ADDITION RECOVERY: PERCEPTIONS OF MOTIVATION FOR, AND BARRIERS TO TREATMENT ENTRY.

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Abstract

The prevalence of alcohol and drug misuse, abuse and dependency constitute a chronic, relapsing disorder that affects more than twenty-three million Americans. Only one in 10 of them (2.6 million) receives the treatment they need. Successful treatment of this disorder would potentially decrease the risk of negative interpersonal and health consequences these individuals are likely to encounter. Additionally, treatment and recovery would lessen the tremendous societal burdens attributed to this disorder. According to the American Society of Addiction Medicine (2011) recovery is defined as overcoming both physical and psychological dependence to a psychoactive drug while making a commitment to sobriety. The purpose of this study is to examine the motivation for, and barriers to, recovery and/or treatment entry from the perspective of alcohol dependent individuals and mental health professionals. Specifically, this study sought to explore the degree to which alcohol dependent individuals’ and mental health professionals’ perceptions regarding treatment entry are similar or different.

Keywords: Substance abuse, research, perceptions, barriers and treatment

1.0. Introduction

Alcohol and drug dependence are chronic, relapsing disorder that affects more than twenty-four million Americans (Sahker, Acion, & Arndt, 2015). Successful treatment of this disorder would potentially decrease the risk of negative interpersonal and health consequences these individuals are likely to encounter. Additionally, treatment would lessen the tremendous societal burdens attributed to this disorder. Research studies have cited several reasons as to why individuals with substance abuse problems enter treatment. In a review of the literature, Gehart, (2012) reported that negative consequences as a result of substance misuse and interpersonal pressure are related to treatment entry. While others reported similar results (Becker, 2013; Edelman, & Fiellin, 2016; Tucker, Vuchinich, & Rippens, 2004b), additional factors related to treatment entry have been found to be self-reflection, positive life changes, and perception of control over one’s life (Jakobsson, Hensing, & Spak, 2005; National Institute on Drug Abuse, 2012; Yeh, Che, Lee, & Horng, 2007). Although many individuals require treatment for drug and alcohol abuse or dependence, many individuals with substance abuse problems do not enter treatment (Karim, & Chaudhri, 2012; Saunders, Zygowicz, D’Angelo, 2006).

In a review by Sahker, Acion, and Arndt (2015), it was reported that a ratio of untreated individuals needing treatment to treated individuals ranges from 3:1 to 13:1. Similar to the reasons for entering treatment,
barriers to substance abuse treatment are reported to vary in a wide range. Dow and Kelly (2013) said that the main barrier to treatment is the fear of stigmatization. Others reported that barriers to treatment include not recognizing substance misuse as a problem, privacy concerns, and practical/economic barriers (Becker, 2013; Tucker, Vuchinich, & Rippens, 2004a; Whitley, Gingerich, Lutz, & Mueser, 2009). Whereas those mentioned above are person-related barriers to treatment, program-related barriers also exist. Frequently reported program-related barriers include a lack of confidence in the treatment system, a lack of awareness of available treatments or what treatment entails, dissatisfaction with counselors, and the program’s negative expectations about treatment efficacy (Fletcher, 2013; Howland, 2013; Redko, Rapp, & Carlson, 2007; Saunders et al., 2006; Laudet, Stanick, Sands, 2009). Other program-related barriers include location, schedule inflexibility, and the client being unsure if their insurance would cover the treatment cost (Laudet et al., 2009; Saunders et al., 2006).

Research studies exploring decisions to enter, avoid, or delay utilization of services and how the contexts that lead to care-seeking may affect intervention, engagement and outcomes are limited (Jayne, & Valentine, 2016, Tucker et al., 2004a). Moreover, research on mental health professionals’ views as to why addicts enter treatment and what barriers exist for these same individuals is scant. Specifically, there is a lacuna in the literature with limited studies comparing the perspectives on joining the treatment of addicted individuals and mental health professionals. Research comparing the perspectives of addicted individuals and mental health professionals may provide information as to whether these two groups share similar views about the reasons for and barriers to treatment. Additionally, studies in this area may assist professionals in gaining a better understanding of how to open the dialogue with clients regarding these issues and subsequently improve treatment outcomes (Addiction Center, 2017).

2.0. Literature Review

Substance dependence and abuse problems are prevalent in the United States. In 2016, an estimated 22.3 million people were classified with substance dependence or abuse based on criteria specified in the Diagnostic and Statistical Manual of Mental Disorders, 5th edition, text revision [DSM-V] (Substance Abuse and Mental Health Services Administration [SAMHSA], 2018). Of these 22.3 million individuals, 3.2 million were classified as dependent on both alcohol and illicit drugs, 3.7 million were classified to be dependent on illicit drugs but not alcohol, and 15.5 million were classified as dependent on alcohol but not illegal drugs (SAMHSA, 2018). Further, 23.2 million people in 2007 were found to need treatment for an illicit drug or alcohol use problem (SAMHSA, 2018). Available data may be an underestimate of the true scope of the problem due to the discrepancy between the number of individuals identified as needing treatment and those who seek treatment (SAMHSA, 2018).

