Barriers to Substance Abuse Treatment: Why Validation Plays a Crucial Role

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Abstract
There are several factors that researchers have identified that increase the likelihood of an individual not completing substance abuse treatment services. Some of the factors identified in the literature include the presence of a co-occurring disorder, a drug of choice other than alcohol, involvement in the legal system, unemployment, and low socioeconomic status. However, what has been largely ignored in the literature is the role that demographic variables of discrimination and validation play in client engagement in substance abuse treatment services. The purpose of this paper is to highlight previous research as well as to provide case studies illustrating the impact that culturally competent care and validation can have on overall client engagement and successful completion of treatment services.

Overview: Drug and Alcohol Treatment Programs
Successful completion of a drug and alcohol treatment program and an increase in length of time spent in treatment have been associated with more positive treatment outcomes [1, 2, 3, 4, 5], a higher likelihood of attending aftercare programs [6], and a greater chance at long-term maintenance of abstinence. Conversely, unsuccessful treatment completion has serious clinical implications for the client. Clients who do not complete treatment closely resemble patients who have never received any type of treatment for substance use disorders [7], are at a higher risk of relapse [1], and are at a greater risk of a fatal overdose [5]. Completion of a drug and alcohol treatment program is likely to increase positive results in attending aftercare interventions.

Several factors have been identified in the recent literature that contributes to a higher likelihood of individuals not completing treatment drug and alcohol treatment. Although legal coercion (i.e., court mandated treatment) has been shown to reduce the risk of treatment non-completion [8], having a criminal history and multiple arrests within 12 months preceding treatment admission has been linked to increased rates unsuccessful treatment completion [9]. Furthermore, clients who reported having a primary drug of choice other than alcohol (particularly those who reported using heroin or cocaine) and recent drug use prior to admission tended to exhibit more severe substance use concerns than those who reported their primary drug of choice as alcohol [9, 10].

Hambley, Arbour, and Sivgnanasundaram (2010) found that clients who exhibited a greater severity of substance use and had multiple previous treatment episodes had a higher...
likelihood of not completing treatment. While there are several reasons why people may not complete treatment, reporting other drugs of choice like heroin or cocaine may be associated with not completing treatment.

Co-occurring mental health diagnoses have also been identified as a risk factor for clients who do not complete drug and alcohol treatment. Mental health issues such as depression and anxiety have been found to increase the likelihood of clients leaving treatment prematurely [9, 11]. More specifically, Preuss et al. (2012) found that clients who do not complete treatment had higher rates of DSM Cluster B personality disorders, were more depressed, and had a higher number of suicide attempts. Clients who had low levels of psychological distress tolerance were shown to have higher rates treatment non-completion within the first 30 days of treatment [1] and Clients who were diagnosed with post-traumatic stress disorder in conjunction with low levels of distress tolerance had a lower likelihood of successfully completing treatment [7]. Co-occurring behavioral health diagnoses is a risk factor for clients not completing treatment.

Cultural Competence

Additional factors, such as income, employment status, education, the frequency of use, prior treatment, and referral source have been related to unsuccessful treatment completion. Evans et al. (2009) found that there were more severe employment problems among clients who did not complete treatment, opposed to those who completed treatment. Therefore, individuals who are unemployed and lack a healthy support group are at an increased risk of not completing treatment. Brown (2010) found that frequency of use, prior treatment, unemployment, lower levels of education and cocaine use disorders were related to unsuccessful treatment completion among drug court clients.

Although researchers have established a baseline of factors that are associated with treatment non-completion in substance abuse treatment, one factor that was largely overlooked in the aforementioned literature was the impact of the demographic variables (e.g., gender, sexual orientation, ethnicity) of both the counselor and the client. More specifically, how demographic variables either facilitate or create barriers in the treatment process. To increase client engagement in the treatment process, it is of paramount importance that counselors are able to recognize the interconnectedness of treatment outcomes when providing culturally competent care for all clients.

While providing culturally competent care has been long recognized in the helping professions, the outcome data for members of underrepresented groups remains nearly unchanged for the past three decades. Members of diverse populations have an increased likelihood of being misdiagnosed and prematurely discharged from treatment [12, 13]. Further, service outcomes tend to be significantly impacted by bias associated with the patient’s race, socioeconomic status, gender, and culture for members of diverse populations [13, 14]. It is difficult to deny how a person’s looks can have counterproductive results when connected to our social and human service agencies in the United States.

