1996

The effect of chemical dependency counselors' spiritual well-being on the spiritual well-being of their clients

Clifford Wilson Brooks Jr.
College of William & Mary - School of Education

INFORMATION TO USERS

This manuscript has been reproduced from the microfilm master. UMI films the text directly from the original or copy submitted. Thus, some thesis and dissertation copies are in typewriter face, while others may be from any type of computer printer.

The quality of this reproduction is dependent upon the quality of the copy submitted. Broken or indistinct print, colored or poor quality illustrations and photographs, print bleedthrough, substandard margins, and improper alignment can adversely affect reproduction.

In the unlikely event that the author did not send UMI a complete manuscript and there are missing pages, these will be noted. Also, if unauthorized copyright material had to be removed, a note will indicate the deletion.

Oversize materials (e.g., maps, drawings, charts) are reproduced by sectioning the original, beginning at the upper left-hand corner and continuing from left to right in equal sections with small overlaps. Each original is also photographed in one exposure and is included in reduced form at the back of the book.

Photographs included in the original manuscript have been reproduced xerographically in this copy. Higher quality 6" x 9" black and white photographic prints are available for any photographs or illustrations appearing in this copy for an additional charge. Contact UMI directly to order.

UMI

A Bell & Howell Information Company
300 North Zeeb Road, Ann Arbor MI 48106-1346 USA
313/761-4700 800/521-0600

THE EFFECT OF CHEMICAL DEPENDENCY COUNSELORS' SPIRITUAL WELL-BEING ON THE SPIRITUAL WELL-BEING OF THEIR CLIENTS'

A Dissertation

Presented to

The Faculty of the School of Education

The College of William and Mary in Virginia

In Partial Fulfillment

Of the Requirements for the Degree

Doctor of Education

---

by

CLIFFORD WILSON BROOKS, JR.

May 1996

UMI Number: 9623241

UMI
300 North Zeeb Road
Ann Arbor, MI 48103

THE EFFECT OF CHEMICAL DEPENDENCY COUNSELORS' SPIRITUAL WELL-BEING ON THE SPIRITUAL WELL-BEING OF THEIR CLIENTS'

by

Clifford W. Brooks, Jr.

Approved May 1996

Charles O. Matthews, Ph.D.
Chair of Doctoral Committee

Charles F. Gressard, Ph.D.

Victoria A. Foster, Ed.D.

ABSTRACT

BROOKS, JR. CLIFFORD WILSON. The Effect of Chemical Dependency Counselors' Spiritual Well-Being on the Spiritual Well-Being of Their Clients.

The purpose of this study was to evaluate the impact an inpatient substance abuse counselors' spiritual well-being had on chemically dependent patients' spiritual well-being over the course of two weeks in treatment.

Raymond Paloutzian and Craig Ellison developed the Spiritual Well-Being Scale which was utilized in this study along with the Rokeach Value Survey, the Personal Orientation Inventory, and the Profile of Adaptation to Life Scale. Pre and Post test packets containing the Spiritual Well-Being Scale and the Profile of Adaptation to Life Scale were administered to one hundred ten inpatient alcohol and drug patients. A total of forty-five alcohol and drug counselors from around the Commonwealth of Virginia were also administered packets containing the Spiritual Well-Being Scale, the Rokeach Value Survey, and the Personal Orientation Inventory. Eleven of the forty-five counselors were inpatient counselors that selected ten patients from their groups to give the pre and post test packets. The remaining packets were

sent by mail to a random sample of Certified Substance Abuse Counselors in Virginia.

Multiple Regression statistics were utilized in the analysis indicating a significant correlation between the dependent variable of spiritual well-being and self-acceptance from the Personal Orientation Inventory, wisdom and loving from the Rokeach Value Survey. The results also indicated a significant change score in the patient's spiritual well-being scale pre and post test, however, it was not related to the counselor's spiritual well-being.

Overall, the Spiritual Well-Being Scale appeared to be a helpful tool for evaluating addiction treatment benefits. This instrument in particular could be used as a quality assessment tool not only for treatment programs, but for patients to be able to see improvement in their well-being.

Further research on the impact of a treatment milieu group consciousness on well-being would also be recommended. To this end, further research could compare the effects of the inpatient treatment milieu with that of outpatient group therapy on spiritual well-being.

DEDICATION

This study is dedicated
to my Mom, Alberta L. Brooks
and to my Dad,
Clifford Wilson Brooks,
God rest his soul.

To
The Fish and the Owl
The Alpha and Omega
Synchronicity at Time of Death
Brought Forth Life
and
Spirit

ACKNOWLEDGEMENTS

I saved this part for last, yet paradoxically, it is at the beginning. It is the same paradox that has taught me throughout this research process.

My biggest thanks go to my wife, Christine, who has lived with a den of disaster for the past three years. She has been a continuous inspiration and support when I had little energy to forge ahead. Christine has put up with my late nights, not being around, and overall crankiness and anxiety during comprehensives. Her love and encouragement has been instrumental in continuing on with this project.

When I walked into the then "Chuck" Matthews' class on advanced theories in 1986, I was not prepared for the events to follow for the next ten years. Since that class my life has taken on new meaning and understanding. This paper has been an internal process facilitated by many special individuals.

Chas Matthews, my dissertation chairman, has supported me throughout the years, even when the answer initially was no. I have never worked so hard for any project in my life. Rick Gressard, one of my committee members, spent many hours helping me on the computer entering, analyzing, and interpreting data. His support, gentleness and humor helped me feel less inadequate throughout the analysis and defense. Kevin Geoffroy was on my

comprehensive examination and proposal defense committee. He gave me suggestions and ideas that added significantly to the project. Special thanks go to Ronald Forbes, M.D. for taking time out of his busy schedule to be my fifth committee member for orals. My appreciation also goes to Victoria Foster for her willingness to be my third defense member due to Kevin Geoffroy's retirement. Finally, spiritual guidance from Sally Franek who taught at William and Mary for a short time in the late 80's. Her encouragement helped me look at my purpose and need for focus in my life.

I will be forever grateful to Willow Oaks Treatment Center and Kelly Affleck, 919 and Denise Holland, and the Turning Point at the direction of Lee Gardner. Each of these individuals helped make my job of collecting data easier. Immense gratitude to the many patients and counselors in each facility that participated in the study as well as the certified addiction counselors in Commonwealth of Virginia.

Fond memories and thanks go to our comprehensive exam study group which helped make my preparation for the comprehensive examinations complete. Special kudos to Joel Diambra for his jocularity and continued anxiety which helped distract me from my studies.

Donnie Conner has been a continuous guiding force for many years in my life. His wisdom, compassion, and experience helped me in my darkest moments. It has been through his love and support that this project has carried through. Kathy Benham, a spiritual woodsperson, has led me to new realms both physical and spiritual. May the eagle fly with her always.

I know as I write these final pages that my Dad has been watching. The seeds for this dissertation came about at the time of his death. Since that time I have been on a path that can only be described at times as joyous and yet paradoxically very lonely. I believe I have continued with what he was unable to say, that which was deep within his heart. I also know that my mother is extremely proud of my accomplishments. She has supported me in my endeavors as long as I can remember.

In closing, I have often laughed at my own arrogance in measuring spiritual well-being. Purposefully I have focused on the spiritual rather than the religious, to examine the water in the glass, to understand the hollow bones. I believe we are vessels of life, in community we are healers of souls and of the earth. To this end I bring you this study.

TABLE OF CONTENTS

LIST OF TABLES

THE EFFECT OF CHEMICAL DEPENDENCY COUNSELORS' SPIRITUAL WELL-BEING ON THE SPIRITUAL WELL-BEING OF THEIR CLIENTS

CHAPTER ONE

INTRODUCTION

Statement of the Problem

This study was concerned with the impact an inpatient substance abuse counselor's spiritual well-being had on a chemically dependent patient's spiritual well-being over the course of two weeks in treatment.

Few theories have singled out the meeting between the therapist and patient. Viktor Frankl posits that this meeting is the true healing center of psychotherapy:

> Provided that one does not shudder at that so fashionable word, one can aptly speak of human meeting (Begegnung) as the actual agent in the modes of acting in psychoanalytic treatment. The so-called transference is also probably only a vehicle of such human meeting...
>
> Within the framework of psychotherapy, the methodology and techniques applied at any given time is least effective of all: rather it is the human relationship between physician and patient which is determining (Frankl, 1973, p. 24).

Fichter (1981) found that most patients felt health care professionals should have a spiritual perspective on life and that hospital work, in particular, was a form of spiritual ministry. Millison and Dudley (1990) believed that professional care-givers have long avoided the spiritual component of care, choosing to emphasize the physical, social, psychological and financial aspects of their patients (p. 63).

The human spiritual experience is the ultimate meaning which lies at the core of all human existence. Adrian Van Kaam maintains that to be distinctively human is to experience this desire or disposition for transcendence. To be human is to long for ultimate meaning and direction in life; it is to live a spiritual existence (Mckenzie, 1991, p. 327). Van Kaam also believes the degree to which a culture promises that intimacy is found in anything other than the transcendent dimension of life, to that degree addiction or unauthentic spiritual existence will flourish (Mckenzie, 1991, p. 330).

Without a spiritual component, recovery from addiction is reduced to an empty activity which is externally directed and motivated by a desire to gain approval of one's peers and to avoid the fearful possibility of relapse. This would equate

recovery with a rigid, mechanical, and joyless pattern of life (Small, 1983). Friedman suggests that to become aware of a person means to perceive his or her wholeness as a person defined by spirit: to perceive the center of all his or her utterances, actions and attitudes (Friedman, 1988, p. 22).

The following parable describes the belief in healing through meeting. "When one person is singing and cannot lift his voice," said a Hasidic rabbi, "and another comes and sings with him, another who can lift his voice, then the first will be able to lift his voice," "That," said the rabbi, "is the secret of the bond between spirit and spirit." The story was not titled "The Healer" or "The Helper," but "When Two Sing." As Martin Buber describes, this is the secret of the bond between spirit and spirit (Friedman, 1988, p. 39).

The spiritual dimension of recovery is very important and it has been neglected in the literature (Corrington, 1989, p. 151). Kurtz (1979) views alcoholism as a misguided thirst for transcendence and believes that it is the alcoholic's denial and misunderstanding of spiritual needs that is the root of addiction.

Justification

The Dalai Lama of Tibet (1991) states:

> Although attempting to bring about world peace through the internal transformation of individuals is difficult, It is the only way. Wherever I go,I express this and I am encouraged that people from many walks of life receive it well. Peace must first be developed within an individual. And I believe that love, compassion, and altruism are the fundamental bases for peace. Once these qualities are developed within an individual he or she is then able to create an atmosphere of peace and harmony. This atmosphere can be expanded and extended from the individual to his family, from the family to the community and eventually to the whole world.

On a grand scale, this is the ideal task at hand for psychotherapists and more specifically substance abuse counselors. To be true healing, it must eventually burst the bounds of psychotherapy and enter in all seriousness into the interpersonal, the family, the group, the community, and even the relations between communities (Friedman, 1988, p. 25). It

appears that contemporary Western society is giving off strong signals of a desire for increased spiritual experience (May, 1974, p. 85). It may be the result of a very specific, unfulfilled need for which there is increased demand.

It has been postulated by transpersonal therapists such as Stanislov Grof (1993) and Jacquelyn Small (1983), that addiction to chemical substances is only the most extreme expression of a much larger and more general phenomenon.

In treating substance abuse clients the element of spiritual well-being has been minimally investigated in research. This study concerns how the spiritual well-being of a substance abuse counselor effects the spiritual well being of the clients in their therapeutic care. Up until the last fifteen years, minimal attention has been given to the spiritual dimension of the therapeutic process which transpires between the substance abuse counselor and the client. Within the past ten years, research on spirituality and the substance abuser has been limited to how clinicians in the field of addiction can provide tools for clients to learn how to access their guiding force.

This research study examines the effect of the counselor's spiritual well-being on the client's spiritual well-being over a

two week inpatient period. The therapeutic relationship is used as a spiritual crucible for change. What is crucial is not the skill of the therapist, but rather what takes place between the therapist and the client and between the client and other people. The "between" cannot totally make up for or take the place of the other (Friedman, 1988, p. 24).

In order to begin explaining the concept of spiritual well-being, one must note the cultural and historical context. It seems Western civilization has lost a connection with the inner life and shows a fascination with external and material pursuits. Individuals cut off from their spiritual source will have a great difficulty finding genuine satisfaction through external pursuits and achievements of any kind and scope (Grof, 1987).
Perhaps the prominence of addiction jargon in today's environment indicates a deeper truth, that the human being longs for something or someone to provide ultimate meaning.

For some health care professionals, the spiritual component of care with their clients is avoided (Millison & Dudley, 1990, p. 63). The basis of Alcoholic's Anonymous is a spiritual foundation. Inpatient and outpatient treatment programs for chemical dependency use group discussion or educational groups to

discuss spirituality. However, Brown, Peterson & Strachan (1982) observed that "there is a regrettable and undesirable trend among counselors of all social science disciplines to neglect and even ignore the importance of a patient's well-being" (p. 51). May (1974) believes that if we do deal with spirituality at all, we do so in a superficial manner (p. 117).

Theoretical Rationale

In 1956 the American Medical Association declared alcoholism a disease. Since that time, addiction to chemicals has continued to be treated as such. It is a disease of the mind, body, and spirit. Treatment of this illness consists of addressing each part of the whole person. Carl Gustav Jung believed that the ultimate recovery from addiction was from spiritual sources and that God was experienced primarily as an inexpressible archetype (Hanna, 1992). Carl Jung was also highly influential in the development of Alcoholic's Anonymous (Jung, 1963).

In the following quotation, Carl Jung (1963) describes Bill Wilson's, co-founder of Alcoholics Anonymous, "great white light" experience:

> what I really thought about was the result of many experiences with men of this kind. His craving for alcohol was the equivalent on a low level, of the

> spiritual thirst of our being for wholeness, expressed in medieval language: the union with God (p. 118).

Jung continues to elaborate on the path of the counselor or healer and the importance of them meeting their own needs in order to help their clients. The following quotations by Jung describe this point:

> At all events the doctor must consistently try to meet his own therapeutic demands if he wishes to assure himself of a proper influence on his patient. All these guiding principles in therapy confront the doctor with important ethical duties which can be summed up in the single rule: be the man through whom you wish to influence others. Mere talk has always been considered hollow, and there is no trick, however cunning, by which one can evade this simple rule for long. The fact of being convinced, and not the subject-matter of conviction it is this which has always carried weight.....Who can enlighten his fellows while still in the dark about himself, and who can purify if he is himself unclean?
> (Jung, 1933, p. 51)

Jung continues to elaborate on the relationship between client and therapist:

> Just as the discovery of the unconscious shadow-side once forced the school of Freud to deal even with questions of religion, so the latest advance of analytical psychology makes an unavoidable problem of the doctor's ethical attitude. The self-criticism and self-examination demanded of him radically alter our view of the human psyche. This cannot be grasped from the standpoint of natural science; it is not only the sufferer but the physician as well; not only the object but also the subject; not only a function of the brain, but the sine qua non of consciousness itself (Jung, 1933, p. 53). What was formerly a method of medical treatment now becomes a method of self-education, and therewith the horizon of our modern psychology is immeasurably widened. The medical diploma is no longer the crucial thing, but human quality instead (p.53). The personality of the patient demands all the resources of the doctor's personality and not technical tricks (Jung, 1933, p. 53).

Burns (1975) went as far to state that alcoholism is due to the fact that Western culture, followed by most of the rest of the world, has abandoned God and that "there is only one possible solution to the problem: spiritual conversion, return to God" (p.8).

Substance abuse counselors have had the experience of being faced with a client's spiritual questions concerning the need for faith and forgiveness. The counselor's options are to ignore the spiritual dimensions of the client and move on to another therapeutic issue the counselor is comfortable discussing or refer the client to a clergy person without participating in that particular aspect of that client's care. The counselor could also refer the patient to the clergy and be in cooperation with the clergy member and participate in an interdisciplinary fashion (Dombeck & Karl, 1987).