The prevalence of substance abuse and dependence is only one piece of the puzzle. Health-related costs to individuals and social costs to the United States economy are another aspect of the problem. Edelman and Fiellin (2016) reported that alcohol plays a role in 40-60% of domestic violence cases. Additionally, alcohol is linked to various medical conditions, including malignant neoplasms, neuropsychiatric disorders, cardiovascular disease, diabetes, and liver cirrhosis. Further, more than 3% of the global mortality rate can be attributed to alcohol (Jayne, & Valentine, 2016). Annually, costs of substance abuse problems, including health- and crime-related costs and losses in productivity exceed half a trillion dollars (National Institute on Drug Abuse [NIDA], 2018). Costs for treatment, even treatment for relapses, are reduced when compared to the economic costs for untreated addiction (Inaba & Cohen, 2007; Lee, 2013).

There is a lacuna in the current literature of studies that explore reasons for, and barriers to, treatment. Additionally, there are a limited number of studies comparing the perspectives of addicted individuals and professionals. Acquiring a better understanding of the process of change may help practitioners to determine
key influences that promote change and increase recruitment, retention, and the successful cessation of substance abusers (Sahker, Acion, & Arndt, 2015).

2.0. **Key Concept of Addiction**

According to the American Society of Addiction Medicine (2011), addiction is defined as having characteristics including (a) a strong desire or compulsion to engage in an activity; (b) impaired control over oneself in relation to the activity; (c) distress when the behavior/substance is no longer present; (d) persisting despite negative consequences resulting due to engaging in the activity. Previously, addiction was a term used to refer to compulsive use of substances; however, addiction is now understood and applied to various activities including sex, gambling, and the Internet.

2.1. **Alcohol Dependence**

Individuals who have a specific addiction to alcohol can be described as having alcohol dependence, or more commonly as alcoholics. Alcohol dependence is a disorder influenced by both genetic and environmental factors. Edelman, and Fiellin (2016) and Greenfield, and Tonigan (2013) have delineated two sub-types of alcoholism (Type I and Type II) as well as identified personality traits that are correlated with the disease. Whereas Type I alcoholism affects both men and women and requires the presence of genetics and an environmental predisposition, Type II alcoholism mainly affects sons of male alcoholics and is only weakly influenced by environmental factors. Type I alcoholism occurs later in life, is characterized by binge drinking, and accompanied by guilt about one’s drinking. Type II alcoholism, on the other hand, is associated with early onset alcohol problems and is typically associated with criminal behavior (Jayne, & Valentine, 2016). Personality traits correlated with alcoholism include novelty seeking (NS), harm avoidance (HA), and reward dependence (RD) (Jaffe, 2012; Stappenbeck, & Fromme, 2014) these traits are differentially expressed in type I and type II alcoholics. Each of these personality traits is also correlated with behavioral patterns associated with alcoholism, including a display of impulsivity, pessimism, and a tendency toward dependence and persistence (Edelman, & Fiellin, 2016).

Alcohol dependence is characterized by alcohol use that interferes with one’s physical and mental health. Alcohol dependence also interferes with one’s family and work-related responsibilities and may cause relationship and legal difficulties. DSM-V-TR defines specific criteria that must be met for an individual to be given a diagnosis of substance dependence. The DSM-V-TR describes alcohol dependence as “a maladaptive pattern of substance use, leading to clinically significant impairment or distress” (American Psychiatric Association [DSM-V-TR], 2018, p. 110). The individual’s impairment and distress may be manifested in several ways, including but not limited to tolerance, withdrawal, unsuccessful efforts to reduce or control use, and continued use despite negative consequences. Symptoms must be present for a period of twelve months (American Psychiatric Association, 2018).

2.2. **Rock Bottom**

There are many definitions of “rock bottom” and the somewhat subjective nature of this complex phenomenon makes it difficult to develop an operational definition. In general, rock bottom is typically defined as persistent use of alcohol despite accumulating significant negative consequences. Participants in one study (Smith, 1998) described rock bottom as the “ultimate experience of suffering lived physically, socially, mentally, and spiritually” (p. 219). Others have used the term rock bottom interchangeably with a turning point, existential crisis, and epistemological shift (Horvath, & Yeterian, 2012).