In order to provide culturally competent care, it is essential that the counselor be aware of (1) his or her cultural values and biases; (2) the client’s worldview; and (3) culturally appropriate intervention strategies [15, 16, 17]. While this appears to be straightforward and simple, applying these concepts in a counseling setting is much more complex. In order to provide culturally competent care, the counselor must be able to not only recognize the impact of demographic variables, but must also be able to provide counseling that is consistent with the client’s worldview in addition to being able to validate the client’s values, beliefs, emotions, and culture.

Validation psychotherapy

We define validation as providing truth to one’s own story [18]. In our combined 35 years in the helping profession, many clients have expressed that it is their common experience that they do not feel that they are heard by their counselor or that they felt that they knew more about their counselor than they did about themselves. We submit the following actual case study to illustrate what validation is and what validation is not. Lastly and more importantly, it is not necessary for providers to believe or understand the client’s worldview to validate what their clients are communicating during treatment. There is more to say about this last point. However, it is beyond the purview of this article.

Case Study: What Validation is and is not

Courtney is a European American/White American substance abuse counselor in her early 30s. She was just assigned to work with Eugene who is a Black Native American male in his mid-30s. Eugene’s mother is Native American, and his father is a Black American/African American. Eugene was referred for substance abuse treatment by his probation officer for possession of
marijuana. He indicated that he was arrested for having less than a gram. Eugene was incarcerated for three years after his charge and is currently on probation for the next year. Eugene told Courtney that he was supposed to be off of probation two years ago, but that his probation was extended due to testing positive for marijuana twice. When assessing Eugene’s substance abuse history, there was some past alcohol use in his 20s, but never more than two to three drinks per month. Eugene denied any other substance abuse except for using marijuana. His last use was about two weeks before his probation officer gave him a drug screen which he tested positive for marijuana. When asked about his previous use, Eugene stated that he smoked marijuana during a family ceremony on his mother’s side where marijuana was used during their annual ritual where junior family members are transitioned into being senior members of the family. Eugene explained that he had mixed emotions about participating in the ceremony because he knew that he was not supposed to be smoking marijuana while he was on probation, but he also felt that he would be betraying his family if he did not take place in the ceremony. Eugene said that his probation officer thought that he was making the situation up and was just using the family ritual as an excuse to smoke marijuana.

When assessing for co-occurring disorders, Eugene stated that he had a diagnosis of schizoaffective disorder. Eugene was then asked when he received this diagnosis. He further stated he received the diagnosis around the time a negative encountered occurred between his ex-wife and her new boyfriend. He went on to explain that he wanted to be able to see his two children. Eugene told his counselor that his wife left him for another man, a White male, and that they put a restraining order on Eugene. When asked why there was a restraining order, Eugene stated “It was really for no reason at all on my part. I went over to give my kids their birthday gifts, and my wife’s new boyfriend came to the door with a gun and said that if I did not get out of there that he was going to shoot me”. The next day, I saw her new boyfriend in town and he came after me and shot a warning shot into the air. Someone called the police, and the police made me leave saying that I aggravated the situation. There were no charges pressed on him. What I started to notice is that her new boyfriend would start following me in his car while I was out and about in town. Eugene did not have a driver’s license, but would walk to and from work and to the store. He was unemployed for about two years, but recently became employed at a local restaurant where he made minimum wage. He said “I was in counseling at this time and I was telling my counselor -

a White female in her late 50s - about the situation and she became concerned that I was making this up and that I was not being followed. She felt that I was just being paranoid, so she referred me to inpatient treatment for psychosis. They (the inpatient facility) gave me some drugs that made me like a zombie and locked me in a room for about three days, and then they let me out”.

Examples of Counselor Invalidation in the Case Study

Over the years, we have heard several clients express dissatisfaction with their treatment services. The overwhelming majority had to deal with not being validated in a counseling session by human service providers there to facilitate interventions on their behalf. Here, we will use Eugene’s case to display some of the common invalidating statements that clients experience. Concerning Eugene smoking marijuana as part of his family ceremony, an invalidating dialogue would be as follows:

Eugene: “My probation was extended for a year because I tested positive for marijuana after my family ceremony. I was hesitant to participate because I know I am on probation, but it was my family ceremony that I have waited my whole life for”.

Counselor: “But you knew you were on probation, and you smoked anyway. You were aware of the consequences and decided that it was more beneficial for you to participate in the ceremony than to avoid the negative consequences of smoking marijuana.”