Professional care-givers tend to avoid the spiritual components of care, choosing to emphasize the physical, social, psychological and financial aspects (Millison and Dudley, 1990). This aversion denies the patient the opportunity to grow spiritually which could lead to healing (p. 64). O'Conner and Kaplan (1986) found strong agreement that spiritual care for patients was too critical to hospice care to be left exclusively to

clergy, and that holistic care nearly always includes the spiritual (p. 64). Kohnm (1984) observed that "even in those centers where the AA approach is used, spirituality is discussed, and the chaplains are even employed, the role of chaplain is seen as primarily significant in grief work, crises that may involve religion, the fifth step, or confessional aspect of the AA program" (p. 51).

Abraham Maslow (1970) believed that every individual was born with spiritual needs and a longing for transcendent experiences. Scott Peck (1989) believes that spirituality is not merely personal but it is also collective and practical, involving recognition of that which is greater than oneself. Healthy spirituality involves peace, truth and love. Those that emulate these characteristics are the teachers. Ghandi said, "My life is my message" (Vaughan, 1991, p. 116).

The capacity to stir the spiritual realm is a human potentiality that has been explored in many cultures in various ways. To be human is to long for ultimate meaning and direction in life; it is to live a spiritual existence.

Jung describes the spiritual experience as,

> The only right and legitimate way to such an experience is that it happens to you in reality, and

> it can only happen to you when you walk on a path which leads you to higher understanding. You might be led to that goal by an act of grace or through a personal and honest contact with friends, or through a higher education of the mind beyond the confines of mere rationalism (Jung, 1974, p. 21).

The client-therapist relationship is one that Jung presents as "dialectical". He believed it to be "an encounter, a discussion between two psychic wholes, in which knowledge is used only as a tool." The goal he says is of "transformation-not one that is predetermined, but rather an indeterminable change, the only criterion of which is the disappearance of egohood." And again, he makes reference to a process which is much greater than the therapeutic relationship. In humility Jung states, "No efforts on the part of the doctor can compel this experience. The most he can do is to smooth the path for the patient and help him to attain an attitude which offers the least resistance to the decisive experience" (Jung, 1933, p. 98:904).

Mystical experience transcends the personal self and the subject/object distinction. This brings about a strong sense of unity and identity which then creates a strong awareness of a transcendent reality beyond time and space (Hanna, 1992, p. 173).

The healer must have achieved a measure of integration which encompasses an understanding of the struggle and predicament of the client on the way to resolution and transcendence. Without this, the healer will encounter blind paths and the state of both healer and client may grow worse (Dossey, 1984, Guggenbuhl-Craig, 1982, Muktananada, 1984 & Trungpa, 1983, p. 254). In a world of people crying out for spiritual food, the clergyman, lonely because of his own hunger, frequently goes begging, giving what he can , however meager. The same can be said of therapists, according to May (1974).

More specifically, the care-giver and the client need to experience union, but a union that occurs beyond the level of ego, at the level of spirit. Spirit can be understood as the fundamental sacredness and unity of all life (Quinn, 1989, p. 553).

What is important is the assumption that the substance abuse counselor is not doing the healing of the client. Nor is the client doing the healing. It is a process that happens between the client and the counselor. The therapist, however, must be willing to participate in their own spiritual growth and healing for this to happen (May, 1977, p. 88). Therapists who are unaware of, or closed to the deeper levels of the unconscious, will be less effective with those clients whose psychopathology has roots in these deeper

levels, according to Grof (1987). They will also fail to respond sensitively to the intense spiritual needs of their clients. (White, 1979, p. 125).

Small (1982) relates in the following quotations the importance of helpers helping themselves before they can help others on their clients spiritual growth. She believes that transformers (healers/therapists) act as catalysts for the process of self-creation. She sees the transformers as having already tapped into their creative, higher self. "with hardly any effort, they seem to know how to give spiritual principles a concrete expression....Transformers are instrument of self-empowerment" (p. 247).

> Awareness and a willingness to work on ourselves provide the springboard for this inward, upward journey that takes us first into ourselves and finally beyond ourselves in service of others.....
> real helpers are fellow travelers, who invite others to discover the meaning of their suffering,
> relieve suffering wherever they can, but who resist interfering with another's free will
> (Small, 1982, p. 247).
> I challenge you to a deeper life, and for the sake of

> those you serve to seek a stronger bond with your own soul so that you will continually bring new truths to light and help fit others for the living and understand of these truths.... (Small, 1982, p. 248).

Friedman (1986) states:

> One of the most important issues the approach of healing through meeting addresses is the extent to which healing proceeds from a specific healer and the extent to which it takes place in the "between" in the relationship between therapist and the client among the members of a groups or family, or even within a community" (p. 24).

If counselors or healers do not understand their own inner spirit, than it will be difficult for them to help access this within clients.

Jacquelyn Small, a transpersonal therapist, says in response to the issue of counselors helping their clients,

> If the recovering addict has been taught nothing about how to connect with his inner wisdom and leaves the treatment program believing some expert "fixed" him, he can do nothing but become, once again, dependent on something or someone to worship outside

himself. And another addiction has now set in " (Small, 1987, p. 24).

Spirituality is a central component of Alcoholic's Anonymous (Corrington, 1989, p. 151). Substance abuse professionals need to examine their own spiritual convictions in light of this fact. The purpose of this research was to examine the spiritual well-being of substance abuse counselors and to determine the impact their spiritual well-being had on the clients in their therapeutic care. Since spiritual well-being is a relatively new concept, it was decided for purposes of this research to see what correlations spiritual well-being would have with a self actualization scale and a values inventory.

Definition of Terms

Addiction. The term addiction is described as existing wherever persons are internally compelled to give energy to things that are not their true desires as well as sidetracking and eclipsing the energy of their deepest, truest desires for love and goodness (May, 1974).

Chemically Dependent Patient. Any patient that meets the DSM-IV criteria for substance dependence.

Inpatient Chemical Dependency Treatment. It is described as a facility where the patient lives and attends therapy for the

prescribed course of treatment. (Individual, Group, Education, AA/NA, Medical/Psychiatric care)

Spiritual-Well-Being. The affirmation of life in a relationship with God, Self, Community and Environment that nurtures and celebrates wholeness" (National Interfaith Coalition on Aging, 1975).

Spirituality. Charles Whitfield, M.D. says:

> Spirituality is about relationships with self, others, and the universe. It has to do with things like trusting, forgiveness and zest for living. It has to do with meaning, purpose in life, and with getting free of suffering (Prugh, 1985, p. 29). This in turn can mean creating a greater connectedness between oneself and others which encourages growth and potential.

Substance Abuse Counselor. For the purposes of this study it is defined by the Commonwealth of Virginia as, "a person to provide substance abuse counseling in a state-approved public or private substance abuse program and/or facility." (Va. Board of Health Professionals, VR560-01-03, p. 1) This involves direct counseling (group and individual) provided by a person who is certified as an addictions counselor or is under supervision for certification as an addictions counselor.

Hypotheses

1. There will be a statistically significant positive correlation ($p < .05$) between the inpatient chemical dependency counselors' scores on the Spiritual Well-Being Scale and their scores on the inner harmony, self-respect, wisdom, honesty, and loving scales of the Rokeach Value Survey and their scores on the time competence, self-actualizing, existentiality and self-acceptance scales on the Personal Orientation Inventory.

Null Hypothesis: There will not be a statistically significant positive correlation ($p < .05$) between the inpatient chemical dependency counselors' scores on the Spiritual Well-Being Scale and their scores on the inner harmony, self-respect, wisdom, honesty, and loving scales of the Rokeach Value Survey and their scores on the time competence, self-actualizing, existentiality and self-acceptance scales on the Personal Orientation Inventory.

2. There will be a statistically significant positive correlation ($p.<.05$) between the inpatient chemical dependency counselors' scores on the Spiritual Well-Being Scale and the gain scores between the pre and post tests of their patients on the same instrument.

Null Hypothesis: There will not be a statistically significant positive correlation ($p < .05$) between the inpatient chemical

dependency counselors' scores on the Spiritual Well-Being Scale and the gain scores between the pre and post tests of their patients on the same instrument.

3. There will be a statistically significant positive correlation ($p < .05$) between the Spiritual Well-Being Scale Scores of the patients, post-treatment, and the pre-test measures on patients and the counselor information obtained from the Personal Orientation Inventory, and the Rokeach Value Survey.

Null Hypothesis: There will not be a statistically significant positive correlation ($p < .05$) between the Spiritual Well-Being Scale Scores of the patients, post-treatment, and the pre-test measures on patients and the counselor information obtained from the Personal Orientation Inventory, and the Rokeach Value Survey.

4. There will be a statistically significant positive correlation ($p < .05$) between the Alcohol and Drug Use Sub-Scale of the Profile of Adaptation To Life Clinical Scale Scores, of the patients, post-treatment, and the pre-test measures on the patients and the counselor information obtained from the Personal Orientation Inventory, the Spiritual Well-Being Scale, and the Rokeach Value Survey.

Null Hypothesis: There will not be a statistically significant positive correlation ($p < .05$) between the Alcohol and Drug Use

sub-scale of the Profile of Adaptation To Life Clinical Scale Scores, of the patients, post-treatment, and the pre-test measures on the patients and the counselor information obtained from the Personal Orientation Inventory, the Spiritual Well-Being Scale, and the Rokeach Value Survey.

Description of the Sample

The patient sample size consisted of (110) individuals that were taken from three inpatient chemical dependency treatment centers. In the treatment facilities, all the counselors had separate treatment groups that were involved in the research if they chose to do so. Each counselor collected data from the first ten patients that met the two week stay criteria and were under their care in treatment. All of the patients met the criteria for substance dependence according to the DSM-IV. A total of eleven inpatient counselors participated and thirty four certified alcohol and drug counselors were also sampled by mail from around the Commonwealth of Virginia.

Limitations of the Study

This study was limited by a number of factors. In each treatment facility the patients were exposed to lectures, group therapy, Alcoholic's and Narcotic's Anonymous meetings, recreational therapy and the patient therapeutic milieu. Thus a major limitation was the number of variables that could have affected the change scores in spiritual well-being.

CHAPTER TWO

A SELECTED REVIEW OF THE LITERATURE

Introduction

"The therapist with a spiritual orientation is commonly accused of using methods and philosophies with the recovering alcoholic and addict that appear to be abstract, esoteric, or irrelevant for effectiveness in the ongoing everyday lives of their clients" (Small, 1987, p. 23). Traditional psychotherapy presents a paradoxical message that therapists are supposed to care very deeply about their patients; however, they should not get too involved. This paradox can create a therapeutic barrier as well as confusion.

It appears that there is little interest in or understanding of the natural unfolding of the human personality toward wholeness, which has been referred to as the inner healer. Chandler, Holden, and Kolander (1992) concluded in their paper that choosing to ignore the spiritual component of wellness out of fear or ignorance is somewhat irresponsible of those in health service fields. Spiritual wellness is not an undefinable, unworkable construct. "Counselors are the likely facilitator for the enhancement of spiritual wellness" (Chandler, Holden, and Kolandar, 1992, p. 174).

Alcoholic's Anonymous views spirituality as the core quality

of the recovery process.

> In order for addicts to go within and uncover or explore the inner self, counselors must help them identify the distortions of truth that they have unconsciously created. In the therapeutic environment the clients must be given a large enough context within which to understand their experience, a loving heart to offer warmth, and validation as he or they undergo the painful vulnerability that ensues once they begin the journey home to the inner self (Small, 1987, p.26).

According to Carroll (1993) spirituality as a factor in alcoholism recovery has been neglected in research. She believes that alcoholics are trying to achieve a quality of life through a quantity of experiences with alcohol. Burns (1975) goes as far to state that alcoholism is due to the fact that Western culture, followed by most of the rest of the world, has abandoned God and that "there is only one possible solution to the problem: spiritual conversion, return to God" (p.8). Tart (1975) believes that psychology has generally not studied these kinds of phenomena, (which have been labeled ephemeral, subjective and unreliable) because they are purely internal experiences with few known physical manifestations. Mann (1973) suggested that it is only

those people who are experientially close to alcoholism that feel there is a "spiritual component" to the disease of addiction. She described good treatment programs in the nineteen fifties consisting of proven treatments, some of them being closely allied with Alcoholics Anonymous, often being run by AA members.

The early substance abuse counselors were primarily recovering alcoholics. It was important to understand that the counseling of alcoholics was a relatively new specialty, and the alcoholism counselor was a new kind of professional. On August 24, 1973, the National Institute of Alcoholism and Alcohol Abuse's top priority was to generate greater third-party payments of alcoholism treatment from the private health insurance industry. The way was also being paved for accreditation of alcoholism facilities and certification of counselors. In May of 1974, the National Association of Alcoholism Counselors and Trainers was formed and organized alcoholism counseling as a profession. Mann (1973)

The recovering alcoholism counselor was able to experientially relate to the clients in their care. As the field progressed, individuals not recovering from chemical addiction began to work in the alcohol and drug treatment field. Philip

Flores (1988) states:

> While I do not completely believe that a person has to be an addict or an alcoholic in order to help and treat one, I do believe a person has to leave the realm of objectivity and immerse themselves as much as possible in the subjective experience of the other who has sought help (p. 382).

Carl Jung believed that the ultimate sources of recovery from addiction came from spiritual sources. He felt the moving force in the psyche was not biological but cosmic, and related in his letter to Bill Wilson, co-founder of Alcoholics Anonymous:

> The only right and legitimate way to such an experience is that it happens to you in reality, it can only happen to you when you walk on a path which leads you to higher understanding. You might be led to that goal by an act of grace or through a personal and honest contact with friends, or through a higher education of the mind beyond the confines of mere rationalism....You see, "alcohol" in Latin is spiritus, and you use the same word for the highest

> religious experience as well as for the most depraving poison. The helpful formula therefore is: spiritus contra spiritum. (A spiritual disease requires a spiritual cure) (Jung, 1961).
>
> Spiritual growth is a process, not a concept. It is the "hero's journey" through ego-dominance, ego death, and a re-awakening to soul dominance, or to a higher, more inner directed way. It requires a willingness to empty oneself of old programming, to really let go of the ideas and beliefs held at the intellectual level. It is the process of individuation, explicated by Jung (Small, 1987, p. 29).

The more secure humans are in their own philosophical base as individuals, the more they will emit the quality of potency, which is one of the traits that research has found in high-functioning counselors. In this way, the client resonates to an authentic person, a guide willing to use his or her whole self in relation to the client's process of healing (Small, 1987, p. 29).

No specific study was found focusing on the substance abuse counselors with regards to the impact on their clients of their spiritual well-being. Therefore, a majority of the studies used in this literature review were found in the area of hospice care that specifically focused on the spirituality of the care-giver

and the impact on the patient. It is the contention of this study that the recommendation for care-givers in these studies are equally valid for substance abuse counselors.

Montgomery (1991) tried to determine the nature of caring from the perspective of the care-giver's experience. She wanted to determine the nature of caring communication, and what this experience was for the care-giver. An over-riding theme from her interviews was the experience of spiritual transcendence. This transcendence was defined as experiencing oneself in a relationship as a part of a force greater than oneself. This transcendence was critical, not only in terms of the nurses' satisfaction with caring, but also as an explanation of the paradox of distance and closeness.

Montgomery broke the spiritual dimensions into three properties. The first property was the nature of the connection. The second property was the source of the energy. The third and final property of spiritual transcendence was the effect on the care-giver.

The nature of the connection concerned a deep sense of personal involvement. The term "love" was used frequently in describing their feelings for patients. A rehabilitation nurse described caring as "unconditional love". The use of the term

boundaries was also found in the literature to describe the appropriate amount of interpersonal distance between therapists and clients. There seemed to be a contradiction between the need for union and the need for distance in the therapeutic relationship.

In Montgomery's study a nurse tried to calm a heart patient before his surgery. The patient at one point said, "I am just no hero, I just can not go through this!" The nurse replied by saying , "Heros are ordinary people faced with extra-ordinary circumstances, and instead of running away they stand and face whatever the circumstance is!" He said, "Where did you hear that?!" She said that she had just thought of that then. He repeated her statement and credited her for helping him get through the surgery.

When asked about her response she said she had no idea where the statement came from. She allowed herself on some level to become one with his experience, and subliminally received from him what he desperately needed to hear. It was as though her consciousness acted as a conductor to provide the completion of his idea, in the way an electric current completes a circuit if it has a medium (Montgomery, 1991, p. 94-95).

Montgomery's research looked at the nature of the connection

itself. Her research suggests that in a caring encounter, the care-giver and the client experience union, but that this union occurs beyond the level of ego, at the level of spirit.