While rock bottom is a term commonly referred to in the field of substance abuse and addiction, there is a lack of consensus as to the definition of this term among researchers, psychologists, and addicts alike. Glatt...
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(1975) reports that rock bottom is, “not a fixed material bottom but is an individual experience” (p. 25). One’s personality and environment may influence the rock bottom experience and how they define it. Some individuals may report experiencing their rock bottom when they encounter a blackout, relationship difficulties, problems at work, or begin to have a poor self-image. These individuals may be described as hitting an “early bottom” (Glatt, 1975, p. 31). Others may not report hitting rock bottom until they lose the support of family and friends, lose their home or attempt suicide. One individual described their rock bottom as “… I just thought I can’t go on like this and I went and took the whole bottle of antidepressants…” (Smith, 1998, p. 219).

2.3. Recovery

According to Whitley and Campbell (2014), recovery is defined as overcoming, both physical and psychological dependence to a psychoactive drug while committing to sobriety. While this and other definitions of the term exist, public perceptions and media messages describing recovery provide varying descriptions of the term. Similarly, those in the field of addiction demonstrate little consensus as to what the term means. Even addicts themselves differ in the way they define recovery (Laudet, 2007). While overall recovery is often used synonymously with the term remission, resolution, and abstinence, there is a growing trend toward harm reduction. The harm reduction movement attempts to implement incremental changes to protect the addict from further harm rather than work toward total behavior change as in abstinence (Mackert, Mabry, Hubbard, Grahovac, & Steiker, 2014). Harm reduction includes concepts such as drug replacement therapy, needle exchange, and controlled drinking/drug use (Substance Abuse and Mental Health Services Administration, 2015).

As there are different perceptions of what recovery from substance abuse/dependence means, Whitley, and Campbell (2014), examined how individuals who identified themselves as being in recovery defined the concept of recovery. Participants included those who met DSM-V criteria for substance abuse or dependence, identified themselves as being in recovery for a minimum of one month, and were not currently in residential treatment. Interviews were conducted at three intervals: baseline, 1- and 2- year follow-ups; at each of these interviews’ information was obtained and analyzed about participants’ substance use, participation in treatment, and recovery-related experiences and beliefs. A majority of the participants were of ethnic minority status and polysubstance abusers, with the most frequently used substance being crack. Questions about recovery definition included a forced-choice item which asked participants to choose the response that best fits their definition (i.e., moderate use, no use) and an open-ended question which asked the participants to describe how they define recovery from substance abuse.

Analysis from forced-choice and open-ended responses demonstrated that a majority of respondents define recovery as total abstinence from drugs and alcohol. However, others described recovery as controlled use consistent with the harm reduction movement (Fuehrlein, & Gold, 2013; Laudet, Harris, Kimball, Winters, & Moberg, 2014; LeVine, 2012). Factors including exposure to 12-step programs and greater lifetime addiction severity correlated with respondents’ report that recovery was total abstinence (LeVine, 2012). Additionally, respondents’ view of their recovery at 1 and 2-year follow-up influenced their definition of recovery with those endorsing total abstinence more likely to be in recovery at follow-up. Recovery was further described as an ongoing process as opposed to an endpoint with respondents defining it as a process which involved getting there and going back and finding oneself (Whitley, & Campbell, 2014).

Different perceptions of what recovery means makes it difficult for professionals to operationalize and measure. Laudet, et al. (2014) notes that recovery definitions may be influenced by exposure to treatment and severity of dependence as well as the sociocultural context of the individual. Additionally, LeVine (2012) notes that recovery from substance use commonly involves multiple attempts and treatments episodes spanning two decades or more. In conceptualizing recovery as an ongoing process encompassing
numerous attempts, it is essential to take into consideration the occurrence of relapses including whether one considers relapsing a part of the recovery process or interference in the process requiring it to begin anew.

As previously noted, there is a growing trend toward the harm reduction movement, and for some individuals, this is equated with recovery. It may be as Laudet (2007) noted that recovery definition is equated with treatment exposure. Greenfield and Tonigan (2013) found that among alcohol-dependent individuals those who related recovery with abstinence participated in 12-step programs, whereas those who equated recovery with problem-free drinking attended client-centered treatment. Moreover, research has reported that those with greater lifetime addiction severity are more likely to endorse total abstinence (LeVine, 2012). Alcohol-dependent individuals and problem drinkers are therefore expected to support varying definitions of recovery and may display different patterns of recovery.

3.0. Pathways to recovery among problem drinkers

Previous research has been conducted on problem drinkers’ pathways to recovery, including an understanding of the pathways that lead to natural recovery, also referred to as the natural remission process. An individual who is a problem drinker experiences social and physical problem as a result of drinking, however, the impairment or distress in these areas is not significant enough to warrant a diagnosis of alcohol dependence (Fuehrlein, & Gold, 2013). Further, problem drinkers do not exhibit clinical features of alcohol dependence, including tolerance and withdrawal (Jaffe, 2012). A problem drinker is defined as an individual who drinks at “hazardous levels” as defined as more than 12 “standard” drinks per week (Stappenbeck, & Fromme, 2014). Problem drinking is consistent with the International Statistical Classification of Diseases and Related Health Problems (ICD) category of “harmful use of alcohol. Finn, Bakshi, and Andréasson (2014) reported that fewer than 25% of problem drinkers seek help through professional treatment or AA. This is supported by other researchers who reported that only a minority of those with alcohol abuse problems seek treatment with the majority recovering through a natural recovery process (Blomquist, 2002; Hill, & Leeming, 2014; Kelly, Saitz, & Wakeman, 2016; Kulesza, Matsuda, Ramirez, Werntz, Teachman, & Lindgren, 2016).

