

IDENTIFYING VALUES IN DRUG ABUSE COUNSELING

Carlton E Munson, University of Houston

INTRODUCTION Values, personal or professional, are hard to define, conceptualize, measure, and teach. The helping professions have long struggled to clarify values. This has led to accusations that the values of the helping professions are global, vague, inconsistent, and irrelevant. These weaknesses often lead drug counselors to develop the mind-set that professional values are not worth assimilating because of the great gap between the real and ideal which many view as verging on hypocrisy.

. To combat these problems, values are often viewed as such complex concepts that one is tempted to despair or to forget them until they become problematic (Jones 1970 35). But the literature on values demonstrates an evolutionary process that can be identified, and we can document a unified, clear conception of these values for practical use. More precision in clarifying values for drug counselors is essential since workers in these roles need a code of ethics to help sort out personal and professional values, like more established professions. Values are defined as highly regarded attitudes and behaviors that enhance interpersonal relations.

EVOLUTION OF PRACTICE VALUES

Practice values have evolved from the general to the specific. Early concepts were based on global statements of social values like democratic participation, basic human rights, the importance of the family to one's growth and development, the role of religion in developing moral values, and the assumption that all are concerned with biological, psychological, and social survival (Towle 1965 3; Perlman 1957 6). These concepts were simplified by: 1) concern for the client's welfare; 2) accepting the individual; 3) recognizing the client right to self-determination; 4) non-coerciveness; and 5) avoiding social

control of the client (Hollis 1966 12). As society becomes more complex and diverse, more emphasis is placed on value conflicts met in the helping professions (Briar & Miller 1971 32). Human services have emerged as a professional function. To deal with value conflicts, we emphasize flexibility in professional treatment and we recognize that values change constantly, and differ culturally and ethnically (Boyer 1975 13).

. Recent discussion of values has turned to operational referents and behavioral manifestations. Values surround workers' 1) personal values; 2) professional values; 3) organization values; 4) client system values; and 5) prevailing societal values. People overtly and covertly represent these various value systems by interaction. Values are communicated directly, indirectly, and symbolically. They often cause conflicts. In relating behavioral values discussion has turned to ideas of social responsibility, how people are similar or different, and means of reaching self-realization, group survival, recognition, security, identity, self-respect, competence, and privacy (Siporin 1975 65). Values result from a complex socialization process, and introduce order and a way of coping with the world.

. The question remains: How can values be identified, changed, and reinforced in the worker client relation? There is disagreement about how to categorize values in practice. There are distinctions between values, knowledge, and beliefs (Feibleman 1973 14; Marsh 1971 132; Scheibe 1970 41). These have been studied in practice settings without clear distinctions. Pinkus & Minahan (1973 38) hold that values are beliefs that cannot be verified, and Bartlett (1970 63) argues that values are qualitative judgments which are not empirically demonstrable, and are invested with emotions representing a purpose to which the

worker's actions are directed.

ORGANIZATION IMPACTS

In a democratic society people have the right to know the actual and potential facts regarding their existence, and when people are informed they tend to become more involved. Values in drug counseling must be developed with this basic concept of democracy, knowledge, and participation in mind. Values of drug counselors cannot exist in isolation from the organization. To minimize value conflict, the organization must be flexible. Its values must be clearly defined, and responsible administrators have an obligation to implement these values. This does not mean that value conflict is to be completely avoided. Only by openly exploring such conflicts can value stances of the organization, the client, or the counselor be changed or reinforced. Value exploration in the context of the organization is important for the paraprofessional drug counselor since a traditional code of ethics does not exist which distinguishes personal and professional values. Value exploration is also important because the counselor can be in turmoil by identifying with the conflicting values of the organization, the client, and the client system.

The drug counselor must be trained to identify, articulate, and use his or her values to promote the welfare of clients. Drug abusers are skilled at manipulating systems for their own ends. Counselors who have not been trained to profess values that help define the limits of performance in their roles are easily used by the client, and often find themselves in a trap between the organization and the client, with equally poor alternatives for the counselor. Unprepared counselors experiencing such dilemmas may develop a sense of defeat, and frustration, and may become cynical about counseling.

VALUES & KNOWLEDGE IN PRACTICE

Values and knowledge are

connected by choices people make. Scientific knowledge alone is not enough to produce change in behavior. But values and practice can be used to: 1) develop awareness of options; 2) predict outcomes for each option; 3) assess importance of each outcome for the client; 4) combine the outcomes; and 5) measure the degree of goal attainment (Bloom 1975 102). This distinction between relatedness of values & knowledge is important. Lacking scientific knowledge about drug effects, a counselor can be manipulated by the client value that drug usage does not produce negative outcomes. Clerical staff in some agencies know more about drugs than counselors, and paraprofessionals tend to devalue the importance of drug information in counseling.

Having such knowledge need not produce a value impasse among workers, clients, and the organization, but it is essential to the process of clarifying values. The worker can persuade the client of his right to self-determination, on the assumption that the client does have alternatives. But the worker has to make the value judgment that the client does have viable alternatives.