Spirit can be understood as common to all humanity, the fundamental sacredness and unity of all life (Quinn, 1989). The intentions were simply to connect, rather than to achieve any particular agenda. Montgomery believes care-givers may not recognize the person behind the mask of schizophrenia or a person with a personality disorder, or even the individual suffering from extreme abuse and deprivation, but ministering to that person's spirit allows the care-giver to connect with the patient (p. 97). One nurse described the existence of some greater force as described further:

> Spiritualness is important. I don't define that according to any particular religion; it comes from a deep sense of ministration to the individual. You minister to the spirit within the body. Sometimes you will not even recognize the person outwardly because of the deterioration. You minister to the spirit... I wasn't aware of that twenty years ago, and I think for many nurses it's dormant (Montgomery, 1991, p. 97).

The second property outlined by Montgomery was the source of energy. The energy needed for caring was seen to come from a greater source beyond the self. This spiritual sense explained why they did not experience burnout. Caring itself allows access to a very important source of energy and renewal. One nurse stated: " A part of them is a part of my heart, and helping to heal them, by bringing them to a peaceful end, or however that healing takes place, heals my heart" (Montgomery, 1991, p. 99).

In order to have access to the experience of spiritual transcendence, these nurses had to have a philosophical or spiritual understanding that allowed them to deal with being "repeatedly confronted with one's own mortality, the inhumanity of others in cases of violence, and the threat of pain and disfigurement. .." (Benner, 1984, p. 377).

When counselors take the risk of involvement with their clients from a standpoint of caring, they expand their consciousness such that their notion of self includes another, and consequently all others. Counselors then have access to what is called a primal and universal psychic energy, a reservoir for wisdom and self-renewal (Montgomery, 1991). Those in the business of helping to heal physical, emotional or psychological pain draw upon a kind of courage which enables them to expand their

consciousness to incorporate the experience of others in pain. Clients become a part of their hearts, and helping to heal them heals their hearts as well.

Spirituality is not the special property of any group or religion. It exists in the hearts of men and women of all races, creeds and cultures, both within and outside of religious institutions. Spirituality presupposes certain qualities of mind, including compassion, gratitude, awareness of a transcendent dimension, and an appreciation for life which brings meaning and purpose to existence. Spirituality is not merely personal, it is collective and practical, involving recognition of that which is greater than the self (Vaughan, 1991, p. 105).

While there is no consensus as to the boundaries between religiosity and spirituality, this research utilizes the distinction most frequently drawn between them in the literature. Religiosity refers to "adherence to the beliefs and practices of an organized church or religious institution" (Shafranske and Malony, 1990, p. 72). Spirituality describes the transcendental relationship between the person and a Higher Being, a quality that goes beyond a specific religious affiliation (Peterson, 1987).

In a study done by Shafranske and Gorsuch (1985) a survey was sent to 1400 members of the California State Psychological

Association. The return rate was 29%. They found 23% of the sample reported themselves to be committed to a traditional religious institution and 33% indicated that they were involved in an alternative spiritual path that was not part of a religious institution. There was a high level of agreement with the statement "Spirituality has direct relevance to my personal life."

Millison (1988) examined the role spirituality played for caregivers. Open ended interviews were conducted with eight caregivers. Each was asked to discuss his/her own spirituality, describing how he/she thought that it might impact the patients in their care. The respondents acknowledged "the heightened spirituality experienced... as a result of their work with the terminally ill, and the impact it had upon the patient... they felt they received more from their patient than they were able to give" (Millison, 1988).

May (1977) sees the process of healing and growth as inborn, given, natural components of human be-ing. He originally assumed that he somehow had to engineer the growth and healing of his own person and the clients that he worked with. He believes that when that assumption is held, healing ceases to be healing and becomes fixing. The growth ceases to be growth and becomes

building. As a therapist and counselor he ceases to participate in the process of healing and growth. He see himself as being separate and that his clients become an object and his own mind becomes an object as well. Part of the reason for counselors not raising the issue of spirituality is the fear that they might have to do something about it. May sees spiritual counselors as helping people talk about their spiritual needs and experience; they help them explore and clarify but do not get caught up in telling them "how to do it". A counselor can support and nurture, encourage, and affirm, and does not have to worry about mastery. A spiritual director on the other hand must have gone some way along the path himself or herself (May, 1977, p. 88). Most importantly however, is the assumption behind all of these approaches that the counselor or director is not doing the growth or the healing of the clients in their care. Nor is the client doing it. Those who purport to be counselors must have the courage to participate in their own spiritual growth and healing in order to experience its transcendent nature.

Saint Teresa, in her autobiography Peers (1960) delineates the qualifications of a spiritual director as a person of prudence, sound understanding, experience and learnedness. Shelton Kopp says that the therapist's role is to provide the client with another human being to interact with or

encounter. "there is no master and there is no student" there are only fellow pilgrims. Kopp (1972) The most important behavioral trait the counselor brings to therapy is his or her humanness. If the therapist is in recovery then he and his or her client will be able to share similar experiences. For the non-recovering counselor, he or she must be involved in a personal spiritual growth program or his or her clients will soon outgrow them.

Research has demonstrated that patient self-disclosure behaviors are best facilitated by therapist self-disclosure behaviors (Jourard, 1979). It is the belief of Brown, Peterson, and Cunningham (1988) that if the therapist's tale is also that of a spiritual path of recovery, then mutual empathy and identification will, again, be enhanced. Peck (1978, 1987), Pelletier (1977), and Bergin (1988) have emphasized, the growth of Twelve Step movement has occurred at a time when the "crisis" or stresses of society are such that a very large portion of the world population has chosen to turn or return to a more values conscious and or spiritual orientation toward life.

According to Elkins (1988) more research focused on the spiritual dimension and its role in pathology, health, and

psychotherapy is needed. However, if psychology uses definitions, models, and assessment approaches to spirituality that confuse it with religious belief and practice, it will only overlook at best or discount at worse spirituality.

Description of Instrument

The Spiritual Well-Being Scale yields three scores. The magnitude of these coefficients suggest that the spiritual well being and subscales have high reliability and internal consistency. The index of internal consistency also shows high reliability. Across seven samples, the internal consistency coefficients ranged from .94 to .82 Religious Well-Being (RWB), .86 to .78, Existential Well-Being (EWB), and .94 to .89 Spiritual Well-Being (SWB) (Bufford, Paloutzian, & Ellison, 1991).

It appears that the Spiritual Well-Being Scale has sufficient validity for use as a quality of life indicator. The SWBS has good face validity as seen by the content of the items. Research has shown that the items cluster as expected, into the religious well-being and existential well-being subscales. It has also shown that spiritual well-being is a good general indicator of well-being, and is sensitive to the lack of well-being. People who scored high on the Spiritual Well-Being Scale tended to be less lonely, more

socially skilled, higher in self-esteem and more committed to their religious beliefs (Peplau & Perlman, 1982).

The Spiritual Well-Being Scale has been helpful in evaluating the well-being of clients in both individual and group settings. The Spiritual Well-Being Scale is sensitive for those scoring in the low range, making it useful for individuals whose primary task is to assess and correct dysfunctionality.

The study of spiritual well-being began in 1971 when the White House Conference on Aging helped stimulate research. The committee pertained to "man's inner resources especially his ultimate concern, the basic value around which all other values are focused, the central philosophy of life-whether religious, anti-religious, or nonreligious-which guides a person's conduct, the supernatural and nonmaterial dimensions of human nature" (Moberg, 1971, p.3).

The National Interfaith Coalition on Aging (NICA) dealt specifically with the question of definition and presented that "Spiritual Well-Being is the affirmation of life in a relationship with God, Self, Community and Environment that nurtures and celebrates wholeness" (NICA, 1975). Ellison and Paloutzian took this NICA definition and began to develop the Spiritual Well-Being Scale.

The challenge it seemed was to evaluate spiritual well-being in a way that it could be measured. Ellison (1983) recommended the understanding of well-being articulated by the National Interfaith Coalition of Aging (1975)

"Spiritual well-being is the affirmation of life in a relationship with God, self, community, and environment that nurtures and celebrates wholeness" (p.1). The definition by the coalition suggests that spiritual well-being involves a religious component and a social-psychological component. Blaikeie and Kelsen (1979) said, "to know what to do and why, who we are, and where we belong" (p. 137).

A significant event in research in this area was Paloutzian and Ellison's development of the Spiritual Well-Being Scale to measure existential, religious, and spiritual well-being. They are significantly associated in expected directions with such psychological variables as loneliness and purpose in life.

Moberg said in his article that a strong dose of humility is needed by those who work on the topic of spiritual well-being. It borders upon transcendent and supernatural domains that lie beyond the scope of direct empirical observations even more than most conventional subjects of inquiry do (Moberg, 1984, p. 359).

Moberg and Brusek (1978) suggested that spiritual well-being is best conceived as having two dimensions. A vertical dimension referring to one's sense of well-being in relationship to God. A horizontal dimension connotes one's perception of life's purpose and satisfaction apart from any specifically religious reference.

Since the Spiritual Well-Being Scale is relatively new, two more instruments will be used to check it's validity. They are the Personal Orientation Inventory and the Rokeach Value Survey both of which will be discussed in Chapter Three.

Ellison (1983) believes if we are spiritually healthy we will feel generally alive, purposeful, and fulfilled, but only to the extent that we are psychologically healthy as well. Spiritual well-being may not be the same as spiritual health.

CHAPTER THREE

DESIGN AND METHODOLOGY

Sample Population

The two populations in this study consisted of substance abuse counselors and alcohol and drug addicted patients. The patients in the study met the DSM-IV criteria for alcohol and drug dependency and their length of stay was two weeks or more in treatment. All three of the inpatient programs were located in Virginia.

In each facility, all the inpatient substance abuse counselors were given an opportunity to participate in the study. Each substance abuse counselor needed to have their own group which they facilitated. The substance abuse counselors utilized in this study also needed to be certified or under supervision for certification as a substance abuse counselor.

Due to the current nature of insurance reimbursement and state budgeting, few such inpatient programs still exist. Not only have the inpatient units been limited but the length of stay has also been shortened. Therefore, the patient sample was restricted to those individuals able to stay for two weeks or more in treatment.

Data Gathering

A random mailing was done to Certified Addiction Counselors in the Commonwealth of Virginia. The packets sent consisted of the Spiritual Well-Being Scale, the Personal Orientation Inventory, and the Rokeach Value Survey. Included in the packets were self-addressed stamped envelopes for the participants to send back within two weeks. Forty-five packets were sent to counselors around the Commonwealth of Virginia.

Following the mailing of packets the inpatient substance abuse counselors participating in the study were administered the Spiritual Well-Being Scale, the Personal Orientation Inventory, and the Rokeach Value Survey to complete. They were instructed to fill the instruments out and return them to their direct supervisors for this researcher to collect.

The counselors then selected the patients fitting the two week criterion in the treatment program. The counselor gave the patients a pre-test envelope containing the Spiritual Well-Being Scale and the Adaptation to Life Scale to complete. The counselor was not aware that the tests being given to the patient were the Spiritual Well-Being Scale and the Profile of Adaptation to Life Scale. The counselors instructed the patients to fill out the instruments and

not discuss it with them and to put the completed forms back into the envelopes. The counselor followed the same procedure with a total of ten patients in their group.

After two weeks, the counselors gave post-test envelopes to the patients containing the Spiritual Well-Being Scale and the Adaptation to Life Scale. The counselor again did not know the contents of the envelope being given to their patients.

The inpatient facilities in Virginia were all adult inpatient alcohol and drug treatment programs. One inpatient program had five counselors, one had four counselors and one had three counselors. One of the counselors was unable to participate due to limited time with patients so the total number of counselors was eleven. Each of the counselors obtained approximately ten patients which created a patient population of 110 participants.

Instrumentation

Spiritual Well-Being Scale Reliability and Validity

The Spiritual Well-Being Scale developed by Raymond F. Paloutzian and Craig W. Ellison was selected for this study. The Spiritual Well-Being Scale is suggested as a general indicator of personality integration and resultant well-being. The spirit is an integrative interwoven body and soul of the individual, comprising the person (Ellison & Smith, 1991).

Paloutzian & Ellison developed a systematic quality of life measure that included both general life satisfaction and religious well-being known as the Spiritual Well-Being Scale. The scale is broken down into three separate scales. The first scale is the total of the Spiritual Well-Being Scale (SWB), the second is the summed score for the religious well-being (RWB), and the third is the summed score for the existential well-being (EWB). SWB, RWB, and EWB are correlated positively with a positive self concept, physical health, a sense of purpose in life, and emotional adjustment. The scales are correlated negatively with ill health, lack of purpose in life, and emotional maladjustment (Bufford, Paloutzian, & Ellison, 1991).

Spiritual well-being is an expression of spiritual health, "much like the color of one's complexion and pulse rates are expressions of good (physical) health" (Ellison , 1983, p. 332). It is seen as a continuous variable that can probably be deepened and enhanced throughout the lifespan of the individual. If this is true then it has obvious individual and corporate implications for the larger community of faith that is committed to spiritual formation (Butman, 1990).

The scale consists of 10 existential and 10 religious items that are answered using a Likert Scale. The Test-retest

reliability coefficients were .93 (SWB), .96 (RWB), and .86 (EWB). Internal consistency was .89 (SWB), .87 (RWB), and .78 (EWB). This suggests that the SWB Scale and subscales have a high reliability and internal consistency. It also appears to have sufficient validity for the use in a quality of life indicator. People scoring high on the SWB tend to be less lonely, more socially skilled, higher in self-esteem and more intrinsic in their religious commitment (Paloutzian & Ellison, 1982).

The concept of spiritual well-being appears to have such subjective meanings that behavioral scientists have avoided the study of spiritual health and disease. The definition by the National Interfaith Counsel on Aging of spiritual well-being suggests that it involves a religious component and a social-psychological component. Both the vertical and horizontal dimension involve transcendence. Because human beings function as integrated systems the expectation is that there are two dimensions. Each partially distinctive, would also affect each other, and there would be some statistical overlap. Consequently, if humans are spiritually healthy, they generally feel alive, purposeful, and fulfilled, but only to the extent that they are psychologically healthy.

Paloutzian and Ellison make a distinction between spiritual well-being and spiritual health. The following describes spiritual well-being:

> Spiritual well-being measures may then be seen more like a stethoscope than like the heart itself. If this an accurate conception we are free from the burden of trying to exactly or empirically measure the inner contours of one's spirit--a task which is most likely impossible. We are freed to consider the reported expressions of spiritual well-being as general indicators and helpful approximations of the underlying state. As we develop more sensitive measures we may someday be able to identify specific dimensions of spiritual well-being and prescribe "spiritual medicine" which will address a particular part of the spirit in a differentiated way (Ellison, 1983, p. 332).

Paloutzian and Ellison see spiritual well-being as a continuous variable, rather than as dichotomous. It is not a matter of whether or not humans have it, it is how much and how it can be enhanced. The revised Spiritual Well-Being Scale has

been used since 1982 with men and women, housewives, college students, young adults and senior citizens, high-school students, married and single persons, religious and non-religious people, people from large cities, small cities and rural areas.

Recommendations for the utilization of the Spiritual well-being scale are that it can be instructive on a pre and post test basis in helping clients to more clearly understand the short and long-range impact of specific religious exercises and events upon spiritual well-being. This study examined the substance abuse counselors in an inpatient setting and evaluated pre and post testing results for patients and compared their change scores to the counselor's Spiritual Well-Being Scores.

Normative Data on SWBS

Sherman (1987) presented data-on a sample of psychiatric patients in a special program for persons with eating disorders operated by a private hospital. One group was composed of inpatients who had been hospitalized because of (1) actual or potential danger to self or (2) deterioration or failure to improve in outpatient or residential treatment program. The second group consisted of eating disordered patients in outpatient treatment. A combination of Sherman's study along with two other mental health treatment groups Frantz (1986/1988) and

Rodriguez (1989) were used as the basis for patient norms. No normative data has been collected specifically with substance abusers; again the normative data must be inferred from a general psychiatric population.

Kirschling and Pittman (1989) looked at the spiritual well-being of family caregivers with terminally ill relatives. They found that studies which included spiritual well-being as a major variable are limited Miller (1985) and Reed (1987) and only a handful of existing measure of spiritual well-being. Their study was done in order to assess the reliability and construct validity of existing measures that had not been tested with family caregivers of the terminally ill. Caregivers were referred by five hospice programs in two northwestern states. The sample consisted of 164 referrals over a 6 month period. Of the 164, 75 agreed to participate. Six measures were used, four of which were used to assess the reliability and construct validity.