In examining the natural recovery process, two pathways out of problem drinking have been identified. The outcome of the two paths differ as one lead to moderate, non-problem drinking, and the other culminates in abstinence (Cooper, 2012). Sociocultural factors and the individuals’ problem severity influence the path an individual take. Individuals who become moderate drinkers are described to have higher levels of self-esteem, education, occupational status, and social support from friends and family (Edelman, & Fiellin, 2016). These individuals were also described to have fewer alcohol-related health problems. In contrast, individuals who become abstinent had lower levels of income, education, and social support. These individuals were described as fitting the prototypic AA story in which one hits bottom before they begin the road to recovery (Kelly, Saitz, & Wakeman, 2016).

Besides, individuals who recover through abstinence describe more severe health-related and relationship problems. These individuals are described as being well into the course of alcohol abuse (Cooper, 2012) before they recognize that alcohol is a problem and they may report a realization that alcohol was having a damaging effect on themselves or their loved ones or that they have hit their personal bottom (Edelman, & Fiellin, 2016). Overall, it was concluded that education level, more significant partner resources, and extended family were positively correlated with one becoming a moderate drinker as opposed to abstaining. Similar findings were noted by Finn, Bakshi, and Andréasson (2014), who said that individuals with more significant social resources and stability were more likely to resolve alcohol misuse without treatment.
Therefore, it appears that these factors may play an essential role in the resolution of problematic alcohol use. An understanding of the factors leading to natural recovery and the factors related to each pathway may assist researchers in gaining an understanding of pathways to help-seeking. It is possible that the processes of change, including the psychological processes that an individual undergoes, may be similar in those who recover with and without treatment. Therefore, a better understanding of spontaneous remission and factors playing a role in this process may be necessary for determining factors that play a role in treatment-seeking (Horvath, & Yeterian, 2012).

4.0. Addicted Individuals’ Reasons for Recovery/Treatment

Research into factors that motivate individuals to drink less and enter treatment for alcohol abuse problems has been conducted utilizing both general population and treatment samples. This research is pertinent to the investigation of motivation for treatment because the use of varying samples has yielded different results.


A comprehensive understanding of help-seeking behavior in problem-drinkers is lacking; however, research into factors and mechanisms leading to natural recovery provide a foundation for understanding this behavior. Mason and Spoth, (2012) found that one-third of individuals in their sample who admitted to alcohol problems and sought help utilized multiple services, including medical detoxification (33%) and Alcoholics Anonymous (29%), as well as various other services for treatment. In their research, Edelman, and Fiellin (2016) reported that both individual characteristics and structural characteristics of the treatment service play a role in the type of treatment that is pursued. Based on these characteristics, two models of help-seeking were reported, a traditional model and a nontraditional model.

The traditional reason of help-seeking, which was initially postulated by Pringle (1982) and labeled as a help-seeking model, is comprised of four stages with stage one being especially important as it is in this stage that the client recognizes alcohol use as a serious problem. The individual must realize that while there are problems in other areas of his/her life (i.e., work, relationships), it is alcohol use that is the foundation of his/her. Following this realization, the individual enters stage two, during which he or she may make efforts at self-help and attempt to solve the problem without the assistance of a professional. As these attempts fail, the individual enters stage three and begins the process of choosing an agency to assist him/her in the process of recovery.

Furthermore, Edelman, and Fiellin, (2016) and Lally, O’Conghaile, Quigley, Bainbridge, and McDonald (2013) explained that the agency of choice to assist in the process of recovery must be informed through family, friends, physicians, and counselors. The final stage is a decision that treatment can help, and this is when the treatment process begins. After the initial onset of treatment, individuals may become disillusioned and begin to rethink earlier stages at which time they may change treatment modalities or drop out of treatment altogether. While the traditional model focuses on alcohol use as being the crux of the problem and that for which treatment is sought, the nontraditional model does not take this approach.

