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ABSTRACT

The Use of Therapeutic Rituals in Substance Abuse Treatment

by

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This study explored the use of rituals in substance abuse counseling. Data were obtained from a total of 25 mental health workers in the substance abuse field from the northern region of Utah. Four research questions were asked about rituals and their use in substance abuse counseling: (1) Are addictions therapists using rituals? (2) How did therapists determine when to use rituals? (3) What types of rituals do they use? and (4) How do therapists assess ritual effectiveness? Results indicated that about three fourths of the mental health workers questioned were using rituals in their treatment protocol with substance abuse clients. The most common methods used for determining when to implement rituals into treatment were (a) clients were emotionally stuck, (b) client’s cognitive ability, and (c) therapist’s perception. The findings also suggested that therapists presented means of assessing the effectiveness of the rituals they implemented,
but the data also supported past literature findings that showed little empirical means of assessment.
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A ritual is a behavioral symbolic event with meaning that represents perceptions, emotion, and realities (Imber-Black, 1986). In the behavioral science literature, the importance of rituals has been established both theoretically and empirically. Rituals ranging from yearly community events to single symbolic events have been linked to improved relationship cohesiveness, individual growth, and healthy ways of coping. When used as therapeutic intervention, rituals have been used to help clients celebrate, grieve, make life transitions, move forward, and so forth.

This study examines use of rituals in therapy within the specific context of addictions. First, support for associating rituals with addictions comes from literature identifying rituals as a protective factor against effects of growing up in an alcoholic family (Bennett, Wolin, Reiss, & Teitelbaum, 1987; Fiese, 1993; Wolin, Bennett, & Noonan, 1979). Second, by nature, addiction is a ritualistic behavior. “Rituals accompany drug use, and are important elements in continued use, so much that to eliminate essential rituals can cause an addiction to lose its appeal” (Peele, 1985, p. 14). And third, addictive behaviors represent a way of adjusting to or coping with one’s environment, whereas rituals also offer a way to cope or adjust to one’s environment. There is evidence that individuals who use substances for coping are capable of changing their addiction by altering their cognitive and environmental circumstances (Peele, 1985). So if both addiction and rituals are ways of coping, defining the self, demonstrating one’s values, and increasing comfort, then it seems worthwhile to explore the development of rituals in the therapeutic process of addictions counseling.
Conceptual Framework

Symbolic interactionism is a theoretical framework that offers understanding of human interaction and communication. It is the "connection between symbols (shared meaning) and interactions (verbal and nonverbal actions and communications)" (LaRossa & Reitzes, 1993, p. 135) that explore how the cognition, affect, and behavior are used to create our symbolic realities.

Herbert Blumer (1969), an early and influential symbolic interactionism theorist, suggested that meaning largely influences behavior and how reality is defined. Using this approach, rituals can further be understood. Rituals are a behavioral representation of our thoughts and feelings. A wedding, for example, is a ritualistic event that symbolizes a couple's love, commitment, and devotion for each other. Blumer further stated that individuals constantly and actively reform, shape, and revise meanings when stimuli are interpreted. Rituals also reshape how individuals see themselves in terms of families and society (Laird, 1984; van der Hart, 1983). Some rituals even change as life changes throughout the life cycle, for example, graduations, anniversaries, and holiday celebrations.

Symbolic interactionism is built on three main assumptions to describe human behavior (Blumer, 1969). First, meaning is an important factor in determining behavior. Individuals act towards objects based on the meanings the objects have for them (Blumer, 1969; LaRossa & Reitzes, 1993). Rituals have been described as a safe way of expressing our emotions, or the meanings placed on relationships or events (Imber-Black & Roberts, 1992). The second assumption suggests that people develop a sense of self through interaction with others. Rituals provide a sense of identity in relation to family,
society, and ourselves (Fiese, 1992). And the final assumption suggests that sense of self develops through personal feelings and interpretation of how others feel about us (Blumer, 1969).

Understanding the symbolic interaction framework provides insight into how rituals are used in society. Symbolic interactionism suggests that people behave based on the meaning that events or situations have for them. Participation in ritual behavior is based on meanings given to relationships and events. Rituals are the symbolic behavioral act of displaying interpretations of reality. And in terms of addiction, ritualistic use of substances are used as methods of coping with an individual’s perception of the world.

