (Eric's aunt)

Well probably their going to want you to do drug and alcohol treatment. They're probably want you to do parenting. There may be some other things they want you to do or might even be able to help you with. Child care so you can look for a job...job readiness and stuff like that...

I'm just trying to maybe prioritize some of the issues you have. I don't doubt that you're very sincere that you would jump through any hoop to get your kids back.

Your kids sound like they're really important to you, more important than anything.

I believe the DA is correct that there are some drug and alcohol issues going on that it might be beneficial for you to address.

I know you have some issues that happened just because you're young, you have two kids at home, but I also know that you have some issues that are happening because you've gotten into some drug use here. And whatever problems you were having it's making them worse.

I kind of have some concerns about Eric. And, I don't know where to go with them. I know he broke your arm a while back and you see that as an accident...I mean yeah, he could of just grabbed you at a stress point in your arm. But, I'm still concerned about that in general. I'm concerned that the two of you interact that way...whether he deliberately hit you or not.

So, one of the things you said about your mom was that you didn't think she had an alcohol problem because she was able to hold a job and run her own life. But in some respects Eric was too. You just said he was a good provider, he had a job, all those things and he still had a drug problem.

So, if the meth were suddenly to go away do you think all the other problems would go away. So, before he started using meth, you guys weren't having any problems?

Okay so, it sounds like you have your own issues that are separate from him. He's complaining about your drinking…

Did it feel like teasing? Did it hurt your feelings at all?

You say that he doesn't say anything to you that's different from ordinary couples but most husbands don't call their wives sluts.

You love him right?
So, maybe it doesn't just affect you (the fighting also affects the kids)

How would it be if you get off drugs while Eric's in jail and Eric comes home and decides not to…

So, for each of you this is really going to be your first attempt where there are going to be some consequences if you really don't stop.

When Eric gets out of jail, whatever plan there is with DHS will include him. So, they will expect him also to be in treatment and getting a job.

And that's good. It shows he cares about is kids so that's good. I think for the two of you it's going to require a lot of changes. Because someone else now is running the show. Its gonna be DHS that makes all the decisions now, tells you what to do, and that might be kind of hard. Because they may not have the same view point about family and the relationship with Eric or the kids as you do. So, you better watch it really closely and make sure it doesn't happen again.

I haven't heard anything that you abused the kids. You've done drugs and been impatient wit them but that doesn't constitute abuse. So, it may be the case that they're there until the crisis is done and then they may try to integrate them right away as you start your plan. Or they may wait until Eric is out of jail…so I can't really speak to how long they'll be gone. Typically, they work very hard to try to get a family back together again. The worst case scenario for you is you have another relapse and you're really struggling with this then a lot of times they will place your children with the nearest family member which may be your mom or Eric's aunt, which would still mean that you would have contact with your kids so you could still have a relationship.

I do think that particularly meth has created problems in your life. And even though you don't like beer you're consuming enough that it could be a problem in the future if you continue at that rate. And marijuana is not the drug it used to be so I take that much more seriously than I would have twenty years ago. It's a much stronger drug. One of the things is that you take speed because Eric is taking it or whatever reasons you wanted to take speed and then to come down you take beer. So, you have this cycle, up down, up down. And the two of those go together so it means that you're not just having to quit speed but you're having to quit beer as well. You may find that it's very difficult to not drink beer or do meth if you're smoking tobacco. So, what I'm suggesting to you is that you think about quitting that too. Second hand smoke really poses a threat to little kids.

I wouldn't be surprised that if you continue to smoke that they might develop some respitory problems, asthma....

You'll be surprised at how these rituals you do overlap.

Some of those issues that might come up might be about your relationship with Eric and how to make that a stronger relationship.
You have a very short drug history here and that's good. For me that gives me a lot of hope that you can get through this. I don't think you're having any problems with withdrawal right now. So, I don't think we have to be concerned about those kinds of issues.

At this moment I don't see any mental health issues.

Right now, that's out of your system though

I know you're thinking I want to quit for my kids and then you get to that point and you want to make it go away...I don't doubt your commitment at all...to getting off drugs and being there for your kids, but when you get to that down part it's really hard. (but you're basically clean so no problem is what the counselor says next)

If you decide to quit smoking that will be worse for a few weeks. That worst part is clearing out all that stuff has built up. That's not a reason to STOP ...