The nontraditional model consists of six stages. Stage one is similar to that of the traditional model, however, in the nontraditional model the recognition of a significant problem is often something other than alcohol and may include a problem in the individual’s relationships, work, or health (Pringle, 1982). In stage two, the individual recognizes that outside help is needed, often due to pressure the individual receives from others (Pringle, 1982). Stage three is similar to that of the traditional model in that the individual chooses an agency, formal or informal, to assist them with the problem (Pringle, 1982). In stage four, the individual recognizes that alcohol use plays a role in the initial problem and that his/her alcohol use may be more critical than the problem for which he or she initially sought treatment (Pringle, 1982). Once recognition of the role of alcohol and its significance is achieved, individuals begin to engage in self-help.
for their alcohol problems (stage five) (Pringle, 1982). Similar to the traditional model, these self-help efforts typically fail, and the individual then recognizes that the chosen agency may assist with the alcohol problem leading them to stage six of the process. In this final stage, the client reassesses the need for treatment, and treatment planning is focused on the alcohol-related problem (Pringle, 1982). Edelman and Fiellin (2016) reported that problem drinkers are likely to experience slow growth of awareness of the need for help and that treatment likely begins as a false start with one apt to retrace their steps several times. Therefore, the nontraditional model as an alternative framework may be more successful as many individuals with alcohol-related problems are in denial of the drinking problem and its ties to current life situations.

The models mentioned above provide researchers in the field of substance use with a framework for understanding help-seeking behaviors among problem drinkers. As noted, a recognition that a problem exists is necessary for both models before the treatment process can begin. Often, however, individuals do not recognize that a problem exists until consequences become severe. Cooper (2012) reported that physical damage and negative social or personal consequences were identified as significant reasons for help-seeking in several studies (Cooper 2012; Edelman, & Fiellin, 2016, Lally et al., 2013; Laudet, 2007; Orford et al., 2006).

4.2. Self-reflection

Negative consequences of drinking behavior may lead to self-reflection in which the individual reflects on the negative impact that substance use had in their lives. Several studies have shown that self-reflection plays a role in an individual determining that a change in behavior was necessary (Cox, Ketner, & Blow, 2013; Edelman, & Fiellin, 2016; Jakobsson et al., 2005; Yeh et al., 2007). Additionally, Herman-Kinney and Kinney (2013) conducted semi-structured interviews to examine reasons those who utilized illegal drugs entered recovery and noted that a successful decision to stop using drugs occurs after a rational decision to discontinue use is made based on recognition of one’s spoiled identity. Similarly, two other studies interviewed those in recovery to examine reasons for treatment-seeking and found self-reflection to be a factor implicated in motivation for recovery (Jakobsson et al., 2005; Yeh et al., 2007). Herman-Kinney and Kinney (2013) cited existential threats, which were not clearly defined, as initiating periods of self-reflection about one’s life leading the problem drinker to decide change is necessary.

Moreover, adverse life events were described as motivating forces creating worry about the future for individuals (Jakobsson et al., 2005). Additionally, Yeh et al., (2007) identified the individual’s experience of “being down at the bottom” as alcohol use had “extensively damaged” many areas of their life (i.e., family, health, work, and finances) as leading to an internal awakening, or inner consciousness arousing (Yeh et al., 2007, p. 923-924). It was through this period of inner awakening that the alcoholic began to engage in self-reflection and self-dialogue, which facilitated the recovery process.

4.3. Positive factors influencing recovery

While negative consequences of drinking have been shown as a primary reason for treatment seeking in several studies (Cox, et al., 2013; Fuehrlein, & Gold, 2013; Matzger et al., 2005; Laudet, et al., 2014; Orford et al., 2006; Tucker et al., 2004b), additional factors including those that are more positive in nature often propel individuals into recovery (Jakobsson et al., 2005; Gilburt, Slade, Bird, Oduola, & Craig, 2013). In one study, positive life events, which included becoming a parent or falling in love, increased one’s motivation to change their lifestyle (Jakobsson et al., 2005). Ofina, Prentiss, and Cooper (2014), similarly noted the significance of new social relationships as decisive factors in beginning the recovery process. Additionally, inner strength (i.e., finding the strength within to overcome adversity) was found to be a critical factor that started the recovery process (Gehart, 2012).
Related to positive factors influencing recovery is hope for the future. Two studies discussed one’s vision of the future as related to the recovery process. Fuehrlein and Gold (2013) reported that the decision to stop using drugs occurs based on one’s ability to envision a renewed future with a new identity. Similarly, Jakobsson et al., (2005) note that motivation to enter treatment is related to one’s hope to turn the situation around. This includes one’s anticipation of a better future, seeking reconciliation from oneself and others, and enhancing one’s well-being (Jakobsson et al., 2005). The ability to envision and anticipate a better future may be related to one’s perception of his/her control over the future.

4.4. Intervention from others

Several studies examined how intervention from others influenced one’s decision to enter treatment (Cox et al., 2013; Fletcher, 2013; Tucker et al., 2004a; Orford et al., 2006). In the analysis of the results, no clear pattern of significance emerged. While participants in several studies reported social pressure as a factor that contributed to treatment entry (Addiction Center; 2017; Fletcher, 2013; Orford et al., 2006), participants in another study conducted by Jayne, and Valentine (2016) demonstrated conflicted feelings regarding the receipt of social pressure. Participants in this study expressed conflicted feelings about whether to give in to the social pressure from others or to continue their drinking behavior. This support was viewed as beneficial when perceived by the individual as genuine, trustworthy, and caring.