During the pilot testing, a question arose concerning items on the assessment that specifically asked about God for those individuals in the study who did not believe in God. Paloutzian was contacted and said he had not directly experienced that problem. In the past individuals were given the test and would

either not answer it or cross through it (Kirschling and Pittman, 1988, p. 5).

The finding of this study indicated a high degree of internal consistency reliability. Religious well-being and existential well-being subscale correlate highly (.65) for those caregivers who complete both subscales. The use of face to face interviews, recording comments by respondents, provided information that was not available on the tests. An example was of a respondent that had problems responding to a statement about life being a positive experience. She considered the most painful experiences as the most learning and growth related. This kind of response would not have shown on the test and supports a qualitative approach to the study of spiritual well-being.

Ganje-Fling and McCarthy (1988) looked at the comparative analysis of spiritual direction and psychotherapy. The scarcity of empirical articles in the spiritual direction literature may be partially explained by vague terminology and by the authors's lack of training in empirical methods. Although the psychological literature has contained some studies of the role of spiritual values in psychotherapy Bergin (1980), research on the connection between spirituality and psychology has been rare (Ganje-Fling, p. 104).

Brown and Peterson examined the spiritual practices of individuals in recovery and found that all participants reported engaging in the practice of prayer (69% upon rising, 63% before going to sleep, and 72% often during the day; Ninety-one percent reported engaging in spiritual readings or reading personal growth books.

Studies which include spiritual well-being as a major variable are limited (Miller, 1985; Reed, 1986/1987). The new "spiritual climate" has spiritual activities and perspective interwoven with the numerous aspects of life which are found in a wide range of contexts other than religious ones.

Summary of Spiritual Well-Being Scale

Ellison and Smith (1991) summarized the research on the Spiritual Well-Being Scale from 1982 to 1990 and divided their findings into categories. Spiritual well-being was positively correlated for individuals close to their ideal body weight (Hawkins & Larson, 1984).

Spiritual well-being was positively correlated with the acceptance of a kidney disability, healthy assertiveness and religious coping. In the health care profession nurses with high spiritual well-being have more positive attitudes regarding the

spiritual aspects of nursing care and are more perceptive of spiritual needs of their patients (Champagne, 1986; Deane & Cross, 1987; Dettmore, 1984; Edgar, 1989; Soeken & Carson, 1986).

Research supports the assertion that the Spiritual Well-Being Scale has merit as a general indicator of health and well-being. Research examining relationships between SWB and physical well-being and health care might include a comparative study of post operative patients identified as having different levels of SWB before their operations looking at the length and quality of recovery for a variety of different operations (Ellison & Smith, 1991). For hospital settings, Spiritual Well-Being Scale scores may be helpful in evaluating the impact of various forms of nursing care intervention upon the subjective well-being of patients and residents (Forbis, 1988). If strong positive relations between SWB and recovery from various medical procedures continue to be found, the ethical necessity of providing spiritually sensitive interventions which would enhance health would be established.

Ellison (1983) believes if we are spiritually healthy we will feel generally alive, purposeful, and fulfilled, but only to the extent that we are psychologically healthy as well.

The usefulness of this measurement may be from a standpoint of prescribing a certain spiritual remedy that will help the client in

spiritual crisis. The SWBS score can be only looked upon as an indicator helpful in determining the internal or underlying state. This indicator should be looked at as a continuous variable rather than dichotomous. This indicator does not appear to be the same as spiritual maturity; however, it may be an indicator of quality of life.

The Spiritual Well-Being Scale is suggested as a general indicator of personality integration and resultant well-being and reflects the proper functioning of persons integrated systems. The hope is that it ought to be possible to show positive relationship between healthy spirituality and measures of health and subjective well-being. Gartner, Larson, and Allen (1991) urged that more careful attention be paid to the issue of mental health being utilized in order to avoid apparent anti-religious values and biases. This scale has the advantage of a non-sectarian and direct measure of spiritual well-being that can be effectively used with anyone who has a meaningful conception of the term God.

According to Ellison & Smith (1991) numerous studies have indicated that the spiritual well-being of nurses impacts on their attitudes and practice of spiritual care-giving to patients. Those nurses with higher spiritual well-being have more positive

attitudes regarding the spiritual aspects of nursing care and are more perceptive of the spiritual needs of their patients.

VandeCreek (1990) found that spiritual well-being scores for patients increased as the length of time since a diagnosis had been made increased, suggesting that the most stressful spiritual time for patients is at or near the time of diagnosis. The Spiritual Well-Being Scale is found to be positively related to self-esteem and hope. It is found also to be correlated positively with assertiveness, self-confidence, giving of praise, and asking of help, whereas it has been negatively correlated with physical and passive forms of aggression, dependency, and orientation toward passivity or avoidance of conflict (Ellison & Smith, 1991).

The research up to this point reflects that the Spiritual Well-Being Scale has merit as a general indicator of health and well-being. It is important that the researcher not only look at the scale and other variables but should also look carefully at the subscales as well as the overall spiritual well-being score.

Rokeach Value Survey

Values play an important part in the role of human behavior. The Rokeach Value Survey (RVS) is a popular instrument for measuring values (Rokeach, 1973). The instrument consists of 36 concepts which purportedly measure two separate categories of

values: 18 Terminal values or desirable end states of existence and 18 Instrumental values or preferable modes of conduct.

The test-retest correlations over periods of 3 to 7 weeks range from .51 to .88, with a mean of .65 for the terminal values; and .45 to .70, with a mean of .60 for the instrumental values. **The Nature of Human Values** by Rokeach offers extensive data on the construct validity of the Rokeach Values Survey relative to his theory of values in relationship to the quality of life in America, attitudes, political and social behavior and cognitive change. It has been used with persons from age 11 to 90, from a wide variety of social and ethnic backgrounds. Among it applications have been social and psychological correlates of values and value change. The survey was revised in 1982 in that two instrumental values and two terminal values were changed in the value listings themselves.

In a study by Stefferud and Bolton (1981) the Rokeach Value survey was utilized. They stated that the advantage of the value survey is that it is simple in design and economical to administer and core.

Given the contention (Bergin and Garfield 1971) that therapist ratings have as little correlation to other measures of change as these other measures have with each other, it would be

difficult to know to what extent client-therapist value similarity would correlate with other criteria of improvement.

It appears that the value system of a therapist is a relatively pervasive characteristic that has an inevitable influence on the therapeutic process (Greben and Lesser, 1976; Low, 1969) It also seems reasonable that a client's and therapist's similarity of values should exert a positive influence on the client's trust of his or her therapist as well as on the client's perception of the therapist's effectiveness, which is a more global evaluative responses. It also may be indicative of a higher spiritual well-being.

In the article by Hlasny and McCarrey (1980), the nonpossessive warmth of the therapist was considered as a second factor that should positively influence a client's trust of the therapist, as well as a client's attribution of a therapist's effectiveness. This is because warmth is viewed as an important ingredient to a successful psychotherapy on theoretical grounds (Rogers, 1957) (Bergin & Garfield, 1971). This prediction fits with Byrnes's 1971 model of if the therapists's warmth is viewed as another factor which elicits the client's positive affect, and consequently, the clients positive evaluation of the therapist.

In Hlasny and McCarrey's study they administered the Rokeach

(1967) Value Survey (Form D) to eighty male undergraduates. The results showed the finding that client's and psychotherapist's similarity of values had positive effects on client's trust of the therapist may have been interpreted according to the following lines of theoretical reasoning. It is a possibility that the client's awareness of his/her therapist's similar values led to his or her judgement that the therapist possessed those qualities which characterized a trustworthy person; expertness, dynamism, good intentions, and attraction.

The opposite would also be indicated in that if the therapist had a value system low in similarity to that of the client, the client's negative feeling toward him would be needed to provide a state of cognitive balance. Thus assuming that the client's attraction to the therapist influences his attributions of the therapist's trustworthiness and effectiveness, balance theory seems to provide a useful model to account for the results obtained regarding similarity of the client and therapist's values. More specifically, the therapist's high nonpossessive warmth significantly increased the rated client's trust of the therapist only when similarity of their values was low.

The literature review concerning the values of alcoholics appeared limited. In the book , I'll Quit Tomorrow, by Vern

Johnson, (1980), he made the observation that "alcoholism cannot exist unless there is a conflict between the values and the behavior of the drinker" (p.2). Milton Rokeach (1973, 1981) postulated a link between values and drug abuse and proposed the use of self-confrontational value therapy in the treatment of drug abuse, as well as its prevention.

In the article by Brown and Peterson (1990), they distributed 102 copies of the Rokeach Value Survey before and after AA meetings to alcoholics and addicts who stated that they have obtained at least three years' abstinence. They were self-addressed for return to the researchers.

Fifty-seven of the surveys were returned. The authors concluded after reviewing the surveys, that these value differences indicated a link between a change in held values and the recovery process. It was revealed that the reported value of rankings of this sample of successfully recovering alcoholics/addicts "working" twelve step programs differed from the value rankings of alcoholics/addicts in treatment and the value rankings of the normal population (Brown & Peterson, 1990) p. 22).

Munson and Posner (1980) used a modified Likert-type scale that had been frequently employed in lieu of the ranking method.

It required only ten minutes to complete (Munson and McIntyre, 1979). The results suggested that the Rokeach Value Survey, as administered, does yield low distinct sets of higher order values. Using a Likert-scaling approach appeared to offer strong support to the value paradigm proposed by Rokeach.

Munson and McIntyre's research supports the contention that an individual's value structures is comprised of two distinct higher order value constructs, one relating to desired modes of behavior and the other pertaining to desired end state of existence. They also indicated that factors derived from personal values are useful for discriminating between particular groups.

According to Rosenthal (1955), the review of the literature on the therapeutic relationship reveals results supporting the theory that similarity between client and a therapist on the value dimensions is related to judgements of improvement. It also suggested that the relationship between client and therapist value similarity is fundamental to outcome regardless of the technique used to mobilize change. The elements of a client-therapist relationship override technique in their effects on outcome (Truax and Carkhuff, 1967)

In Martini's (1978) study the investigation was done in a clinical setting of the effects of value similarity and its

effect on outcome in group therapy employing three therapeutic modalities; rational emotive, psychodrama, and behavior modification. The postulation was that the greater the value congruence between the therapist and client, the greater the rated improvement for that client, regardless of the modality employed.

The procedure took all clients and all the therapists and pre-tested them with the Rokeach Value Survey. The therapist rated all the clients at the termination of treatment with respect to achieved and anticipated progress on seven-point rating scales. Their results of the study showed a significant association between the client and therapist value similarity and the ratings of improvement for all the clients. The results implied that consideration of values as a vital and viable part of the process of therapy and crucial to judgments of improvement varied with the theory and the method adopted.

Overall, the construct validity, reliability, and norms are such so as to make the Rokeach Value Survey a useful research instrument in an early stage of value theory development (Kitwood, 1975).

Personal Orientation Inventory

The Personal Orientation Inventory is a self report instrument designed to assess values, attitudes, and behavior of

the self-actualizing person. The variables assessed are (a) inner support (I), which is the tendency of a person to act on and be guided by his or her own principles and motives in contrast to responding to a wide variety of external pressures. The second is (b) time competence (Tc), which is the tendency of the person to live in the present free of hangups over past events and future uncertainties.

The instrument is broken into five areas of self-actualization in the interpersonal sphere. There are five pairs, the first dealing with interpersonal values: self-actualizing values (SAV), which is the value of acting on ones' own principles, and existentiality (Ex), which is the valuing of flexibility in applying these principles (Bloxum, 1972). The second pair concerns feeling reactivity (Fr), which is sensitivity to ones' own feelings, and spontaneity (S), which is free expression of these feelings. The third pair deals with attitudes toward the self: self-regard (Sr), which is the liking of one's self as a person and self-acceptance (Sa), which is the attitude of acceptance of one's own weaknesses. The fourth is described as "awareness" : nature of man (Nc), which is the attitude that man is basically good, and synergy (Sy), which is the perception of opposites in life as really having something in

common. The fifth facet deals with sensitivity to important aspects of interpersonal relations: acceptance of aggression (A) and a capacity for intimate contact (C).

The POI has a scale for each of the variables described. The Tc and I scales have 23 and 127 items. The remaining scales are subscales, which contain 9 to 32 items that have been taken from the I scale. The content validity of the scales of the POI are good. The variable being assessed by the items are broadly defined. The content of the items in each score are varied. The reliability coefficients range from .55 to .85. Three subscales have coefficients that might be regarded as substandard .

The normative data in the manual are biased toward the college student population. The standard score profile sheet is based on norms of 2,607 entering college freshmen. Various other groups which have been profiles are business supervisors, Peace Corps Volunteers, high school students, hospitalized psychiatric patients, delinquent sailors, and male alcoholics.

The validity of the POI can be well documented by summarizing the results of studies of the I scale. In five of the six therapy studies using that scale, the scores of patients increased from pretherapy to post-therapy more significantly than the scores of the nonpatient control groups (Bloxum, 1972).

Validity evidence for the POI has also been sought through factor-analytic studies. A study by Knapp and Fitzgerald (1973) using modified scales developed from criterion and item factor-analysis studies found three of the experimental scales showing pre to post-treatment gains, as opposed to five of the original logically developed scales. Correlations of experimental and logical scales were .81 and .88 at pre and post for Tc. and .64 and .78 for Id.

Knapp (1976) reported a study in which alcoholics who had been sober one year were much higher on Tc than a group of practicing alcoholics (p. 62). In a study by Zaccaria and Weir (1967) only the Tc scale discriminated 10 alcoholics from a nominated non-self-actualizing sample.

Shostrom and Knapp (1966) reported test-retest reliability coefficients of .91 and .93 for the time ratio and support ratio scores for the POI. Klavetter and Mogar (1967) reported test-re-test reliability coefficients for the 12 scales that ranged from .52 to .82 with a median of .71. Illardi and May (1968) reported test-retest reliability coefficients for each of the 12 Poi scales that ranged from .32 to .74 with a median of .58.

The usefulness of the modified split-half approach to the estimation of reliability for such factorially complex scales is

suggested by these data. Consistently larger estimates were found that have been reported earlier using alpha coefficients. This approach also yields generally higher estimates than the more conventional split-half approach used by Wise and Davis (1975) ; a comparison of their split half estimates with the alpha coefficients from the three studies, shows the split-half reliability to be higher for only half of the twelve, whereas the modified split-half coefficients were higher for all scales (Wise and Davis, (1975).

In a study by Foulds (1969) it has been reported that the Personal Orientation Inventory can discriminate between two groups of counselors with respect to the ability to communicate the facilitative conditions of empathic understanding, respect or positive regard,and facilitative genuineness during counseling. The results have suggested that the more actualizing counselors are better able to communicate these conditions. Fischer (1975) has shown the effectiveness of intensive training in the core therapeutic conditions of empathy, warmth and genuineness in preparing the counselors to communicate better these condition.

Fischer's study consisted of social work students in three different educational experiences. The first group received specific training in core conditions. The second group did not

receive specific training in the core conditions. The third group had no association with the instructor and was given the POI in a pre-test post-test condition.

Results suggested that all three conditions of Empathy, Warmth, and Genuineness were significantly correlated with Inner Directedness, Feeling Reactivity, and spontaneity; genuineness was also significantly correlated with Synergy. The ability of individuals to communicate conditions of empathy, warmth and genuineness seems to be connected with 1) the feeling or attitude of personal freedom, self-support, or independent direction in life rather than dependency upon and the seeking of the support of others and external influences and expectations; 2) The sensitivity to one's needs and feeling rather than being estranged from one's inner world of experience, 3) ability to express freely one's feelings, spontaneously and behaviorally, a key aspect of empathy, warmth, and genuineness.

The relationship between communicating empathy, warmth and genuineness and POI scales is strong enough to warrant this instrument as a crucial variable for further exploration in examining the personality characteristics of effective helpers.

Fox, Knapp , and Michael (1968), administered the POI to a group of 187 patients hospitalized for psychiatric problems. This

group was compared with self-actualizing samples nominated by practicing, certified clinical psychologists. The patients were significantly differentiated from the self-actualized and normal samples at $p < .05$ by all POI scales.