In this first scenario, Eugene’s internal struggle with either participating fully in his family’s ceremony or not participating was not validated. The counselor invalidated his struggle and Eugene’s culture by placing him at fault for smoking marijuana while emphasizing that he “should have known better” than to smoke marijuana while on probation. While many clients may not say anything verbally about how they may feel when being invalidated, they know and feel not believed.

Here is an example of what validation is not with reference to Eugene having a restraining order placed on him after he tried to deliver gifts to his children after his wife left him:

Eugene: “I really didn’t do anything but try to deliver gifts...
to my kids, but my ex-wife’s new boyfriend came to the front door saying that he was going to shoot me if I didn’t leave. They acted like I was a threat”.

Counselor: “But you must have acted in some sort of an aggressive way for them to react so severely. The courts do not issue order of protections without just cause”.

In this second scenario, the counselor assumed that there was more to the story that Eugene was providing and was operating under the assumption that there is equal treatment across all persons involved in the legal system. This is indeed inaccurate thinking on the part of the provider.

This last example of what validation is not related to Eugene’s diagnosis of schizoaffective disorder after he was placed in residential mental health treatment after saying that his ex-wife’s new boyfriend was following him around town:

Eugene: “I told my last counselor that my ex-wife’s new boyfriend started following me around town and driving really slow whenever he saw me. He would make threatening gestures like he was going to shoot me. When I told her about that, she told me that I was over exaggerating and being paranoid. That’s when she made an inpatient mental health referral for me”.

Counselor: “And what are your thoughts about that?”
Eugene: “I don’t think that it was right. I mean, he really was following me around and threatening me”.

Counselor: “Did you do anything to provoke him?”
Eugene: “No, I did not. This was all him and not me”.

Counselor: “Usually people don’t just act out of nowhere. I am sure it was just coincidence that the both of you were at the same place at the same time”.

In this example, the counselor invalidated Eugene’s feelings of fear about the ex-wife’s boyfriend threatening him in public. In each of these examples, the truth to Eugene’s story was not validated. The counselor was trying to find some rationale for the actions of other people instead of understanding and validating the lived experiences of Eugene.

Being Informed can Facilitate the Validation Process

Many times there is information that the provider may be missing in order appropriately validate their clients. In this case study, there are several demographic and cultural factors that apply to Eugene. The first is his racial identity. Eugene identified as bi-racial being both Native American and Black American. There were several occurrences where Eugene experienced biased treatment. The first was his interpersonal struggle between participating in his family’s ceremony while balancing the fact that he was on probation and not supposed to smoke marijuana. The second was his incarceration for possession of marijuana. The number of Black males that are incarcerated is disproportionate to the number of Black American citizens. According to the Bureau of Prisons [19] 37% of inmates were Black males while Black Americans only represent about 13% of the general population. Furthermore, approximately 46% of inmates are incarcerated for drug offenses [19] and it has been shown that Black males receive longer sentences by nearly 20% when compared to their European American counterparts [20]. To put Eugene’s sentence of three years into context according to the [21], the average sentence for marijuana trafficking was 33 months. Marijuana trafficking is a more serious offense than than amount that Eugene had, which was for personal use and not distribution to others. These factors combined can substantiate the fact that he received a longer and harsher sentence than what would be considered typical for the amount that he had in his possession. Bottom line, when everything is equal, individuals who are part of underrepresented groups tend to receive harsher sentences than European Americans.

A second case where culturally competent care was not being provided was when Eugene’s previous counselor automatically assumed that he was being paranoid about his ex-wife’s boyfriend following him around town. In a study where theracialdisparity in psychotic disorders was examined, Schwartz and Blankenship [22] found that diagnoses of psychotic disorders in Black Americans were three to four times higher than their White American counterparts. To substantiate this finding, we have also found that over the past 35 years it is prevalent for Black clients to express that they feel that they were misdiagnosed with a schizophrenia-related disorder. Evidence suggests that people who are people of color are more likely to get misdiagnosed when compared to European Americans in the United States.
Validation in Action

In this section, the dialogue between Eugene and his counselor is provided to show what validation looks like in a counseling setting. The first dialogue is related to Eugene’s racial identity as Native American and his decision to participate in the family ceremony:

Eugene: “My probation was extended for a year because I tested positive for marijuana after my family ceremony. I was hesitant to participate because I know I am on probation, but it was my family ceremony that I have waited my whole life for”.

Courtney (counselor): “That is a very difficult decision to make. It must have been hard for you to balance the obligation that you have to your family with the ‘rules’ of probation”.