The value of confidentiality will illustrate this. Private interview rooms often are not provided in drug clinics, and conversation is limited only by whether others are within hearing distance. Little is done to clarify the right of privileged communication with the drug counselor. The client who shares information in confidence can be given no convincing assurance on the limits placed on this information as regards the law enforcement and criminal justice systems, or even within the agency. When drug counselors subscribe to traditional professional values, the conflict becomes even more acute due to weak or nonexistent professional sanctions of decisions made in difficult or crisis situations.

Training programs for drug abuse counselors presume a medico-social problem for the drug

abuser (Trader 1974). When counselors internalize this concept as a value, it often produces an impasse in the counseling situation. In a study of 224 drug addicts, the staff viewed the patients as physically and mentally ill, but the patients did not perceive themselves as having either form of illness. Such disagreement was depicted as a serious block in staff-patient communication, which was aggravated where there was cultural conflict. The researchers argue that successful drug counseling is dependent on complementary views of counselors and patients (Ball 1974).

. This value stance is problematic for the field in relation to the client. Dissimilarity of interactants leads to higher levels of verbal accessibility between the participants in direct interaction. Dissimilarity between client and counselor may contribute to the change process. Halmos (1970 91) applies Homans' hypothesis that interactants tend to become more alike over time. If the counseling relation is to promote change in the client, then the worker must offer the client a differential model of values, attitudes, beliefs and behaviors. This view deviates from the professional's traditional belief that the more similar the worker is to the client, the more likely the client will invest in the relation. Paraprofessional counselors often mistrust their intuitive feelings, minimize their street knowledge, and resist what they perceive to be professional control, which increases the conflict for counselors (Dalali 1976).

. We need to know exactly what differences and similarities between counselors and clients are to be minimized and maximized to produce positive therapy. Thus, many drug counselors are confronted with a value-laden question early in the interview when the client seeks the sanction of the worker by asking, "Do you do drugs?" When the worker is presently or formerly an occasional drug user s/he fears becoming too identified with the client, but if

drug usage is denied, s/he takes the risk of being rejected as being straight, and unable to understand. The counselor must be prepared to share values in this regard. Such questions by clients are not really designed to gain knowledge of the worker's drug use, but instead, are a test of the worker's values in working with drug users. It may be a test of whether to invest trust, or to end the relation. A means of overcoming resistance and avoiding rejection is to differentiate counselor values through expressing serious concern about heavy drug dependence while communicating acceptance and concern for the drug-dependent client. This requires relating values and beliefs and knowledge learned both in training and on the street.

. Failure to offer the counselor help with the conflicts and identification with the client and the agency can increase the strain. A negative outcome is not inevitable if the agency is innovative rather than traditional, and if cultural differences in values and beliefs are accepted. Those responsible for planning and administering drug treatment services are obligated clearly to articulate agency and program values for workers and clients, so that they can understand expectations and make choices about the degree to which they want to participate.

THE ADVOCATE ROLE & VALUES

. Openness and acceptance in the agency context lets the counselor fill the advocate role which is appropriate for the position of drug counselor. The role of advocate must be clearly defined for the counselor. Role clarity is important to the success of the paraprofessional counselor, but advocacy is one of the more poorly defined functions in the helping professions. Values are important in providing role clarity in the advocate function. It is one of total commitment to serving client needs and interests in a social conflict (Grosser 1965 18; Brager 1968 6). If the counselor sees the

advocate role as a one-sided struggle against an alien system, and identifies totally with the client's distrust of the professional treatment system, both the client and the counselor are placed outside the system. The drug-abusing client is often totally out of contact or in conflict with institutional treatment systems. That large numbers of drug abusers are outside the system is shown by the wide discrepancy in demographic characteristics of patients in drug treatment programs and those treated for drug abuse in a hospital emergency room. The difference is especially glaring with women, who make up a much higher proportion of the drug patients in emergency room cases than in drug treatment programs (Weppner 1976).

To bring about involvement, the counselor will sometimes have to advocate with the client on behalf of other systems, and may have to confront the treatment system, the educational system, the law enforcement system, the client's family system, the drug culture system and the economic system. The objective is to bring about engagement, or disengagement, depending on the circumstances. On the other hand, the role of advocate often involves supporting and confronting a resisting client in relation to one or more of these systems. In either case, the advocacy role requires providing information, and the counselor must have substantial and accurate knowledge for his values to have genuine meaning for the client. In the first case, the information relates to interpreting the needs of the client to the system. In the second case, information must be given the client in terms of what may happen or what will be done to the client.

By providing information, the advocate can often promote more equity in interaction between the client and a given system. This promotion of equity is one of the primary values of the counselor, specifically in the role of advocate. The role of knowledge has

emerged as a significant variable in health and longevity (Comstock & Tonascia 1977). The application of their findings to drug counseling needs exploration. To be successful in these tasks, the advocate must have good knowledge of treatment, educational, family, law enforcement, drug culture and economic systems. Counselors who attempt advocacy roles without such knowledge will increase the client's resistance, hostility and anxiety.