Numerous studies have used the POI as a pre-post measure with some growth experience intervening (e.g., therapy, encounter, sensitivity training). For example, a group of 37 patients entering therapy was significantly differentiated from 39 patients in advanced stages of therapy by all 12 POI scales at $p < .01$ (Shostrom, 1974)

The study of trends in self-actualization after the early adult years was until recently relatively uncharted territory (Knapp, 1976).

In the Time-competence scale-Tc, Emrick (1970) reported a study of 25 alcoholics, ages 22 to 65 , designed to confirm two other studies showing that alcoholics have shorter time extension into the future (prospective extension) than nonalcoholics. Alcoholics were hypothesized to live in the present unconnected with past and future. The Tc scale was administered along with two measures each of prospective and retrospective time span based on story completion and TAT cards. Durations of abstinence (length of stay in a treatment programs as of testing date) and

quality of abstinence (peer ratings by four rehabilitated alcoholics not in the study) were used as two criterion variables. Tc was related .69 ($p < .001$) to quality of abstinence and .51 ($p < .01$) with duration of abstinence. Tc also correlated .41 ($p < .05$) with prospective time extension as measured by TAT responses. An item analysis showed that the most discriminating items were those concerning guilt over the past and unrealistic predictions about the future, not those showing "pathological" present orientation.

The studies reviewed above bring considerable evidence to bear on the construct validity of the two major POI scales, Id and Tc. Evidence relevant to both variables supports their validity as measures of qualities associated by Maslow with self-actualization. The Id scale in particular has demonstrated sensitivity to change over the course of experiences hypothesized to affect self-actualization.

The Tc scale has supported theoretical formulations as to disturbances in time-orientation in alcoholics, delinquent boys and psychopathic felons. Additional evidence of convergent validity for the Tc scale comes from its correlations with prospective time span, locus of control, the Purpose in Life test, and with high levels of occupational aspiration. The

evidences thus lends considerable support to the use of the Id and Tc scales as measures of two related but distinct aspects of self-actualization (Shostrom, 1974).

A study by Hampton and Derasotes (1979) examined teaching effectiveness, as viewed by students, as a function of the mental health of the teacher (Dandes, 1966). In their research they found that self-actualization and self-evaluation were elements of good mental health, and that they have been effectively incorporated into teacher training programs (Doggett, 1974; Jensen, 1968)

In their study it was revealed that instructors were found to be correlated significantly with two specific scales of the POI, Time-Competence (Tc) and Nature of Man (NC). It may be concluded that students ratings of their instructors appear to be related to two measures indicative of mental health for their instructors. The high TC scores also suggest that the instructor is effective in living in the present as indicated by his or her tying the past and future into meaningful relationships. The students then recognized the instructor as having realistic goals, expectations, and fears; and when rating instructors, they related positively to this characteristic of a teacher. It also could suggest that the instructors with high TC scores can provide students with a secure and stable situation in which learning occurs. (Hampton and Kerasotes 1979)

Profile of Adaptation to Life Clinical Scale

The Profile of Adaptation to Life (PAL) clinical scale was developed by Robert B. Ellsworth for the purposes of measuring the improvement of patients/clients in treatment over time or/and how the clients adjusted over time. Because of no existing self-report scale that measured a broad range of positive and symptomatic aspects of both physical and psychological adjustments, this instrument was developed. It is specifically designed for mental health agencies as well as counselors (Ellsworth, 1978).

The initial research for the PAL Scale began with a sample of 1,738 people that were involved in various activities and life styles. The form was administered to individuals in community clinics, patients admitted to psychiatric hospitals, community college students, individuals responding to a National Enquirer article, people that were Transcendental Meditation participants, people learning conscious control of internal states through guided imagery, and individuals attending a conference on higher consciousness.

Those individuals that were entering training or treatment were administered the form initially and then given the same form three months later. The clinical form of the PAL Scale is a short form used in evaluating the pre and three month treatment adjustment of adults receiving counseling services. The selection

of retained items utilized in the PAL-C form was based on sensitivity to pre and post treatment change, ability of the time to distinguish between groups known to differ in adjustment, and the salience of the item for those taking part in such interventions as counseling in clinics or training.

Dimensions Measured by the PAL Scale. From the analysis performed on the PAL seven factors of adjustment and functioning were found common in all groups: 1. negative emotions 2. psychological well-being 3. income management 4. physical symptoms 5. alcohol and drug use 6. close interpersonal relationships 7. child interpersonal Relationship. These seven factors made up the clinical form of the PAL scale (Ellsworth, 1975).

The negative emotion scale is composed of times that measured the feeling of being troubled or uneasy, unhappy and worried. Psychological well-being consisted of finding enjoyment in conversing with others and finding work interesting, feeling trusted, needed and useful. Income management focused on how well people handled their money that was available to them including feeling free from the worry about debts and having enough money to pay bills and handle unexpected expenses. Physical symptoms were measured by the reports of somatic complaints such as fever,

headaches, and stomach problems. The alcohol and drug use scale included measuring the functioning and adjustment of the individuals using and misusing chemicals and measuring the frequency of their use, getting high and whether it had caused problems with their family or with thinking clearly. The final two areas included close interpersonal and child interpersonal relationships. These scales focused on the quality of the relationships whether the individual enjoyed the times together and feeling close.

Research findings

A large sample of 1,738 participants were broken down into several categories. Six hundred seventy eight (678) were clients seeking mental health services; One hundred twenty one (121) were being trained for TM techniques; Ninety six (96) were community college students four hundred thirty five (435) were responding to a National Enquirer article on psychic experiences; three hundred sixty-six (366) were entering a program to teach methods of conscious control of altered states of consciousness; and forty-two (42) participants were invited to a conference on higher states of consciousness.

The clinic group had more females and were the least educated. The National Enquirer sample was evenly balance on the

male-female variable. Those invited to the higher consciousness workshops were mostly male and 86% were college graduates (Ellsworth, 1975).

Reliability

The reliability for three of the PAL factored scales was .90 or above. Negative emotions=.91, close interpersonal- .92 and child interpersonal-.90. The other dimensions of PAL had reliabilities in the .80's. Therefore the seven PAL factor scores were found to have adequate reliability (Ellsworth, 1975).

Validity

Discriminant validity was considered first. The estimate of the PAL scale validity came from comparing clients' perception of their own pre-treatment adjustment and functioning with ratings by significant others, usually a spouse. Overall, the PAL scales differentiated well with groups that differed in adjustment as well as between the initial and three month follow-up test (Ellsworth, 1975).

Chapter Four

Results

Two phases of data collection were utilized in this study. The first phase consisted of sending by mail (45) forty-five packets to randomly sampled certified substance abuse counselors in Virginia. The second phase consisted of the administration of packets to eleven inpatient counselors, for them to complete, and for each counselor to individually collect pre and post test packets from ten patients in their group.

The substance abuse counselor test battery included: the Spiritual Well Being Scale, the Rokeach Value Survey, and the Personal Orientation Inventory. The patient test battery included: pre and post tests of the Spiritual Well Being Scale and the Profile of Adaptation to Life Clinical Scale. Data collected from both the counselors and patients on the objective measures were scored and compared for significant differences to test the stated research hypotheses.

Demographic Data

Sampling Procedures

In April of 1995, envelopes containing the Spiritual Well Being Scale, Personal Orientation Inventory, and Rokeach Value

Survey were sent out by mail to forty-five (45)Certified Substance Abuse Counselors in Virginia. Of the forty-five (45) envelopes that were sent, thirty-four (34) were returned completed. This yielded a return rate of seventy-five percent(75%).

The initial design was to utilize twelve (12) inpatient counselors; however, due to one inpatient program design, one of the counselor's did not meet the two week criteria; therefore only eleven inpatient counselors were involved in this study. This also reduced the initial one hundred twenty (120)patient sample to one-hundred ten (110).

The inpatient packets, which included the inpatient counselors' and patients' pre/post test packets, were completed and collected by the first week of-August 1995. No specific demographic data was collected in this study other than the individual's identification number designated by this researcher.

The one hundred ten (110) clients in this study all came from inpatient settings. The inpatient treatment structure included daily group therapy, attendance at Alcoholic's Anonymous and Narcotics Anonymous meetings, chemical dependency education groups, individual sessions, activities development, as well as

individual assignments. The eleven (11) counselors that came from the inpatient settings selected ten (10) clients that were in their groups and would be in treatment for at least two weeks.

The clients were given a pre-test of the Spiritual Well Being Scale and the Profile of Adaptation to Life Clinical Scale and a post-test using the same instruments two weeks later. The counselors were to ensure that the same individual received the designated post-test packet.

The inpatient counselors were to take the completed test packets and return them to their respective supervisors, to be picked up by this researcher.

The inpatient programs in this study were all inpatient adult chemical dependency treatment programs. In each program the counselor maintained a caseload of ten or more patients at a time. All three of the inpatient units that were utilized were located within an hour and a half of Richmond. The clients came from all regions of Virginia, primarily referred by community service boards.

The data collection process lasted from the middle of April to the first week of August. At that time all eleven of the inpatient counselors had returned their packets and approximately 110 patients had filled out the pre and post test instruments.

Of the inpatient counselors, only one did not complete all of the instruments. The test that was not completed was the Rokeach Value Survey. Twelve patients out of the 110 did not participate in the study.

The clients that volunteered for this study had a primary diagnosis of chemical dependency. There were no restrictions on gender in this study. The patients were at least eighteen years old.

Review of Null Hypotheses

Null Hypothesis One

Four hypotheses were examined in this study. The first null hypothesis stated there would not be a statistically significant positive correlation ($p<.05$) between the chemical dependency counselors' scores on the Spiritual Well Being Scale and their scores on the inner harmony, self-respect, wisdom, honesty, and loving scales of the Rokeach Value Survey (RVS) and their scores on the time-competence, self-actualizing, existentiality and self-acceptance scales on the Personal Orientation Inventory (POI).

Result of Measures for Null Hypothesis One:

Stepwise Multiple regression was utilized in question one having Spiritual Well Being as the dependent variable in the

equation. The independent variables were from the Personal Orientation Inventory; the time-competence, self-actualizing, existentiality, and self-acceptance scales and from the Rokeach Value Survey the honesty, inner harmony, loving, self-respect, and wisdom scales respectively.

Self-acceptance, wisdom, and loving were included in the stepwise regression equation. The inclusion level for this equation was .05. The Beta weights for all three variables were significant at the .05 level. The variable with the highest Beta weight was self acceptance. Wisdom and loving had similar beta weights. The R squared for the equation was .47 which indicated that these three variables accounted for about half the spiritual well-being variance. The F for this equation was 11.99 which was significant.

Table One

Multiple R	.68803
R Square	.47339
Adjusted R Square	.43389
Standard Error	12.41191

Analysis of Variance

	DF	Sum of Squares	Mean Square
Regression	3	5539.41591	1846.47197
Residual	40	6162.22046	154.05551
F	11.98576	Signif F= .0000	

Table One

Variable	B	SE B	BETA	T	Sig T
Self-Acceptance	2.676548	.621428	.509639	4.307	.0001
Loving	8.412498	3.982136	.251178	2.113	.0409
Wisdom	-9.417003	4.121909	-.263461	-2.285	.0277
(Constant)	50.358713	10.657082		4.725	.0000

Null Hypothesis one was rejected for the Rokeach Value Survey scales of wisdom and loving and the Personal Orientation scale of self acceptance; however, was accepted for the Rokeach Value Survey scales of inner harmony, self-respect, and honesty, and the Personal Orientation Inventory scales of time-competence, self-actualizing and existentiality. The data for hypothesis one are presented in Table 1.

Null Hypothesis Two

The second null hypothesis stated that there would not be a statistically significant positive correlation ($p<.05$) between the inpatient chemical dependency counselors' scores on the Spiritual Well-being Scale (SWBS) and the gain scores between the pre and post tests of their patients on the same instrument. The

change scores of the patients' on the Spiritual Well Being was correlated with the Spiritual Well Being Scale of their counselors.

Results of Null Hypothesis Two

The results yielded a correlation of .12 which was not significant; thus accepting the null hypothesis that there was no correlation between counselor Spiritual Well-Being and the gain scores for their patients on the pre and post-test of the Spiritual Well Being Scale.

Results of Null Hypothesis Three

The third null hypothesis stated that there would not be a statistically significant positive correlation ($p<.05$) between the post-test Spiritual Well-Being scale scores of the patients and their counselors' scores on the time competence, self-actualizing, existentiality, and self acceptance scales obtained from the Personal Orientation Inventory and the Rokeach Value Survey as well as the Spiritual Well-Being Scale.

Results of Null Hypothesis Three:

The post-test scores on the Spiritual Well Being Scale were identified as dependent variables. Stepwise Multiple Regression

statistics were used and no independent variable met the .05 significance level criteria for inclusion in the regression equation. The results were not significant and the null hypothesis was accepted.

Null Hypothesis Four

The fourth null hypothesis stated that there would not be a statistically significant positive correlation ($p<.05$) between the alcohol and drug use sub-scale, (Profile of Adaptation to Life Clinical Scale Scores), of the patients, post-treatment, and the pre-test measures on the patients and the counselors' scores on time-competence, self actualizing, existentiality, and self acceptance scales obtained on the Personal Orientation Inventory and the honesty, inner-harmony, loving, self respect, and wisdom scales on the Rokeach Value Survey.

Results of Null Hypothesis Four:

Profile of Adaptation to Life Clinical Scale post-test scores were identified as the dependent variables. Stepwise Multiple regression statistics were used and no independent variable met the .05 significance level criteria for inclusion in

the regression equation. The null hypothesis that there would not be a statistically significant correlation ($p<.05$) between the patients' Profile of Adaptation to Life Scale and Spiritual Well-Being and the counselor scores time-competence, self-actualizing , existentiality, self acceptance scales obtained from the Personal Orientation Inventory and honesty, inner-harmony, loving, self-respect, and wisdom scales on the Rokeach Value Survey was therefore accepted.

Chapter Five

The focus of this research as stated in chapter one was to explore the impact counselor spiritual well-being had on substance abusing patients in a treatment setting. Throughout the literature review in Chapter Two the question that seemed to consistently appear in the research with respect to the addiction recovery process involved the spiritual dimension. It also appeared that care-givers historically avoided the spiritual component of recovery and therapeutic care. Therefore the basis of this study came out of the apparent need for research into the area of spiritual well being of clinicians and patients.

Although it seemed that spirituality had been avoided in treatment, spirituality has continued to be a central component of Alcoholic's Anonymous. For this reason alone, it is important for substance abuse counselors' to examine their own spiritual convictions. The primary purpose of this research was to examine the spiritual well-being of substance abuse counselors and to determine the impact their spiritual well-being had on their clients. In addition this research examined correlations among the instruments of the Spiritual Well-Being Scale, the Personal Orientation Inventory, the Rokeach Value Survey and the

Adaptation to Life Scale in an effort to establish concurrent validity for the Spiritual Well-Being Scale.

This study consisted of forty-five (45) substance abuse counselors and one-hundred ten (110) patients in three inpatient alcohol and drug treatment settings. Eleven (11) of the forty-five (45) counselors were inpatient counselors that administered pre and post tests with the patients in their care. The remaining thirty-four (34) counselors were randomly sampled from the Virginia certified addiction counselors' list. Each of the eleven inpatient counselors selected ten patients that met the two week stay criteria. The counselors than administered the pre and post-tests to the ten clients in their care.

The theoretical base presented in Chapter Two followed Carl Jung's belief that the ultimate sources of recovery from addiction are spiritual. The previous research cited encouraged care-givers to gain insight and awareness into their own spiritual path, so that they would have greater impact on their patients. However, the literature review revealed no research that had been done with the same goal of this study: to directly measure the impact of counselors' spiritual well-being on their clients.

The instruments administered to the counselors in this study

were the Spiritual Well Being Scale, the Rokeach Value Survey, and the Personal Orientation Inventory. The patients received a pre and post-test of the Adaptation to Life Scale-Clinical, and the Spiritual Well-Being Scale. Eleven inpatient counselors administered ten packets to ten patients in their groups that met the two week stay criteria. Following collection of the data, multiple regression and correlational statistics were performed on the data. There were statistically significant positive changes in the spiritual well-being scores pre to post-test; however, it did not correlate significantly with the counselor's well being as initially hypothesized. There were however, statistically significant correlations among the spiritual well-being of the counselor, self-acceptance from the Personal Orientation Inventory and the loving and wisdom scales from the Rokeach Value Inventory.