Friends and family often provide one source of intervention and support; professionals are another group of individuals who may play a role in the decision to enter treatment. Inconsistent results emerged in the analysis of intervention from these groups as well. While Fletcher (2013) reported that treated alcohol remitters did not recognize professional intervention as a significant factor in the resolution of their alcohol misuse behavior, utilizing a longitudinal method Hill, and Leeming (2014) noted that intervention from others played a more significant role in later stages of use. Results from their study indicated that while at 1-year follow-up pressure from family, friends, and medical professionals were not predictive of treatment entry, at 3-year follow-up, intervention from a medical professional was significant in predicting treatment entry with those receiving this type of intervention being twice as likely to enter treatment.

It was predicted that increased physiologic symptoms due to the continued use of alcohol led to the increased significance placed on intervention from medical professionals. This correlates with the finding that those experiencing more dependence symptoms are more likely to enter treatment (Galanter, Dermatis, Stanievich, & Santucci, 2013; Jaffe, 2012).

4.5. Self-remitters compared to treatment-seekers

Many individuals with substance abuse problems do not enter treatment (Howland, 2013). Understanding the reasons for resolution among those who resolve their problems without treatment may provide professionals with a better understanding of the treatment-seeking process. Several studies examined and compared reasons for drinking less/entering treatment in the general population and treatment groups. In two studies that examined reasons for reducing drinking behavior, the reasons for resolution most often endorsed were that the individual had weighed the pros and cons of drinking and not drinking and experienced a significant lifestyle change (Matzger et al., 2005; Weinstein, Gorelick, 2012). In both studies, few individuals in the general population sample (16.7% & 10%, respectively), as compared to a significant number (67% & 68.8%, respectively) in the treatment group, endorsed “hitting rock bottom” as a key factor in reducing drinking behavior.

Similar findings were reported by Blomquist, (2002) and Jayne, and Valentine (2016) who reported that among problem-drinkers and drug misuser’s existential crises, defined as “rock bottom experiences” (p. 143) were less likely to be reported by self-remitters as opposed to treatment-seekers. Additionally, self-remitters were more likely to attribute intrapsychic factors (i.e., willpower) and specific frightening or
humiliating experiences to recovery. Moreover, self-remitters were more likely to focus on positive experiences as being motivating factors in their recovery.

5.0. Barriers to Recovery/Treatment

While various reasons have been reported for substance abusers seeking treatment, research demonstrates that the majority of individuals with substance abuse problems do not enter treatment (Finn, Bakshi, & Andréasson, 2014; Saunders et al., 2006; Tucker et al., 2004b; Whitley, Gingerich, Lutz, & Mueser, 2009). Barriers are defined in the literature as reasons individuals have for not utilizing addiction treatment services or modifying their problem behavior (National Institute on Drug Abuse, 2012). Barriers impact the recovery and treatment process by inhibiting one’s motivation to change the addictive behavior. Research suggests that individuals report a range of barriers to recovery and treatment. The reported barriers include both person and program-related barriers.

5.1. Program-related barriers.

Research on program-related barriers to treatment requires further attention; however, there is evidence to suggest that staff and service characteristics may affect recruitment and retention rates, client satisfaction, and treatment outcome (Finn, Bakshi, & Andréasson, 2014). The most commonly reported program-related barriers include doubts about treatment effectiveness, a lack of awareness of available treatments or what treatment involves, dissatisfaction with counselors, and the program’s negative expectations about treatment efficacy (Laudet et al., 2009; Redko et al., 2007; Saunders et al., 2006; Tucker et al, 2004a).

Other program-related barriers include location, schedule inflexibility, and being unsure if one’s insurance would cover the cost of treatment (Finn, Bakshi, & Andréasson, 2014; Laudet et al., 2009; Saunders et al., 2006). Barriers to effective treatment and successful outcomes among substance abusers have cited the therapeutic alliance as a key factor. Patients’ evaluations of the quality of their relationship with therapeutic staff are an essential factor in treatment perception (Chandler, & Wilson, 2014).

Similarly, other studies noted that the relationship with counselors was an essential influence on treatment retention and outcome, often playing a more significant role in positive results than type of treatment or personal characteristics (Laudet et al., 2009; Nordfjaern, Rundmo, & Hole, 2010; Redko et al., 2007). Not only do patients’ perceptions of their counselors influence the current treatment episode, but future treatment-seeking may also be impacted (Redko et al., 2007).