Statement of Purpose

Although there are many articles and books about rituals, there remains a lack empirical research on how and why rituals are used in therapy. The ritual research tends to be focused on correlation with convenience samples. In most empirical studies a ritual inventory is correlated with another variable, such as rituals and alcohol transference (Fiese, 1992, 1993; Wolin, Bennet, Noonan, & Teitelbaum, 1980) and rituals and relationship satisfaction and cohesion (Berg-Cross, Daniels, & Carr, 1992; Bruess & Pearson, 1997; Fiese, Hooker, Kotary, & Schwagler, 1993). The rest of the research remains more qualitative in nature, giving a case by case description of successful ritual outcomes. There is a lack of empirical research on how rituals are prescribed in a therapy session, the impact of actually performing the ritual, and how the therapist determines if the rituals were successful or not. There is research supporting the notion that rituals facilitate personal and relationship progress as well as therapeutic progress. Research
shows their importance and gives some empirical backing, but the present study goes further to investigate how and why ritual prescriptions are used in therapy.

To somewhat narrow the vast area of rituals, the examination of their prescriptions will be viewed in the context of addictions counseling due to the ritualistic behavior of addiction and the correlational studies connecting rituals and substance abuse. The purpose of this study is to set the stage and preliminary steps to further empirical ritual and addiction research. This study explores whether or not substance abuse therapists, in outpatient mental health facilities, are using rituals, why, and how they are using them. The purpose of this study is to answer the following questions: (1) Are substance abuse counselors using rituals? (2) How do therapists determine when to use rituals? (3) What type of rituals do they use? (4) How do therapists assess the effectiveness of rituals?
CHAPTER II
LITERATURE REVIEW

This chapter provides a definition of rituals and gives a general perspective of their purpose. How rituals have been used in therapy is also examined as well as their association with client progress. Finally, the specific treatment focus is on addiction to substances, so this literature also is briefly reviewed.

Rituals

“A ritual is a symbolic form of communication that is acted out in a systematic fashion over time” (Wolin & Bennett, 1984, emphasis in original). Others have described rituals as a behavioral method of communicating thoughts and perceptions about personal world views and the people in it (Bossard & Boll, 1950; Laird, 1984). The symbolic act provides a safe and routinized way of expressing our emotions or beliefs. Rituals help us say goodbye, celebrate the new, celebrate beliefs, grieve, make transitions, maintain or improve, unite, renew, define relationships and healing trauma’s or losses (Imber-Black & Roberts, 1992; van der Hart, 1983). “Rituals have the capacity of holding multiple points of view, providing support and containment for intense emotions, while facilitating social coordination among individuals, family members, and community going through transition” (Roberts, 1988, p. 19).

Shipman (1982) specified three types of rituals: periodic rituals, seasonal/recreational rituals, and strategic rituals. Periodic rituals happen once a year, once a month, or once a week and include occasions such as holidays, birthdays, and Sunday brunch. Seasonal/recreational rituals include activities such as a particular
hunting season, sporting events, and vacations. Shipman described these rituals as helping to develop certain physical and cognitive skills for individual growth and learning. The third type of ritual, strategic rituals, are those that happen when the situation calls for it. Strategic rituals include bed-time rituals, kissing children's wounds when they get hurt, or mealtime rituals. Shipman (1982) concluded his article by emphasizing how rituals help in self-growth and give the opportunity to express the self in creative ways, as well as sharing feelings of compassion, empathy, and affection.

Therapeutic rituals are different from the above-mentioned types of rituals, in that therapeutic rituals do not necessarily involve everyday events or historical events accumulated over the years. Therapeutic rituals center more on creating new meanings for clients by either experiencing new situations or reevaluating situations within a different context (Roberts, 1988). The literature indicates that rituals can be useful in the therapeutic process by creating a new perspective, creating a new experience, or providing a safe way of communicating thoughts and feelings (Hecker & Schindler, 1994; Imber-Black, 1988; Imber-Black & Roberts, 1992; Laird, 1984; van der Hart, 1983). In family therapy literature, there is support for positive associations between participation in rituals and relationship cohesiveness, satisfaction, and unity (Berg-Cross et al., 1992; Fiese et al., 1993); identity, sense of belonging, and clear boundaries (Fiese, 1992; Wolin & Bennet, 1984). Rituals designate family and individual roles, functions, rules, and boundaries. Rituals provide structure and help define how individuals and families think about their world (Bossard & Boll, 1950; Laird, 1984).

The findings of these studies suggest that rituals serve a protective function to buffer against family and individual problems. Rituals facilitate individual and family
growth, as well as emotional stability and identity. Rituals are a way of expressing a multiplicity of emotions in a safe way.