Hypothesis One

Hypothesis one stated that there would be a statistically significant positive correlation between the chemical dependency counselors' scores on the Spiritual Well-Being Scale and their scores on the inner-harmony, self-respect, wisdom, honesty, and loving scale of the Rokeach Value Survey and their scores on the time competence, self-actualizing, existentiality and self-

acceptance scales on the Personal Orientation Inventory. The results indicated a significant positive statistical correlation between the Spiritual Well-Being Scale of the counselor, self acceptance, wisdom and loving scales. This indicates that spiritual well-being in a counselor could correlate significantly with the traits of self-acceptance, love and wisdom. The main text of Alcoholic's Anonymous called the Big Book suggests that "acceptance is the answer to all our problems" (p.449), and that problems come about when people cannot or will not accept where they are at any given time. It is interesting to note that both acceptance and wisdom are key concepts in the Serenity Prayer of AA, which specifically asks for the "Serenity" or well-being to "accept" the things I cannot change, the "courage" to change the things I can, and the "Wisdom" to know the difference.

Hypothesis Two:

Hypothesis two posited that there would be a statistically significant positive correlation between the inpatient chemical dependency counselors' score on the Spiritual Well-Being Scale and the gain scores between the pre and post-tests of their patients on the same instrument. The results showed no significance between the change scores of the clients' and the

counselors' well-being score. This non-significance could be related to a number of factors.

Foremost would be the possibility that the Spiritual Well-Being Scale does not adequately measure spiritual development. Another possibility would be the numerous influences that could have impacted the change score of the patients. Each patient is exposed to the therapeutic milieu, regular attendance at Alcoholic's Anonymous meetings, daily group therapy, education groups, and overall socialization with patients. The amount of individual therapeutic time spent with their counselor was small in comparison to all the activities done in group settings. The pre and post-test scores of the patients' spiritual well-being indicated that the spiritual well-being of the patients did improve. One could infer that the change in the scores happened as a result of group factors or the entire inpatient milieu, which would support the importance of inpatient treatment. This could have positive implications for justifying inpatient treatment and the importance of having the milieu as a significant factor in improvement or Spiritual well-being. It might also support the idea of the "fellowship" in recovery and how people get well and heal in groups, whether inpatient or

outpatient.

Of note is the strength of the R squared which counted for half of the Spiritual Well Being variance. These could be overlapping instruments.

Hypothesis Three:

Hypothesis three stated that their would be a statistically significant positive correlation between the Spiritual Well-Being Scale scores of the patients post-treatment and the pre-test measures on the counselor's information obtained from the Personal Orientation Inventory, Spiritual Well-Being Scale, and the Rokeach Value Survey. There was no significant correlation between the patients' Spiritual Well-Being post-test and the pre-test measures of the counselor.

Hypothesis Four:

Hypothesis four stated that there would be a statistically significant positive correlation between the alcohol and drug use subscale of the Adaptation to Life Scale of the patients post-treatment and the pre-test measures of the Spiritual Well-Being Scale and Profile of Adaptation to Life Scale on the patients and the counselor information obtained from the Personal Orientation Inventory, Spiritual Well-Being Scale, and the Rokeach Value Survey.

The statistics indicated no significant correlation, however, there was a change in the pre and post-test scores of the Profile of Adaptation to Life Scale. The scores went down, which was an indicator that treatment in an inpatient setting effects the Profile of Adaptation to Life alcohol and drug subscale positively. There appeared to be an improvement, however, it did not correlate with the counselor variables. Again, one could postulate that the improvement was related to the inpatient group milieu, the therapy groups, and attendance at 12 step meetings.

Further Findings

The substance abuse counselors in this study had a mean score very close to the mean for caregivers reported in the Spiritual Well-Being Scale manual. This lends support for the validity of the Spiritual Well-Being Scale with respect to caregivers, particularly since substance abuse counselors were not among the caregivers cited in the manual. It appeared that this was the first study utilizing the Spiritual Well-Being Scale with substance abuse counselors and substance abusing inpatients. The results support the validity of the spiritual well-being scales with substance abusers.

Results of the Personal Orientation Inventory with respect to time-competence indicated that the counselors may be

experiencing difficulty in personal effectiveness and that changes in value orientations would be beneficial in facilitating further personal development toward actualization. Both self actualizing and existentiality appeared to be normal with self acceptance scoring below normal. According to the Personal Orientation Inventory Manual, individuals who received low scores on time competence tended to hold values rigidly to the point that they may become compulsive or dogmatic.

The change in the Profile of Adaptation to Life Scale scores indicated that most patients stopped using; however, consequences or problems related to their use may have surfaced and brought the scores down. Fourteen patients did not complete the Profile of Adaptation to Life Scale. This could be due to the fact they were unaware that the test continued on the other side of the sheet. Some individuals filled out the front side but did not complete the back side.

In follow up tests there appeared to be a correlation between self respect and items on the Personal Orientation Inventory as well as wisdom with items on the Personal Orientation Inventory. Inner-harmony correlated with all the variables on the Personal Orientation Inventory. This

indicated that three of the items on the Rokeach Value Survey correlated with at least three of the items on the Personal Orientation Inventory. It appeared that there were significant relationships between the values of wisdom, honesty and inner-harmony with self actualizing, self acceptance, and existentiality.

Results of the change scores of the Profile of Adaptation to Life Scales showed that time-competence, self-actualizing, and existentiality and inner-harmony were correlated with change scores of the Profile of Adaptation to Life.

Limitations of the study

There were numerous limitations of this study. The first was the small sample of inpatient counselors. Many inpatient addiction treatment programs have closed over the past five years making it difficult to have a large inpatient counselor sample. The small number may have contributed to not finding a significance between counselor and patient spiritual well-being.

The second limitation was the vast number of other variables affecting treatment outcome. Each of the inpatient facilities provided daily group therapy, weekly attendance at twelve step meetings, substance abuse education, recreational therapy, and

finally individual therapy. The consistent factors were the same therapy groups and the same counselors coordinating all of the services for the ten patients in their care. The amount of individual contact by the counselor, however, was minimal.

The change scores of the Spiritual Well-Being Scale and the alcohol and drug subscale of the Profile of Adaptation to Life Scale could be related to any of the above variables. It was difficult to pinpoint the factor or factors contributing to change. Further research will need to limit the number of variables, perhaps by focusing on therapeutic factors within the group and counselor interventions.

In order to preserve the confidentiality of the patients and counselors, a number was given to each subject. Future studies might want to incorporate age, sex and race into the data collection.

A future study could include giving both the counselors and clients the same instruments as well as giving the counselors pre and post tests.

A third limitation was the time frame used to obtain the pre and post-test information from the patients. Since the time frame was only two weeks, remembering the pre-tests could have influenced the patients.

Recommendations

Further study in the area of spiritual well being would need to include a larger counselor population as well as patient population.

Overall, the spiritual well-being scale appears to be a helpful tool for evaluating addiction treatment benefits. This instrument in particular could be used as a quality assessment tool not only for treatment programs, but for patients to be able to see improvement in their well-being. Nevertheless, possible interview or questionnaires to explore with the patients what they believed to be most helpful could be used to augment the Spiritual Well-Being Scale. This could help patients analyze what was most beneficial in their treatment process to their spiritual well-being.

Further research on the impact of a treatment milieu group consciousness on well-being would also be interesting. To this end, future research could compare the effects of the inpatient treatment milieu with that of outpatient group therapy on spiritual well being.

REFERENCES

Alcoholics Anonymous. (1976). New York: AA world services.

American Medical Association, (1956). Journal of the American Medical Association,162.

Bellingham, R., Cohen, B., Jones, T., & Spaniol, L., (1989). Connectedness: Some skills for spiritual health. American Journal of Health Promotion,4(1).

Benner, P. (1984). From novice to expert: Excellence and power in clinical nursing practice. Menlo Park, CA: Addison Wesley.

Bergin, A.E. (1980). Psychotherapy and religious values. Journal of Consulting and Clinical Psychology,48, 95-105.

Bergin, A. E. (1988). Three contributions of a spiritual perspective to psychotherapy and behavior change. In W.R. Miller and J.E. Martin (Eds.), Behavior Therapy and Religion: Integrating Spiritual and Behavioral Approaches to Change. Newbury Park: SAGE Publications.

Bergin, A.E., & Garfield, S.L. (1971). (Eds.) Handbook of psychotherapy and behavior change: An empirical analysis. Toronto: John Wiley & Sons,

Blaikie, N.W., & Kelsen, G. P. (1979). Locating self and giving meaning to existence: A typology of paths to spiritual well-being based on new religious movements in Australia. In D. O. Moberg (Ed.), Spiritual well-being: Sociological perspectives. Washington, DC: University Press of America.

Bloxom, B., (1972).Tests and reviews. In O.K. Burros (Ed.), The seventh mental measurements yearbook. Vol. 1., Highland Park, N.J.: Gryphon Press, pp. 290-292.

Brown Jr, H.P. & Peterson J.H. (1988). Rationale and theoretical basis for a behavioral-cognitive approach to spirituality. Alcoholism Treatment Quarterly, 5(1/2), 1988.

Brown Jr, H.P., & Peterson Jr, J.H. (1990). Spiritual values in the treatment of dependency. Alcoholism Treatment Quarterly, 7(3).

Brown Jr, H.P., & Peterson Jr, J.H. (1991). Assessing spirituality in addiction treatment and follow-up: Development of the Brown-Peterson recovery progress inventory,(B-PRPI). Alcoholism Treatment Quarterly, 8(2), p. 21-45.

Brown Jr., H.P., Peterson Jr., J. H., & Cunningham, O. (1988). An individualized behavioral approach to spiritual development for the recovering alcoholic/addict. Alcoholism Treatment Quarterly, 5(1/2), 177-191.

Bufford, R.K., Paloutzian, R.F., & Ellison, C.W. (1991). Norms for the spiritual well-being scale. Journal of Psychology and Theology, 19(1), 56-70.

Burns, J. (1975). and three other recovered alcoholics. The answer to addiction. New York: Harper & Row.

Butman, R.E. (1990). The assessment of religious development; Some possible options. The Journal of Psychology and Christianity, 9(2), 14-26.

Byrne, D. (1971). The attraction paradigm. New York: Academic Press.

Carroll, M.M. (1987). Alcoholism as an attachment and a gift on a spiritual journey. ReVision, 10(2), 45-48.

Champagne, K.E. (1986). The relationship between nurses' spiritual well-being and nurses' perceptions of patients' spiritual needs. Unpublished master's thesis, The Catholic University of America, Washington, D.C.

Chandler, C.,Holden, J. & Kolander, C. (1992). Counseling for spiritual wellness: theory and practice. Journal of Counseling and Development, 71, 168-174.

Clemmons, P. (1991). Feminists, spirituality, and the twelve steps of alcoholics anonymous, women and therapy, 11(2), The Haworth Press, 97-109

Collins, W.E. (1987). Keeping the therapist alive. Journal of Religion and Health, 26(3), p. 206-213.

Corrington Jr., J. (1988). Spirituality and recovery: relationships between levels of spirituality, contentment and stress during recovery from alcoholism in AA. Alcoholism Treatment Quarterly, 151-161.

Dalai Lama, (1991). Foreword. In Thich Nhat Hanh. Peace is everystep. New York: Bantam.

Deane, D., & Cross, J. (1987). Spiritual well-being and role attitudes of student nurses. Unpublished manuscript, Wright State University, Dayton, OH.

Dettmore, D. (1984). Nurses conceptions of and practices in the spiritual dimension of nursing. Unpublished manuscript, Marquette University, Milwaukee, WI.

Diagnostic and Statistical Manual-Fourth Addition. (1994). American Psychiatric Association.

Dombeck, M. & Karl, J. (1987). Spiritual issues in mental health care. Journal of Religion and Health, 26(3) 183-184.

Dandes, H.M., (1966). Psychological health and teaching effectiveness. Journal of Teacher Education, 17, 301-306.

Doggett, M., (1974). A self-actualization process for teachers.(ERIC Document Reproduction Service N. ED 100823, SP 008732).

Dossey, L. (1984). Beyond illness. Boulder: Shambala Publishing.

Edgar, M. (1989). An investigation of the relationship between nurses' spiritual well-being and attitudes of their role in providing spiritual care. Unpublished manuscript, California State University, Los Angeles.

Elkins, D. N, (1988). On being spiritual. Journal of Humanistic Psychology, 28(4), 5-18.

Ellison, C. W. (1983). Spiritual well-being: conceptualization and measurement. Journal of Psychology and Theology, 11(4),330-340.

Ellison, C. W., & Smith, J. (1991). Toward an integrative measure of health and well-being. Journal of Psychology and Theology,19(1), 35-48.

Ellsworth, R.B., (1975). Profile of adaptation to life clinical scale manual. Palo Alto, CA, Consulting Psychologists Press, Inc.

Emrick, C.D.,(1970). Abstinence and time perception of alcoholics. Quarterly Journal of Studies on Alcohol, 31, 384-389.

Fichter, J. (1981). Religion and pain. New York: Crossroads Press.

Fischer, J. (1975). Training for effective therapeutic practice. Psychotherapy: Theory, Research and Practice, 12, 118-123.

Flores, P. J. (1988). Group psychotherapy with addicted populations. New York: Haworth Press, Inc.

Foulds, M.L. (1969). Self actualization and the communication of facilitative conditions during counseling. Journal of Counseling Psychology, 16, 132-136.

Fox, J., Knapp, R.R., & Michael, W.B., (1968). Assessment of self-actualization of psychiatric patients: Validity of the personal orientation inventory. Educational and Psychological Measurement, 28, 565-569.

Frankl, V.E. (1973). The image of man in psychotherapy (W. Hallo, Trans.). In M.S. Friedman (Ed.), The worlds of existentialism (p. 468).

Frantz, J.L. (1988). MMPI and DSM-III diagnosis related to selected measures of religious and demographic variables in adult outpatients (Doctoral dissertation, Western Conservative Baptist Seminary, 1986). Dissertation Abstracts International, 48, 3678B.

Friedman, M. (1988). The healing dialogue in psychotherapy, Journal of Humanistic Psychology, 28, 19-41.

Ganje-Fling, M.A. & McCarthy P.R. (1988). Comparative Analysis spiritual direction and psychotherapy, Journal of Psychology and Theology, 19(1), 103-117.

Gartner, J., Larson, D.B.,& Allen, G.D. (1991). Religious commitment and mental health: A review of the empirical literature. Journal of Psychology and Theology, 19, 6-25.

Godlaski, T. (1988). Transpersonal psychology and the addicted experience, Alcoholism Treatment Quarterly, 5(3/4).

Greben, S.E., & Lesser, S.R. (1976). The question of neutrality in psychotherapy. Journal of Psychotherapy, 30, 623-630.

Grof, S. (1987). Spirituality, alcoholism, and drug abuse: transpersonal aspects of addiction. ReVision, 10(2), 3-4.

Grof, S. (1987). Spirituality, addiction and western science. ReVision, 10(2).

Guggenbuhl-C. N. (1982). Power in the helping professions. Dallas: Spring Publications.

Hampton, J.D., & Kerasotes, D.L., (1979). Faculty level of self-actualization in relation to student rating of instructors. Educational and Psychological Measurement, 39, 971-975.

Hanna, F.J. (1992). Reframing spirituality: AA, the 12 steps and the mental health counselor, Journal of Mental Health Counseling, 14(2), 166-179.

Illardi, R.L., & May, W.T., (1968). A reliability study of Shostrom's Personal Orientation Inventory. Journal of Humanistic Psychology, 8, 68-72.

Jensen, P.H., (1968). A study of self-evaluation applied to in-service education. (ERIC Document Reproduction Service N. EDO 23642, SP 001875).

Johnson, V.E., (1980). I'll quit tomorrow. San Francisco: Harper and Row.

Jourard, S. M. (1979). Self-disclosure: An experimental analysis of the transparent self. New York: Robert E. Krieger Publishing Co.

Jung, C. G. (1963) Man and his symbols, Garden City, New York.

Jung, C. G. (1933). Modern man in search of a soul. New York: Harcourt, Brace & World, Inc.

Jung, C. G. (1926). Spirit and life. In CW 8: The Structure and Dynamics of the Psyche. 91, 647.

Jung, C. G. (1974). The Bill W. Carl Jung letters. A.A. Grapevine, Reprinted in A.A. Grapevine, 26-31.