It was really nice to meet you, good luck to you...

Appendix H: Video Tape Transcription

Counselor ID: 170
OS: Two (meth)
50 Minutes

This interview was conducted completely off a form and all the questions asked for number of times using this or that and how often and how old, etc. Any transcriptions are honestly stretching what I would normally include.

So, from your perspective it's because you're having problems with meth …

So, from your perspective a lot of this was brought on because of problems with meth… (she talked about the fighting and arrest)

Is it a fair statement because you have a husband and kid that you're a heterosexual …

Only marriage for both…

So, it sounds like based on what you've told me so far that other than your aunt and mother there isn't much support for you to be in recovery is that a fair statement?

So, it's not the worst but it's not too good (relationship with family currently)

So, when you have leisure time, obviously, your kids take a lot of time …

You were sayin' earlier that one of the things that lead to the DA and stuff was fights and arguments because of chemical use …

So you say you're not working now, but you have worked in the past right…

So, he got fired a month ago. Wow that must have been stressful both of you losing your jobs, ha?

So, these charges on you are pending right…

So, he's the one facing legal charges. You're part in coming here, legally, is because the DA sent you here so get this checked out and get your kids back.

No (happily surprised that she was not charged with any crimes or had been arrested)

So, you're on the upswing (because she's happy with her weight now)

So, you've been clean a week. So you must've just been getting over (meth) a few days ago …

Hangin' in there alright? (after almost ten minutes of short answer questions)

So, you worry about that, but that's a good reason to worry (about kids).

How about violent thoughts? Have thought about killing your husband, bashing him over the head while he's sleeping, anything like that? (*Included because odd question*)
So, as your meth use increased marijuana use decreased.

Really!? (in response to her quitting smoking for a month)

Well, medically speaking it's the best thing we could do for our health is to not smoke. Maybe you could take up chewing (a joke, the first sign of him lightening up at all)

Wow, it's only been a year, huh? (using meth)

So, it looks like um, a week ago you stopped all chemical use … what happened.

So earlier you said weight loss occurred and depression …

So, you feel like it kind of caused problems with your mothering…

Okay, you're feeling like while you were trying to come back they were fending for themselves (her kids)

You got a good start over the last week staying clean ….

So, you're pretty motivated to stop…

So, you could possibly need some help in meeting your goal…

So, the biggest motivator at least that I'm hearin' to make a change here is getting your kids back…

Is that specifically your husband (she said having people around is a trigger for her)

So, resolve some family issues (interpreting her priority)

Well, based on everything you told me. Came up with a few things that are probably important for you to know.

There's two diagnoses that indicate that people have some problems related to their chemical use. One is abuse, one is dependence. Abuse is the lesser of the two diagnoses. Abuse diagnosis is formulated by seeing its impact and pattern of use. (more of the DSM criteria by the book)

Tells her amphetamine dependent, alcohol dependent, and nicotine dependence.

Then explains ASAM criteria, including all six dimensions.
I just include the dimension ...he told Debby what they were.

Dimension one: you said yeah up to a few days ago you were but you're feeling pretty good right now, so that's not really an issue.

Dimension two: outside of maybe being a little tired and stuff your weight is back to normal and your feeling better after you haven't used for a week so that's not an issue.

Dimension three: when you first come down you're feeling depressed and stuff, but generally that's not an issue for you so you're feeling okay right now although your mood is a little low right now you wouldn't call yourself depressed you're a little bit down, so that's not really an issue.

Dimension four: You're not in precontemplation. You're acknowledging that you have a problem related to your chemical use. That's really a positive sign. And, you're also willing to do something about it so that puts us into an action stage it sounds like you're willing to do something about it.

Dimension five: I think I didn't ask you that specifically, but (asks how easy staying clean is for her), so, you probably need a more intense level of support, you're feeling kind of strong but you sound a little unsure while your sayin' it so we'll air on the safe side and let's say a level two there

Dimension six: You said that your husband is using or was using along with you until he was arrested and your friends are users. Where are you at with them right now? Have you put them on notice? Have you had a chance to talk to him (Eric) about what you want your recovery environment to be like at home?