PREVENTION VS. RESIDUAL ROLES

Much is written on knowledge of drugs among users and the public based on demographic factors, attitudes, values, and beliefs (Fisher 1974; Schill & Althoff 1975; Wrong & Allen 1976). Little study has been undertaken on drug knowledge of counselors, and still less research relates to how this knowledge affects values and practice. More information is needed on professional organizational and societal sanctions against drug abuse, contrary beliefs by drug users, and how counselors resolve these differences in value orientation. Parents and teachers are found lacking in knowledge, and unqualified to provide accurate drug information, and physicians and peers are considered potential reliable sources of drug information (Smith & Meyer 1974; Fagerberg & Fagerberg 1976). The chief source of drug information is peers. While most people, and particularly drug abusers, consider themselves sufficiently informed on drugs, such knowledge may not be reliable. This raises important questions for drug abuse counselors in their role as residual change agents in dealing with abusers after the fact, and their role in prevention through effective provision of drug education programs.

In residual counseling, and in prevention programs, the personal and professional values of the counselor must be explored, identified, clarified, and available for explanation if the counselor is to be effective. Drug counselors often

have serious value conflicts when they are given the dual function in their role of working in prevention programs and providing residual counseling service at the same time. Prevention programs require a negative value stance on drug usage, while residual counseling requires positive acceptance of the drug user. Many counselors find this rapid shift in value stance difficult. Prevention programs and residual treatment present the counselor with very different client groups. Serious drug abusers do not participate in prevention programs, and regard them with contempt, particularly if they find that their counselor is affiliated with such programs. Counselors need help in making these transitions.

REFERENCES

- .Ball J 1974 Heroin addict's view of methadone maintenance. *British J of Addiction* 69 89-95
- .Bartlett H 1970 *Common Base of Social Work Practice*. Washington DC Nat'l Ass'n of Social Workers
- .Bloom M 1975 *Paradox of Helping: Intro. to Philosophy of Scientific Practice*. New York Wiley
- .Boyer P 1975 *Approach to Human Services*. San Francisco Canfield
- .Brager G 1968 *Advocacy & political behavior*. *Social Work* 13 5-15
- .Briar S, H Miller 1971 *Problems & Issues in Social Casework*. New York Columbia U Press
- .Comstock G, J Tonascia 1977 *Education & mortality in Washington County, Maryland*. *J Health & Social Behavior* 18 54-61
- .Dalali I 1976 *Training paraprofessionals: some caveats*. *J Drug Education* 6 105-112
- .Dembo 1976 *Demographic, value & behavior correlates of marijuana use among middle class youth*. *J Health & Social Behavior* 17 176-186
- .Fagerberg, S & K 1976 *Student attitudes on drug abuse & prevention*. *J Drug Education* 6 141-152
- .Feibleman J 1973 *Understanding Philosophy: A Popular History of Ideas*. New York Horizon
- .Fisher G 1974 *Legalization of marijuana: views of users & non-users*. *Psychedellic Drugs* 6 333-349
- .Grosser C 1965 *Community development programs serving the urban poor*. *Social Work* 10 15-21
- .Halmos P 1970 *Faith of Counselors: Theory & Practice of Social Case Work & Psychotherapy*. New York Schocken
- .Hollis F 1966 *Casework: Psychosocial Therapy*. New York Random House
- .Jones R 1970 *Social values & social work education*. K Kendall ed. *Social Work Values in an Age of Discontent*. New York Council of Social Work Education
- .Marsh R 1956 ed. *Bertrand Russell: Logic & Knowledge*. New York Capricorn
- .Munson C 1972 *Differences in general knowledge regarding abused drugs*. Unpublished
- .Perlman H 1971 *Social Casework: A Problem Solving Process*. U of Chicago Press
- .Pinkus A, A Minahan 1973 *Social Work Practice: Model & Method*. Itasca Ill Peacock
- .Richan W 1972 *Indigenous paraprofessional staff*. F Kaslow ed. *Issues in Human Services*. San Francisco Jossey Bass
- .Sheibe K 1970 *Beliefs & Values*. New York Holt Rinehart Winston
- .Schill T, M Althoff 1975 *Drug experiences, knowledge & attitudes of high & low guilt individuals*. *J Consulting & Clinical Psychology* 43 106
- .Siporin M 1975 *Intro to Social Work Practice*. New York Macmillan
- .Smith H, F Meyer 1974 *Parent & teacher attitudes to knowledge of drug abuse*. *J School Health* 44 152-155
- .Towle C 1965 *Common Human Needs*. Washington DC Nat'l Ass'n of Social Workers
- .Trader H 1974 *Professional school role in training ex-addict counselors*. *J Education for Social Work* 10 99-106
- .Weppner R 1976 *Effects of criminal justice & medical definitions of social problem on delivery of treatment: case of drug abuse*. *J Health & Social Behavior* 17 170-177
- .Wrong M, T Allen 1976 *Three dimensional structure of drug attitudes*. *J Drug Education* 6 181-191