Kirschling, J. M. & Pittman, J. F. (1989). Measurement of spiritual well-being : A hospice caregiver example. The Hospice Journal, 5(2), 1-11.

Kitwood, T.M., & Smithers, A.G. (1975). Measurement of human values: An appraisal of the work of Milton Rokeach. Ed Res (England), 17(3), 175-179.

Klagsbrun, S. (1982). The ethics of hospice care. American Psychologist, 37, 1264-1266.

Klavetter, R.E., & Mogar, R.E. (1967). Stability and internal consistency as a measure of self-actualization. Psychological Reports, 21, 422-424.

Knapp, R.R. (1976). Handbook for the Personal Orientation Inventory. San Diego: Edits.

Knapp, R.R., & Fitzgerald, O.R. (1973). Comparative validity of the logically developed versus "purified" scales for the Personal Orientation Inventory. Educational and Psychological Measurement, 33, 971-976.

Kohn, G.F. (1984). Toward a model for spirituality and alcoholism. Journal of Religion and Health, 23 (3), 250-259.

Kopp, S. B. (1972). If you meet the Buddha on the road, kill him. Palo Alto, CA: Science and Behavior Books.

Kurtz, E. (1979). Not-God: A history of alcoholics anonymous, Hazelden Education Services.

Ledbetter, M., Smith, L., Vosler-Hunter, W., & Fischer, J. (1991). An evaluation of the research and clinical usefulness of the spiritual well-being scale, Journal of Psychology and Theology, 19(1) 49-55.

Lowe, C.M. (1969). Value orientations in counseling and psychotherapy. San Francisco: Chandler.

Mann, M., National council on alcoholism. Paper presented at Canadian Foundation on Alcohol and Drug Dependence Annual Conference, Charlottetown, P.E.I., June 24-28, 1973.

Martini, J. L. (1978). Patient-therapist value congruence and ratings of client improvement. Counseling and Values, 10, 25-32.

Maslow, A. H. (1970). Religions, values, and peak experiences. New York: Viking.

May, G.(1974). The psychodynamics of spirituality, Journal of Pastoral Care, 28(2), 84-91.

May, G. (1977). The psychodynamics of spirituality: a follow-up, Journal of Pastoral Care, 31(2), 84-90.

Miller, J. F. (1985). Assessment of loneliness and spiritual well-being in chronically ill and healthy adults. Journal of Professional Nursing, 12, 79-85.

Millison, M. (1988). Spirituality and the caregiver. American Journal of Hospice Care, 5(2), 37-44.

Millison, M. B. & Dudley, J. R. (1990). The importance of spirituality in hospice work: a study of hospice professionals. The Hospice Journal, 6(3), 63-77.

Moberg, D. O. (1971). Spiritual well-being: background and issues. Washington, DC: White House Conference on Aging.

Moberg, D. O. (1984). Subjective measures of spiritual well-being, Marquette University, Review of Religious Research, 25(4) p. 359.

Moberg, D. O., & Brusek, P. M. (1978). Spiritual well-being: A neglected subject in quality of life research. Social Indicators Research, 5, 303-323.

McKenzie, S. (1991). Addiction as an unauthentic form of spiritual presence. Studies in formative spirituality, 12, 325-327.

Montgomery, C. L. (1991). The caregiving relationship: paradoxical and transcendent aspects, Journal of Transpersonal Psychology, 23(2) 91-104.

Muktananda, S. (1982). Understanding your own mind, in ancient wisdom and modern science. Albany, NY: State University of New York Press.

Munson, J.M., & McIntyre, S H. (1979). Developing practical procedures for measurement of personal values in cross-cultural marketing. Journal of Marketing Research, 16, 48-52.

Munson, J.M., & Posner, B.Z., (1980). The factorial validity of a modified Rokeach value survey for four diverse samples. Educational and Psychological Measurement, 40. 1073-1079.

National Interfaith Coalition on Aging, (1975). Spiritual well-being: a definition. Athens, GA.

O'Connor, P. & Kaplan, M. (1986). The role of the interdisciplinary team. In F. Wald (ed.), Quest of a Spiritual Component of Care for the Terminally Ill, New Haven: Yale University Press, 63-67.

Paloutzian, R. F., & Ellison, C. W. (1982). Loneliness, spiritual well-being and the quality of life, In L. A. Peplau & D. Perlman (Eds.) Loneliness: A Source Book of Current Theory, Research and Therapy, New York: John Wiley & Sons, 223-237.

Peck, M. S. (1978). The road less traveled. New York: Simon and Schuster.

Peck, M. S. (1987). The different drum. New York: Simon and Schuster.

Peck, S. Quoted in : making the spiritual connection, Lear's 2,9, 73., 1989.

Peers, E. A. (1960). The life of Teresa of Jesus. New York: New American Library.

Peltier, K. R. (1977). Mind as healer, mind as slayer. New York: Dell Publishing.

Peplau, L. A., & Perlman, D. (1982). Loneliness: A sourcebook of current theory, research, and therapy. New York: Wiley Interscience, pp. 224-237.

Prezioso, F. (1987). Spirituality in the recovery process, Journal of Substance Abuse Treatment, 4, 233-238.

Prugh, T. (1985). Alcohol, spirituality, and recovery. Alcohol,Health, & Research World, 2(10), 28-53.

Quinn, J.F. (1989). On healing, wholeness, and the healing effect. Nursing and Health Care, 10(10), 553-56.

Reed, P. (1987). Serenity: Challenging the fear of AIDS-From despair to hope. Berkeley, CA: Celestial Arts.

Rogers, C.R. (1957). The necessary and sufficient conditions of therapeutic personality change. Journal of Consulting Psychology, 21, 95-103.

Rokeach, M. (1973). Nature of human values. New York: The Free Press.

Rosenthal, D. (1955). Changes in some moral values following Psychotherapy. Journal of Consulting Psychology, 19, 431-436.

Shafranske, E. & Gorsuch, R. (1985). Factors associated with the perception of spirituality in psychotherapy. Journal of Transpersonal Psychology, 16, 231-241.

Shafranske E. & Malony, H. (1990) Clinical psychologist' religious and spiritual orientations and their practice of psychotherapy, Psychotherapy, 2(1), 72-78.

Sherman, D.B. (1987). A comparison of interpersonal behavior traits and spiritual well-being among eating-disordered patients and medical outpatients. Dissertation Abstracts International, 47, 4680B. University Microfilms International, No, 87-04722).

Shostrom, E.L., (1974). Manual: Personal orientation inventory. San Diego: Educational and Industrial Testing Service.

Shostrom, E.L., (1963). Personal orientation inventory. San Diego: Educational and Industrial Testing Service.

Shostrom, E.L., & Knapp, R.B. (1966). The relationship of a measure of self-actualization (POI) to a measure of pathology (MMPI) and to therapeutic growth. American Journal of Psychotherapy, 20, 193-202.

Small, J. (1983). Becoming naturally therapeutic (rev. ed.). Austin, Tx: Eupsychian Press.

Small, J. (1987). Spiritual emergence and addiction: a transpersonal approach to alcoholism and drug abuse counseling, ReVision, 10(2), 23-36.

Soeken, K.L., & Carson, V.J. (1986). Study measures nurses' attitudes about providing spiritual care. Health Progress, 52-55.

Stefferud, B., & Bolton, B., (1981). Nonverbal counseling behavior and therapists' stated value orientations. Counseling & Values, 26, 19-25.

Strachan, J.G. (1982). Alcoholism: Treatable Illness. Center City, Minn. Hazelden Foundation.

Tart, C., & Deikman, A. (1975). Mindfulness, spiritual seeking and psychotherapy, Journal of Transpersonal Psychology, 22(1), p.24.

Truax, C.B., & Carkhuff, R.R. (1967). Toward effective counseling and psychotherapy: Training and practice. Chicago: Aldine.

Trungpa, C. (1983). Becoming a full human being, in awakening the heart. Weldwood (Ed.). Boulder: New Science Library, 126-131.

VandeCreek, L. (1990). Where do parishioners need the pastor most: In the home or in the hospital? Unpublished manuscript, Ohio State University, Columbus.

Van Kaam, A. (1990). Lectures in "Developments in formation Science,". The concept of form tradition pyramid will be elaborated upon in the soon to be published 5th volume in the Formative Spirituality by Adrian van Kaam, Crossroad, n.y.,1991.

Vaughan F. (1991). Spiritual issues in psychotherapy. Journal of Transpersonal Psychology, 23(2), 105-119.

Virginia Board of Health Professionals, (1995). Substance abuse counselor: a definition, VR560-01-03, p. 1.

White, L. (1979). Recovery from alcoholism: transpersonal dimensions, Journal of Transpersonal Psychology, 11(2), 117-128.

Wise, G.W., & Davis, J.E., (1975). The Personal Orientation Inventory: internal consistency, stability, and sex differences. Psychological Reports, 36, 847-855.

Zaccaria, J.S.,& Weir, W.R. (1976). A comparison of alcoholics and selected samples of non-alcoholics in terms of a positive concept of mental health. Journal of Social Psychology, 71, 151-157.

APPENDIX A

Additional Findings

Spiritual Well Being Findings

In the manual for the Spiritual Well-Being Scale the descriptive statistics for the Spiritual Well-Being Scale scores for caregivers was a mean of 93.91 with a standard deviation of 17.68. The mean counselor Spiritual Well-Being Scale scores in this study was 94.09 and the standard deviation 14.70.

The descriptive statistics in the Spiritual Well-Being manual showed inpatient eating disorder patients as having a Spiritual Well-Being mean score of 77.77 and a standard deviation of 15.06. This study showed the patients' Spiritual Well-Being mean pre score as 85.35 with a standard deviation of 21.17 and the Spiritual Well-Being mean post score as 94.11 with a standard deviation of 17.17. The pre-test scores ranged from 4 to 116.

A t-test was performed on the pre and post-tests of the spiritual well-being. The results yielded a significance of .000, indicating an improvement of the patient's spiritual well-being while in treatment.

Table Two

Spiritual Well-Being Scale Score
Taken from the Spiritual Well-Being Manual

	Mean	Standard Deviation
Caregivers	93.91	17.68
Inpatient Eating Disordered	77.77	15.06

Taken From this Research

		Mean	Standard Deviation
Substance Abuse Counselors		94.09	14.70
Inpatient Alcohol & Drug Patients	Pre	85.35	Pre 21.17
	Post	94.11	Post 17.17

	Pre SWB (patients)	Post SWB (patients)
Number of Pairs	94	94
Correlation	.609	.609
2 tail Sig	.000	.000
Mean	85.5638	94.3830
SD	21.333	17.180
SE of Mean	2.200	1.772

Mean	SD	SE of Mean	t-value	df	2 tail sig
-8.8191	17.425	1.797	-4.91	93	.000

Personal Orientation Inventory Findings

A graph in the Personal Orientation Inventory manual examined and segmented individuals as self actualizing, normal adult or not self actualizing. The scores of the counselors in

this study fell between the non-self-actualizing and normal adult. The normal adult mean was 17.7 and the non-self-actualizing person was 15.8 In this study the mean was 16.55.

Time Competence (POI 1)

In the Personal Orientation Inventory manual, two graphs came close to counselors/caregiver descriptions , one being student nurses and the other was service organization volunteers (Peace Corps) The mean for time competence with student nurses was 16.9 and the Standard deviation was 2.7. The mean for volunteers was 19.4 and the standard deviation was 2.1.This study showed a time competence mean of 16.55 and a standard deviation of 3.59.

Self-Actualizing (POI 2)

The self actualizing mean in this study was 20.27 which is close to the graph in the Personal Orientation Inventory manual for volunteers. That score was 20.6. The student nurses score was 19.4.

The score in this study for self actualizing was the same as the normal adult graph in the manual, however, the standard deviation was .24 higher in this study.

Existentiality (POI 3)

The existentiality mean in this study was 22.73 and the standard deviation was 3.76. This is higher than the student nurse graph (17.4) and the volunteer organization graph (19.1) in the Personal Orientation Inventory Manual. The standard deviations for this study and the student nurse graph in the manual were exactly the same (3.7).

The Personal Orientation Inventory Manual presented norm scores for adult normalcy and self-actualizing persons. It showed that this study's counselor mean score for existentiality (22.73) fell between the manual's normal adult mean score (21.8) and the manual's self actualizing mean score of (24.8). The standard deviation score for the existentiality scale in the manual under the heading of self actualizing was (3.5) ; the standard deviation for the normal adult in the manual under the existentiality scale was (5.1). This study's standard deviation for the existentiality scale was (3.76).

Self-Acceptance (POI 4)

The self acceptance score in this study was (16.55) and the standard deviation score was (3.33). In the manual the graph for student nurses was (14.5) and a standard deviation of (2.6). The volunteer service organization graph scored (16.4) with a

standard deviation of (3.2). In this study the score for self acceptance (16.55) fell between non-self actualizing adult (14.2) and normal adult (17.1) The standard deviation for the non-self actualizing adult was (4.0) and the standard deviation for the normal adult was (4.0).

Table Three

Student Nurses (from Personal Orientation Inventory Manual)

	Mean	Standard Deviation
Time Competence	16.9	2.7
Self-Actualizing	19.4	2.3
Existentiality	17.4	3.7
Self-Acceptance	14.5	2.6

Peace Corps Volunteers (from the Personal Orientation Inventory)

	Mean	Standard Deviation
Time Competence	19.4	2.1
Self-Actualizing	20.6	2.3
Existentiality	19.1	3.8
Self-Acceptance	16.4	3.2

This Study's Findings

	Mean	Standard Deviation
Time Competence	16.55	3.59
Self-Actualizing	20.27	3.24
Existentiality	22.73	3.76
Self-Acceptance	16.55	3.33

Profile of Adaptation to Life (Alcohol and Drug Subscale)

A t-test was performed on the alcohol and drug subscale of the Profile of Adaptation to Life Pre-test and Profile of Adaptation to Life Post-test. The results indicated a two-tailed significance of .000 with a mean on the pre-test of 9.7872 and a standard deviation of 4.999. The mean for the post-test on the Profile of Adaptation to Life Scale was 6.5426 with a standard deviation of 3.904. The range for the alcohol and drug subscale on the Profile of Adaptation to Life Scale went from 2 to a maximum score of 16. Fourteen patients did not complete the Profile of Adaption to Life Scale.

The pre and post tests of the alcohol and drug subscale of the Profile of Adaptation to Life did not correlate with any of the other variables tested.

Rokeach Value Survey Results

The value honesty's mean score was 4.10 and the standard deviation was 3.38. Inner Harmony's mean was 4.30 and the standard deviation was 2.98. Wisdom's mean was 5 and the standard deviation was 2.62. Self respect's mean was 6.10 and the standard deviation was 4.97. The final value was love and it's mean was 8.40 and the standard deviation was 6.

For the purpose of this study a dummy variable was used and

in so doing, if the value was in the top five it received 1.00. If the ranking was above 5, a score of 0 was placed in the data entry.

In research question one the results showed a significant F score (.000) between the variable of self-acceptance on the Personal Orientation Inventory and wisdom and love from the Rokeach Value Survey. Both wisdom and love had a significant F score (.0000).

Follow up Tests

Correlational Follow up tests

In follow up tests, a correlation was performed with the following results: There was a significant correlation between self-respect and time competence (p=.000), self actualizing (p=.005), existentiality (p=.0000), and self acceptance (p=.000) of the Personal Orientation Inventory. There was a significant correlation between wisdom and self actualizing (p=.030), existentiality (p=.000) and self acceptance (p=.053) of the Personal Orientation Inventory. Honesty correlated positively with self actualizing (p=.0000) and self acceptance (p=.0000)of the Personal Orientation Inventory.

Inner harmony positively correlated with time competence (p=.000), self actualizing (p=.000), existentiality (p=.000), and self-acceptance (p=.000). Love correlated significantly

with time competence (p=.003)and self acceptance (p=.000). This correlation can be seen more clearly in Table Four.