Eugene: “Yes, it was and I am not sure if I regret it or not. My probation officer was not happy with me. She asked me why I can’t just stop smoking marijuana”.

Courtney: “I bet that was difficult trying to explain the customs of your family. That must have caused you a lot of stress”.

Eugene: “It really did and people don’t understand that. They just think that I am a pot-head”.

Courtney: “It does become difficult when we have different obligations and the outcomes of the decisions that we make can be very painful. The stress that you are feeling about this situation is very real and must be hard to deal with”.

Eugene: “It really is”.

In this example where Eugene is processing his decision to participate in his family’s ceremony, his culture was acknowledged as well as the internal struggle that he had with making a decision to either participate or not participate in a meaningful ritual. Here, the counselor validated his feelings of uncertainty as to whether or not he made the correct decision.

Eugene’s prior counseling experiences

Courtney (counselor): “It seems that you did not have very positive counseling experiences in the past”.

Eugene: “Well, I just felt like my counselors thought that everything was my fault and that I was making things up”.

Courtney: “That upsets you”.

Eugene: “Yes it does because these things really did happen to me”.

Courtney: “I know they did and that your experiences are very real. It causes a lot of pain when you’re told that you’re lying”.

Eugene: “You know, this is the first time that anyone has said that to me. I really feel that you understand what I am feeling. Thank you”.

Throughout treatment, Courtney and Eugene processed the cultural biases and discrimination that he had experienced. Eugene told Courtney that he did not feel that he would make as much progress in treatment, especially since she was a White female and all of his previous counselors were White as well. Eugene had successfully completed treatment, but elected to continue with Outpatient mental health treatment with Courtney as part of his aftercare planning.

Eugene would have likely dis-engaged in substance abuse treatment if Courtney did not recognize the experiences that clients of underrepresented groups face. Eugene was not validated by his previous counselors because they projected racial stereotypes onto him: They did not believe him when he told his story, and there was a strong assumption that since they felt that Eugene was lying that he was paranoid. A mistake that many European American human service and allied health care providers project on clients that might look differently than they do.

Connecting Eugene’s Case to the Previous Addictions Research

Eugene’s case contained several factors that had been identified as barriers to not completing treatment. Just as Perron and Bright [8] mentioned, a criminal history with multiple arrests increases the likelihood of not completing treatment. Eugene did have a criminal history which included both incarceration and probation. Eugene also met criteria for having a co-occurring disorder. He had a diagnosis of cannabis use disorder and well as schizoaffective disorder. According to Evans et al. [9, 11], individuals with co-occurring disorders tend not to
complete treatment. Eugene did not have a healthy support network and had a history of unemployment. Lack of social support and unemployment were two factors identified by Brown [10] that reduce the likelihood of not completing treatment.

While Eugene fit several of these factors associated with not completing treatment, we contend that the key component in Eugene’s case and his history of not completing treatment was due to lack of culturally competent care and validation of his experiences. While the factors above are key indicators of not completing treatment, the lack of culturally competent care and validation can also have an adverse impact on treatment. As was seen in Eugene’s case, when he was validated, and his lived experiences were provided truth, his engagement in treatment increased to the extent that he volunteered to continue with services even when he was no longer court-ordered to do so. Unfortunately, what Eugene experienced is a common occurrence of many underrepresented groups seeking help who may be alcohol or drug dependent.

**Directions for Future Research**

There have been several factors associated with treatment non-completion in individuals who are in substance abuse treatment. Examples of factors include unemployment, co-occurring disorders, substances of abuse other than alcohol, involvement in the legal system, and low socioeconomic status. However, additional research has shown that individuals of underrepresented groups tend to be misdiagnosed and discharged prematurely from treatment. We have provided illustrations as to how the lack of culturally competent care and validation can play a role in treatment non-completion among individuals in substance abuse treatment. As was seen in the case of Eugene, several demographic variables were not taken into account during his treatment processes, but when his culture and his experiences were validated, he made good progress in treatment and volunteered to continue in mental health counseling as part of his aftercare discharge from substance abuse treatment. We believe that future research on the subject of culturally competent care and validation can be explored to empirically support what we have found in our personal and professional experiences over the past combined 35 years. It would be beneficial for researchers to study the impact of validation and invalidation in an empirical sense so that evidence-based practices of validation can be empirically supported and integrated into the training of counselors as well as the delivery of treatment services.

**References**


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