Empirical Studies in Rituals

The majority of ritual-related research is based on definitions and case studies theorizing about the influence of rituals. Of the studies that do offer empirical evidence, their findings offer further consideration for implementation of rituals in a therapeutic setting. Berg-Cross et al. (1992) evaluated the relationship between rituals and marital success or failure. A sample of married couples and divorced individuals were given the ritual questionnaires, which explored type of rituals used and rated level of importance of their rituals. The study found that those in long term marriages participated in more rituals with significant meaning attached to them. In contrast the divorced individuals reported fewer overall rituals or rituals with significant meaning in their previous marriages. Fiese et al. (1993) used Wolin and Bennett's (1984) family ritual interview to create their own family ritual questionnaire. Using a sample of married couples, they found an association between rituals and marital satisfaction; couples with meaning-filled rituals scored higher on a marital satisfaction scale than those without meaning-filled rituals.

Bruess and Pearson (1997) studied ritual usage in different relationships, namely, marriages and adult friendships. Results indicated that rituals were important in maintaining both marriages and friendships. They found that both types of relationships had similar types of interactions, yet different rituals were used to maintain unique relationships. Marriage relationships tend to rely on more daily rituals and involve more
intimate rituals, whereas friendship rituals are not as intimate and do not require as much time to carry out.

In other areas of research, Fiese and Kline (1993) found a relationship between rituals and adolescent identity. They found rituals to be positively associated with self-esteem and negatively associated with anxiety. Fiese (1992) found a positive relationship between growing up with meaning-filled rituals and adolescent personal identity. Several studies (Bennett et al., 1987; Fiese, 1993; Wolin et al., 1980) offer empirical evidence of negative associations between ritual use and lower alcohol transference (the passing of alcoholism from one generation to the next) in alcoholic families. The results from these studies suggest that rituals act as a buffer against alcohol transference. These particular studies will be discussed further in the review.

These areas of empirical research show the significance and usefulness of rituals with particular variables, however, they do not tell us how rituals have been helpful in a therapeutic situation. Wolin and Bennett (1984) have suggested that understanding ritual use in families could help in understanding how a family operates overall, particularly in times of stress. However, existing research still lacks an emphasis on empirical understanding of how rituals are used in prescribed therapeutic situations. Little empirical data exists on how and why rituals work in therapy and their tested outcomes.

Use of Rituals in Therapy

Literature on therapeutic rituals facilitates understanding of how and why rituals are used in therapy. Rituals used in therapy are different from ordinary assigned tasks mainly due to their symbolism and deeper meaning (Shamai, 1995). The difference between rituals and tasks is that rituals focus not only on behavior change, but also
encompass cognitive and affective levels of change as well (Imber-Black, 1988). They
are a way of nonverbally creating new meanings, helping individuals feel similar to
others, while at the same time creating unique differences. Imber-Black (1988)
suggested that rituals can be therapeutic in three areas, including life cycle transitions,
healing, and redefining identity. Transitional rituals are used in therapy to change the
structure of relationships, while providing aspects of continuity and aspects of change
(van der Hart, 1983). Healing rituals have three common elements: affect:
acknowledging pain and loss; cognitive: vacillating between holding on and letting go;
and behavior: performing a symbolic action of finality. An example of this is given by

Alice ended a several year relationship with a boyfriend she lived with off and on.
When it ended her friends and family were glad to see it end and didn’t seem to
offer much support to Alice. For two years she isolated herself more and couldn’t
seem to get over the break up. As depression increased she went to see a
therapist. The therapist discussed loss and grief and assigned Alice a task to
facilitate her grief. For one hour a day she should review old memories of the
relationship and nothing else. She then was to write down these memories on
separate pieces of paper and bring into session. Therapy then focused on each
card and their meanings. After a while Alice decided an hour was too much time
to devote to thinking about the relationship. She then was instructed to sort the
cards between those she wanted to keep and those she felt she could get rid of.
They then discussed what parts of the relationship were good that she would carry
into another relationship, and those that she would get rid of forever. When she
began talking about the future, the therapist and Alice burned the cards (or aspects of the relationship) that she was finished with.

The above example used three rituals to facilitate healing. The first ritual, reviewing old memories for an hour a day, was designed to acknowledge the grief. The therapist directed the client through the affect process first to validate the pain she was experiencing. In the second ritual, the client was instructed to write down memories on cards, then separate them into piles of memories to keep and memories to discard. This ritual involved the cognitive aspect, that of weighing the choices between holding on or letting go. And the third ritual, burning the discarded cards, was the behavioral act symbolizing that she had completed grieving about some aspects of the former relationship and was ready to move on and redefine her identity.