Table Four

Table Four

Change Score of Profile of Adaptation to Life Scale		Spiritual Well-Being Scale	Time Competence	Self Actualizing	Existentiality	Self Acceptance
Inner Harmony	-.2671 (86) P= .013	.4874 (100) P= .000	.8006 (100) P= .000	.7969 (100) P= .000	.7400 (100) P=.000	.7862 (100) P=.000
Loving		.9077 (100) P= .000	.2971 (100) P= .003			.4724 (100) P=.000
Self Respect		.8641 (100) P= .000	.4754 (100) P= .000	.2807 (100) P= .005	.4792 (100) P=.000	.6783 (100) P =.000
Wisdom		.2917 (100) P= .003		.2169 (100) P= .030	.3750 (100) P=.000	.1938 (100) P=.053
Spiritual Well Being			.4073 (110) P=.000	.2193 (110) P= .021	.2494 (110) P= .009	.5541 (110) P=.000
Time Competence	-.2043 (94) P=.048					
Existentiality	-.2412 (94) P= .019					

Multiple Regression Follow up Tests

A multiple regression was performed on the variable of change for the Personal Orientation Inventory. Inner harmony was the only variable that was included in the regression equation. The equation had an R square of .07.

Table Five

Multiple Regression-Variable-Inner Harmony

Multiple R	.26706
R Square	.07132
Adjusted R Square	.06026
Standard Error	4.71675

Analysis of Variance

	DF	Sum of Squares	Mean Square
Regression	1	143.51665	143.51665
Residual	84	1868.80893	22.24773

F= 6.4508 Significant F= .0129

Variable in Equation

Variable	B	SE B	Beta	T	Sig T
Innerharmony	-3.319643	1.307022	-.267056	-2.540	.0129
(constant)	-.437500	1.179187		-.371	.7116

A correlation was calculated on the change scores of the Personal Orientation Inventory and the variables of time competence (p=.048), existentiality (p=.019) and inner harmony was significantly correlated with the change scores of the

Personal Orientation Inventory.

A significant correlation of the Spiritual Well Being Scale of the counselor with all of the variables on the Personal Orientation Inventory: (time competence (p=.000), self actualizing (p=.021), existentiality (p=.009), and self acceptance (p=.000) was found. There was a significant correlation of self respect with the swb (p=.000). The correlation also revealed a positive correlation between honesty and swb of the counselor (p=.000), self-actualizing and honesty (p=.000) and self-acceptance (p=.000) and honesty.

A test for independent samples of all the variables in the Rokeach survey, (honesty, inner harmony, love self respect and wisdom) were compared with the variables of change for the Personal Orientation Inventory and the Spiritual Well Being Scale. In all of the cases there were no significant correlations found.

APPENDIX B

Inpatient Counselor Consent Form

This consent form is to request your voluntary participation in dissertation research to be conducted in 1995 by Clifford Wilson Brooks, Jr. in partial fulfillment of the requirements for the Doctoral degree in Counseling at The College of William and Mary. Please read the following information carefully and sign the section marked "Informed and Voluntary Consent to Participate" if you are willing to participate in the study.

Purpose of the Study

The purpose of this study is to research the impact of values on chemical dependency inpatient treatment programs.

Amount of Time Involved for Counselors

First, the counselors will be asked to begin identifying ten (10) patients that meet the requirement of staying in their facility for two weeks of treatment under their care.

Next, the participating counselors will administer pre-tests to those patients in their care meeting the two week criteria. Counselor time will then be used in keeping track of the ten (10) patients in their group and administer the post-tests after the two week time frame.

Participating counselors will be asked to fill out a battery of three instruments which in total may take forty-five (45) minutes to complete. A summary of combined results of the study will be sent to participants who wish to receive copies. This researcher will also provide an inservice with results and allow time for questions.

Potential Risk

There are no potential risks in this study. The research does not involve any physical stress or psychological stress. The instruments are brief and non-invasive. There are no biomedical procedures or misleading information. This is an informed consent in which you may choose to discontinue in the study any time without any questions from this researcher or without any penalty. If there are questions that come up for you during the study or following the study, you can contact me at (804) 257-5488. Following the study, this researcher will provide a debriefing along with the study conclusions and recommendations.

Assurance of Confidentiality

All data collected in this study will be kept confidential. Participant data will be assigned a code number and only the investigator will have access to that code number. No names will be used on any of the instruments other than the signed consent form. For purposes of reporting results, only group data or anonymous quotations will be used. No data will be used for any purpose except that expressly specified in the study.

Assurance of Voluntary Participation

Participation in this study is strictly voluntary. You have the right to withdraw participation at any time without penalty. You also have the right to refuse to respond to particular questions on any of the instruments without penalty.

Educational Benefits

The study may contribute to the improved effectiveness of inpatient chemical dependency treatment programs.

Availability of Results

Please check here if you wish to receive a written summary of the results of this study_____.

Informed and Voluntary Consent to Participate

I have been fully informed and consent to participate in the study outlined above. My right to decline to participate or to withdraw at any time has been guaranteed. A copy of this consent form is enclosed for you should you want one.

_____ _____

Volunteers Signature Date

Name_____ (Optional)

(Unless you want results)

Address_____

Phone Number_____

For Comments please forward them to:

Clifford W. Brooks, Jr.
2405 West Main Street
Richmond, Virginia 23220

Dear Inpatient Substance Abuse Counselor,

You have been identified as an expert in the treatment of chemical dependency. This letter is to invite your participation in this study. I am conducting research on the role of values in inpatient chemical dependency treatment as part of my Doctoral program in Counseling at The College of William and Mary.

My sample will consist of eighty (80) counselors, twelve of whom will be directly working in an inpatient facility, and one-hundred twenty (120) adult chemically dependent patients who will be staying two weeks or more in an inpatient treatment facility.

The client's participation will, of course, be confidential, and their contribution to the results of the study will be reported anonymously. This will also be true for your responses and involvement.

The initial commitment of time for you will be the reading of this letter and signing the willingness to participate form. You will then be asked to begin identifying ten (10) patients under your care who will be staying two weeks or more in your facility. You will be asked to administer ten (10) sealed pre-tests to your ten (10) patients at the beginning of two weeks and post-tests after two weeks. This means you will need to keep track of them with respect to the two week criteria. I have enclosed a roster to help streamline your task.

You will also be asked to fill out three instruments which I will provide you. This will take (45) minutes to complete all the instruments. When you are done, mail them in the stamped envelope provided within the next week.

I appreciate your help with this project knowing how busy you are already. Keep in mind you are among the first research participants examining values with respect to inpatient chemical dependency treatment. I will provide you with the results at the culmination of the research in a group format.

Again, your responses will be specially coded, and the responses will remain anonymous. Your patients' data will also be specially coded so as to ensure their confidentiality.

This study design has been approved by the School of Education Human Subjects Research Committee at The College of William and Mary and is intended to protect the rights of your patients.

My dissertation chair, Charles O. Matthews, Ph.D., and I are both Licensed Professional Counselors in the Commonwealth of Virginia and will be available to you and your clients for consultation should an emergency arise.

If you have further questions about the study, please feel free to contact the chair of my dissertation committee,

Charles O. Matthews, Ph.D., L.P.C.
Graduate School of Education
The College of William and Mary
Williamsburg, Virginia 23185
(804) 221-2340

I look forward to the results of this research. I will be glad to provide you with a copy of the results of the study, if you wish.

Sincerely,

Ford Brooks, Ed.S., CSAC, CAC
Licensed Professional Counselor
(804) 257-5488

Dear Patient Participant,

You have been asked to participate in this study of spiritual well-being. You will initially be asked to fill out a brief 20 question rating scale and an adaptation scale. At the end of two weeks you will be administered the same scales. You have the right to not participate and at any time during the study, if you wish not to participate, you may withdraw.

The purpose of this study is to gather ratings and responses concerning spiritual well-being. Your responses will be kept confidential and will be specially coded so that only this researcher will have the coding. If you wish to have results sent to you, please check that item on the consent form and fill in your address so the results can be sent to you.

I want to thank you in advance for your cooperation in this study. I only hope that your stay in this facility will help you live a continuous sober and clean life.

Peace be with you in your journey.

Sincerely,

Ford Brooks, Ed.S., CSAC, CAC
Licensed Professional Counselor

Patient Participant Consent Form

This consent form is to request your voluntary participation in dissertation research to be conducted in 1995 by Clifford Wilson Brooks, Jr. in partial fulfillment of the requirements for the Doctoral degree in Counseling at The College of William and Mary. Please read the following information carefully and sign the section marked "Informed and Voluntary Consent to Participate" if you are willing to participate in the study.

Purpose of the Study

The purpose of this study is to investigate spiritual well-being. Up until this point no research has attempted to examine spiritual well being with respect to substance abuse. The goal of this study is to provide information previously unavailable to substance abuse care providers about the importance of spiritual well-being.

Amount of Time Involved for Patients

Patients will be asked to fill out two pre-tests and two post-tests which in total may take ten (10) minutes each time. This will be over the course of two weeks. Two tests at the beginning and two at the end of two weeks. A summary of combined results of the study will be sent to participants who wish to receive copies.

Potential Risk

There are no potential risks in this study. The research does not involve any physical stress or psychological stress. The instruments are brief and non-invasive. There are no biomedical procedures or misleading information. This is an informed consent at which any time you may choose to discontinue in the study without any questions from this researcher or without any penalty. You also have the right to refuse to respond to any of the questions on the Spiritual Well Being Scale or the Profile of Adaptation To Life Clinical Scale without any penalty. If there are questions that come up for you during the study or following the study, you can contact me at (804) 257-5488.

Assurance of Confidentiality

All data collected in this study will be kept confidential. Participant data will be assigned a code number and only the investigator will have access to that code number. No names will be used on any of the instruments other than the signed consent form. For purposes of reporting results, only group data or anonymous quotations will be used. No data will be used for purposes except that expressly specified in the study.

Assurance of Voluntary Participation

Participation in this study is strictly voluntary. You have the right to withdraw participation at any time without penalty. You have the right to refuse any of the questions on the instrument without penalty.

Educational Benefits

The study will contribute to the importance of spiritual well-being in inpatient substance abuse care. The findings will also help contribute to normative data for each instrument used in the study.

Availability of Results

Please check here if you wish to receive a written summary of the results of this study _____.

Informed and Voluntary Consent to Participate

I have been fully informed and consent to participate in the study outlined above. My right to decline to participate or to withdraw at any time has been guaranteed. A copy of this consent form is enclosed for you should you want one.

_____ _____

Volunteers Signature - Date

_____ (Optional unless interested in results)

Name

_____

Address

_____

Phone Number

For Comments please forward them to:

Clifford W. Brooks, Jr.
Father Martin's Ashley
2405 West Main Street
Richmond, Virginia 23220

Substance Abuse Counselor Consent Form

This consent form is to request your voluntary participation in dissertation research to be conducted in 1995 by Clifford Wilson Brooks, Jr. in partial fulfillment of the requirements for the Doctoral degree in Counseling at The College of William and Mary. Please read the following information carefully and sign the section marked "Informed and Voluntary Consent to Participate" if you are willing to participate in the study.

Purpose of the Study

The purpose of this study is to research the impact of values on chemical dependency treatment programs.

Amount of Time Involved for Counselors

It will consist of reading this consent form and "Dear Counselor" letter plus completing three instruments. The total time is approximately thirty to forty minutes.

Potential Risk

There are no potential risks in this study. The research does not involve any physical stress or psychological stress. The instruments are brief and non-invasive. There are no biomedical procedures or misleading information. This is an informed consent in which you may choose to discontinue in the study anytime without any questions from this researcher or without any penalty. You may also, without penalty, refuse to respond to any of the questions on the instruments. If there are questions that come up for your during the study or following the study, you can contact me at (804) 257-5488.

Assurance of Confidentiality

All data collected in this study will be kept confidential. Participant data will be assigned a code number and only the investigator will have access to that code number. No names will be used on any of the instruments other than the signed consent. form. For purposes of reporting results, only group data or anonymous quotation will be used. No data will be used for any purpose except that expressly specified in the study.

Assurance of Voluntary Participation

Participation in this study is strictly volutary. You have the right to withdraw participation at any time without penalty.

Educational Benefits

The study may contribute to the improved effectiveness of chemical dependency treatment programs.

Availability of Results

Please check here is you wish to receive a written summary of the results of this study_____.

Informed and Voluntary Consent to Participate

I have been fully informed and consent to participate in the study outline above. My right to decline to participate or to withdraw at any time has been guaranteed. A copy of this consent form is enclosed for you should you want one.

_____ _____
Volunteer's Signature Date

Name_____(Optional)

Address_____

Phone Number_____

For Comments, please forward to:

Clifford W. Brooks, Jr.
Father Martin's Ashley
2405 West Main Street
Richmond, Virginia 23220

Dear Substance Abuse Counselor,

You have been randomly selected as an expert in the treatment of chemical dependency. This letter is to invite your participation in this study. I am conducting research on the role of values in chemical dependency treatment as part of my Doctoral program in Counseling at the College of William and Mary.

My sample will consist of eighty (80) counselors, twelve of whom will be directly working in an inpatient facility, and one-hundred twenty adult chemically dependent patients.

Your commitment of time will consist of reading this letter and the consent form along with filling out the three instruments. In total it may take up to forty minutes to complete.

I appreciate your help with this project knowing how busy you are already. Keep in mind you are among the first research participants examining values with respect to chemical dependency treatment. I will provide you with the results if you so desire at the culmination of the research.

Your responses will be coded and will remain anonymous. This study has been approved by the Human Subjects Research Committee at the College of William and Mary and is intended to protect your rights.

My Dissertation chair, Charles O. Matthews, Ph.D., and I are both Licensed Professional Counselors in the Commonwealth of Virginia and will be available to you for questions should they arise.

If you have further questions about the study, please feel free to contact the chair of my dissertation committee,

Charles O. Matthews, Ph.D., L.P.C.
School of Education
The College of William and Mary
Williamsburg, Virginia 23185
(804) 221-2340

I look forward to the results of this research and again thank you for your prompt response in making this research a reality. **Please complete the instruments and return them within the next two weeks in the enclosed stamped envelope. If you choose not to participate, please return the instruments in the envelope provided.**

Sincerely,

Ford Brooks,Ed.S., CSAC,CAC
Licensed Professional Counselor

APPENDIX C

SWB Scale

For each of the following statements circle the choice that best indicates the extent of your agreement or disagreement as it describes your personal experience:

SA = Strongly Agree
MA = Moderately Agree
A = Agree
D = Disagree
MD = Moderately Disagree
SD = Strongly Disagree

1. I don't find much satisfaction in private prayer with God. SA MA A D MD SD
2. I don't know who I am, where I came from, or where I am going. SA MA A D MD SD
3. I believe that God loves me and cares about me. SA MA A D MD SD
4. I feel that life is a positive experience. SA MA A D MD SD
5. I believe that God is impersonal and not interested in my daily situations. SA MA A D MD SD
6. I feel unsettled about my future. SA MA A D MD SD
7. I have a personally meaningful relationship with God. SA MA A D MD SD
8. I feel very fulfilled and satisfied with life. SA MA A D MD SD
9. I don't get much personal strength and support from my God. SA MA A D MD SD
10. I feel a sense of well-being about the direction my life is headed in. SA MA A D MD SD
11. I believe that God is concerned about my problems. SA MA A D MD SD
12. I don't enjoy much about life. SA MA A D MD SD
13. I don't have a personally satisfying relationship with God. SA MA A D MD SD
14. I feel good about my future. SA MA A D MD SD
15. My relationship with God helps me not to feel lonely. SA MA A D MD SD
16. I feel that life is full of conflict and unhappiness. SA MA A D MD SD
17. I feel most fulfilled when I'm in close communion with God. SA MA A D MD SD
18. Life doesn't have much meaning. SA MA A D MD SD
19. My relation with God contributes to my sense of well-being. SA MA A D MD SD
20. I believe there is some real purpose for my life. SA MA A D MD SD

VITA

Clifford W. Brooks, Jr.

Birthdate: August 22, 1961

Birthplace: Reading, Pennsylvania

Education:

1991-1996	The College of William and Mary Williamsburg, Virginia Doctor of Education
1987-1989	The College of William and Mary Williamsburg, Virginia Education Specialist
1983-1985	Virginia Commonwealth University Richmond, Virginia Master of Science
1979-1983	University of Richmond Richmond, Virginia Bachelor of Arts

Work Experience:

1995-1996	Private Practice Richmond, Virginia
1993-1995	Father Martin's Ashley Richmond, Virginia
1991-1993	New Dimensions Counseling Richmond, Virginia
1989-1991	St. John's Hospital Gootchland, Virginia
1985-1989	District 19 Alcohol and Drug Services Petersburg, Virginia