The attitudes and perceptions of staff and patients have been shown to have important implications for the response to treatment (Cooper, 2012). Professional attitudes that facilitate a therapeutic alliance are a necessary component of success. The literature on professional attitudes toward substance abusers has shown that negative attitudes toward this population are prevalent (Hansson, Jormfeldt, Svedberg, & Svensson, 2013). In general, mental health professionals have been shown to have pessimistic attitudes related to treatment motivation and outcomes (Reavley, Mackinnon, Morgan, & Jorm, 2014; Vairo, 2010).

The negative attitudes of mental health professionals are likely to be reflected in their behavior and may lead to dysfunctional behavior in diagnosis and treatment including delayed or missed diagnosis, ineffective referrals, and ineffective treatment placements and plans. Additionally, negative attitudes regarding treatment outcome may lead to a self-fulfilling prophecy in the addicted individual (Ofina, Ja, Prentiss, & Cooper, 2014).

In addition to negative attitudes of professionals providing a barrier to effective treatment, research has cited different treatment goals, and expectancies between clients and staff may provide a barrier to the establishment of an alliance and thus poorer treatment outcomes (Reavley, Mackinnon, Morgan, & Jorm,
Incongruent treatment goals and expectancies may result from differing views about the clients’ reasons for entering treatment. Sahker, Acion, and Arndt (2015) reported that staff and clients agreed in only 50% of cases about the nature of the problem that brought the client into treatment. Not attending to what brings the addicted individual into treatment negatively impacts treatment retention. Additionally, goals and expectancies may differ if clients and professionals have divergent views as to what obstacles the client faces in stopping substance use and entering treatment. Professionals who have an open dialogue with clients at the beginning of therapy in which they identify and explore reasons for help-seeking, expectations, and barriers may experience improved treatment outcomes (Laudet et al., 2009).

5.2. Other barriers.

In addition to person-related and program-related barriers, one additional barrier has been identified in the literature. Intervention from others, may in some circumstances, lead an individual to seek treatment; however, in other circumstances, social pressure may serve as a barrier to treatment. Social influence has been cited as a barrier to therapy more often in women than in men (Finn, Bakshi, & Andréasson, 2014). Kulesza, Matsuda, Ramirez, Werntz, Teachman, and Lindgren (2016) found that compared to men, women were more than 20 times as likely to experience oppositional attitudes from family and friends regarding treatment entry. Specifically, significant others minimized the seriousness of the problem. Women who did seek help reported that they experienced problems with family and friends, and therefore, they associated treatment entry with negative consequences (Stappenbeck, & Fromme, 2014).

Whereas Mason and Spoth (2012), discussed social pressure from family members and friends in a general sense, Gehart (2012) specifically discussed the implications of pressure from spouses. Interviews with women indicated that they sometimes began drinking with their spouses and failed to recognize that the drinking behavior was becoming a problem. Moreover, the women’s perceptions of their drinking as unproblematic or not severe enough to warrant help were supported by their spouses. Women further reported that their partners made attempts to prevent them from seeking help and encouraged them to continue drinking despite her expressions of worry (Mason, & Spoth, 2012).

6.0. Summary

In summary, the literature on the topic of why addicts enter treatment has found that a range of factors may initiate recovery. Additionally, diverse factors contribute to the addicted individual’s decision not to seek recovery and treatment. Factors related to an individual’s decision to enter recovery and treatment may be internal and external. Moreover, these factors may contribute to motivation to change once an individual is in treatment. Hill and Leeming (2014) reported that research on the reasons for or against entering treatment for alcohol and drug misuse is still inconclusive. Therefore, the current study sought to explore the reasons for, and barriers to, recovery and treatment from the perspective of the addicted individual and mental health professionals.

Current literature on mental health professionals’ views as to why addicts enter treatment and what barriers exist for these same individuals is scarce. Besides, there is a void in the literature with limited research comparing the perspectives of addicted individuals and mental health professionals. A study that compares the views of addicted individuals and mental health professionals on reasons for, and barriers to, treatment provides information regarding the degree to which these two groups share similar or dissimilar views. This knowledge may assist professionals to facilitate behavior change needed for treatment and sustained abstinence in this population. Therefore, this study was a quantitative design that explored the perspectives of addicted individuals and mental health professionals as to the reason’s individuals do or do not seek treatment.
7.0. Implications for Practice

Recovery from addiction is a personal journey that is often challenging for both the individual and his/her family. The current research was an exploratory study that began to examine whether professionals and those in recovery share similar views on the reasons for, and barriers to, treatment entry. The results of this study may provide psychologists and other mental health professionals, namely those who work in the field of addictions, with a greater understanding of the factors that impact one’s recovery journey.