Give him some time to think and reevaluate things (the counselor interprets Debby saying that this will scare the shit out of Eric)

To me, you know looking at your situation, you want get your children back, you want to deal with your substance abuse, you want to get a job and you want to repair family issues. I thinking initially probably the most sensible level of treatment would probably be some sort of intensive level out patient treatment. That would make the most sense.

I think that we've got as much as we need today. Let me start working on that. We'll set up another appointment to get you started *(logistics)*.

Thanks for your time and thanks for being open. It really helps when someone is cooperative like that it helps us get to where we need to get to…

Nice meeting you Debby. We'll set up an appointment for you and get this thing rollin for you.

Appendix H: Video Tape Transcription

Counselor ID: 172
OS: One (fighting)
20 Minutes

So your husband and you...how often do you fight?

So you fight him and he fights you. So physically fighting.

Most of the time when people come to see me somebody somewhere thinks they have problems related to a drug.

So, you've been using meth for a year and it's increased a lot more in the last couple months.

So, you have a week clean.

So, half a gram is 50 bucks, fourty bucks.

And their unsupervised in the room (the kids).

So, the children have been... where are they now?

Let me see if I follow you here now. I want to make sure I got everything right. Ok. Up until a week ago you were using a lot of meth. Police came in because you and your husband had been fighting... that had progressed over the last few months... you and your husband fighting...and you believe its due to the meth, your husband coming down off the meth odd jobs and stuff like that. While you guys are fighting your kids are in the other room, supervising one another...kids are four one is two... you didn't think you had that much of a problem cause you were too busy using...now that you're clean and your kids are gone you do realize you have a problem.

So, Hope was one when you got started.

So, you said that uh, it built up over time and you said one of the things you and your husband argued about is jobs.

He sells.

The reason I asked about the detox, for methamphetamine it has one of the most intense withdrawal, a lot of people get real violent and psychosis sets in.

That's good, that's good. (not using in a week)

You're still living at home but Eric's not there. So as far as you being able to stay clean when he's not there you seam able to stay clean.

So, the bust was a result of drug dealing?
So, you don't have any legal troubles with the law other than DHS has your children and you want to get your children back.

So, as a result of the using the fighting occurred, police came, children were taken, you had wanted to quit in the past, really didn't know how to cause when you come down you'd go right back up but since this happened you are willing to go to treatment...to get your kids back.

There are treatment centers where you can go with your children too.

One of the things about these treatment centers is you'll probably have to demonstrate a level of participation in the program where they feel like you're compliant enough that you could manage with your kids there. And from what you've said so far to me it appears as if you're willing to do anything to get your kids returned to you.

You smoke cigarettes too.

You said you're depressed.

Well it seams pretty simple to me. You know you're here you admit your problem. You admit that you want help. You don't have any major medical concerns or any suicidal or homicidal ideation that would prevent you from receiving services. There are treatment programs available, especially now with the methamphetamine epidemic going on. Where treatment slots are paid for already that would provide treatment for you and a residential program that will provide treatment for you and housing for you and your child as well while you do treatment.

You already said you are going to get a job and stuff like that, but if your husband continues to use and is still around ...you said he was a big influence on your using in the first place.

So there was no physical abuse before the meth was involved, just yelling and stuff.

Cause you're sayin' you've been maintaining without getting high for a week on the streets. So it seems like when you want to or Eric's not around or whatever the scenario may be, and you tell me which one it is, you're able not to use.

You said something that is key… is he mandated or do you think he will be mandated? In order for the kids to come back he would have to do something to satisfy DHS that he's gonna be alright.

I'm gonna get some papers to consent to treatment, you know get the people in here and talk to them about getting you into treatment and we can probably get you into treatment today.

We would probably have you sign some releases too so your mom could be involved in your treatment.

All right then Debby, you want to tell me what we said is going to happen, so I know you know where we are at?

And then, if we need other releases signed like for the DHS worker so we can let her know you're doing well. If you want your husband to know what's going on we can get one signed for him. And then we can go from there. Thank you for coming in, get your calls made and we can get you in and hopefully your children and you can get back together.