Literature has cited the therapeutic alliance as the most significant factor in positive treatment outcome (Hill, and Leeming, 2014; Nordfjaern et al., 2010; Redko et al., 2007). Correctly, research has shown that different treatment goals between client and professional, as well as a failure to attend to what brought the client into treatment negatively impacts the therapeutic alliance, as well as treatment retention and outcomes (Fletcher, 2013; Herman-Kinney, & Kinney, 2013). Similarly, divergent views between professionals and clients related to the barrier’s clients face concerning treatment and recovery are likely to impact the treatment goals and expectations of both individuals. Additionally, the therapeutic relationship is expected to be affected, which, in turn, will impact treatment outcomes. Laudet et al., (2009) reported that professionals who have open dialogues with clients regarding motivations for, and barriers to, help-seeking at the onset of treatment are likely to have improved treatment outcomes.

The results of the present study provide professionals with insight into the perspective of individuals in recovery from alcohol dependence. Moreover, results demonstrated areas in which professionals and those in recovery are likely to experience agreement, as well as those areas where different views are present. Whereas both individuals in recovery from alcohol dependence and mental health professionals agreed about the most significant motivation being problem recognition and a desire to improve one’s life, differences emerged in how the two groups viewed the influence of external factors on motivation. Further, while both individuals in recovery and mental health professionals identified stigma and failure to recognize the problem as the most prominent barriers, those in recovery viewed these barriers as more significant than mental health professionals. No differences were shown about the view of negative consequences to drinking as a motivating factor. Similarly, there was regarding the role that privacy concerns and practical and program related concerns play as barriers.

Increased awareness of the perspective of the client and an understanding of similar and differing views provides the professional with a foundation for engaging the client in open and honest communication at the beginning of treatment. As noted above, this conversation will enable those working with these individuals to develop stronger therapeutic alliances and therefore improved retention and treatment outcomes.

Not only do the results of this study provide professionals with a greater understanding of individual client’s motivations for, and barriers to, treatment but the results also provide insight into potential barriers and challenges in the field of substance abuse treatment. Specifically, group therapy is a standard and often utilized modality in the treatment of substance abuse; however, this approach may negatively affect an individual’s engagement in treatment. In previous research (Edelman, & Fiellin, 2016; Tucker et al., 2004a), as well as in the current study, privacy concerns have been identified as a barrier to treatment. These concerns include a dislike for talking in groups, being asked personal questions, and discussing one’s own life with others (Rapp, Xu, Carr, Lane, Wang, & Carlson, 2006). Therefore, it is essential to consider if utilization of a group-based approach with this population is effective. Future research that assesses the outcomes of group therapy with the substance abuse population is recommended; specifically, comparison of group and individual therapy is recommended to determine if privacy concerns are negatively impacting treatment recruitment, as well as treatment success.

While the impact of alcohol and drug addiction may traditionally have focused on the individual, Gifford (2011) identifies that these are “family diseases.” Moreover, statistics indicate that seventy-six million Americans, approximately 43% of the adult population in the US, have experienced alcoholism within their
family system (The National Association for Children of Alcoholics). In the present study, pressure from family and friends to enter treatment was identified as a motivating factor. This is consistent with prior research that has demonstrated that intervention from family and/or friends may be a precipitating and motivating factor in beginning the recovery process; furthermore, the study has shown that family intervention in initiating substance abuse treatment is effective (Cox, Ketner, & Blow, 2013; Gehart, 2012). The Center for Substance Abuse Treatment (2004) noted that the client’s family plays a pivotal role in the treatment of substance abuse.

Besides, research has demonstrated that substance abuse treatment that includes a family component is more effective than treatments that focus solely on the individual (National Institute on Drug Abuse, 2018; Mason, & Spoth, 2012). Therefore, it is imperative that the family is accounted for in treatment and recovery. As noted above, the results of the current study demonstrated that pressure from family and friends to enter treatment was cited as motivation. Additionally, the fear of others, including family, responding negatively, and thinking wrongly of the individual for seeking treatment was noted to be a barrier to treatment. Together, these results illustrate the importance of families having open and honest communication about the addiction and its consequences, including feelings each member may be experiencing. The current research provides family members with information that can assist in opening up the dialogue with loved ones struggling with addiction and help to facilitate an effective intervention. Moreover, these results provide information from the perspective of those who are in recovery from alcohol dependence and, as such, can provide families with increased understanding and awareness (Mason, & Spoth, 2012; Van Wormer, & Davis, 2007).

The results of this study underscore the critical role of families in their loved one’s recovery. This positive family involvement can not only help the addicted individual in his/her journey toward recovery but also improve the family system as a whole to begin to recover from the effects of the addiction (Gifford, 2011). The culture of recovery in the United States is changing, and advocacy for those in recovery is growing (White, Boyle, & Loveland, 2005; White, Kelly & Roth, 2012). The current exploratory study contributes to the existing foundation of research in the area of addiction and recovery and as such, provides an additional layer of understanding about the nature and course of recovery from substance dependence. The researcher hopes that this research will not only offer further advancement of the current recovery movement but also provide addicts with an understanding that they are not alone in their struggle enabling them to reach out for support and keep fighting.

Reference