Other “letting go” rituals have been symbolized by writing letters, freezing, or flushing items of significance such as rings, clothing, pictures, and other memories to help people move beyond their feelings of being stuck in grief (Whiting, 1988). “Symbolic action in therapeutic healing rituals often mirrors that which occurs in normative healing rituals, such as burning and burying” (Imber-Black, 1988, p. 159).

Identity rituals focus on relabeling or setting new roles (Roberts, 1988). Often the purpose of prescribed rituals in therapy is to provide clients with a different framework (van der Hart, 1983) or alternative view from which to believe and act. An example of an identity ritual, “positive labeling,” puts the described complaint or symptom into a new perspective. The clients not only talk about or theorize about their new perspective but they act on it. “In prescribing a ritual it is only assumed that the road
to improvement consists of the following steps: a cognitive change, then a change in behavior that subsequently leads to a change in feelings” (van der Hart, 1983, p. 192).

Rituals have been used in therapy to alter interaction patterns and rules that sustain dysfunction (Selvini-Palazzoli, Boscolo, Cecchin, & Prata, 1978). Laird (1984) gave an example of a boundary-setting ritual for an enmeshed single parent and her two daughters. The daughters missed a lot of school because of staying up all night keeping their depressed mother company, then sleeping during class. The therapist gave them a ritual assignment to carry out at home. First, the mom would send the girls to their room at 9:30 and bring them a snack. For the second part of the ritual, the three of them were instructed to spend the next 20 minutes together talking. For the third step, after the together time, the mother was to have her own “special” hour to herself without interruption from the girls. The ritual was used to maintain alliances, set appropriate rules, and at the same time alter the family structure.

Rituals are also used when breaking up symptomatic behavior, or behaviors that suggest dysfunction in a family system (Brown & Christensen, 1986; Wolin & Bennet, 1984). Selvini-Palazzoli et al. (1978) introduced the odd-even day ritual when dealing with symptomatic behavior. With a child who experienced problematic symptoms due to a mother and father’s conflict in parenting, for example, the parents were instructed to perform the odd-even day ritual. On the even days of the week the father was to make all the parenting decisions, while on the odd days of the week the mother was to make all the parenting decisions. This ritual was prescribed to interrupt the rigid sequence (Nichols & Schwartz, 1991), to change the unspoken rules without the therapist voicing direction (Stanton, 1981), to prevent possible resistance to being given a direct instruction, to
prevent competition between the parents for the therapist's approval (Selvini-Palazzoli et al., 1978), and to prevent resistance to change (Seltzer & Seltzer, 1983). A ritual is “by its nature, more apt than words to unite the participants in a powerful collective experience, to introduce some basic ideas to be shared by everyone” (Selvini-Palazzoli, Boscolo, Cecchin, & Prata, 1977, p. 452).

Rituals are also used in therapy to destroy myths, hidden themes, or secrets that are engulfed in the family’s culture (Seltzer & Seltzer, 1983; Selvini-Palazzoli et al., 1978; Stanton, 1981). In therapy, a ritual engages members in a different way, it lets them experience something different rather than being told how their secrets or myths are interfering with their development. Seltzer and Seltzer (1983) gave the example of a mother whose culture expected her to be and do everything possible for her demanding daughters after their father died. The expectations were so strong that the family could not progress developmentally. The therapist, seeing the hardship that the myth was causing the mother, prescribed a ritual that began by giving the daughters materials to make a mask that would symbolically represent their family’s dilemma. The daughters envisioned the problem as their mother being a witch, and made a witch mask for the mother. The mother was to wear the mask in session, but at home was to act as if she was still wearing the mask. After participating in the mask ritual for a while, the mother realized she was human and lowered her expectations of herself, and at the same time the daughters felt tired of pretending their mother was a witch. The ritual brought out in the open the “inhumane” treatment the mother was getting from her daughters and herself. The cultural belief was exposed through participation in the ritual and did not need to be verbalized.
Hecker and Schindler (1994) built a case for use of rituals in therapy, emphasizing the point that therapists do not understand how rituals fit within family therapy models. They designed an in-session ritual assessment that combined ritual typology and the Circumplex Model. With this combination they provide therapists a way to integrate rituals into their practice of family therapy. While there is much literature on how rituals are used in therapy, there are few articles that explore and test how rituals are used in therapy.

Rituals Summary

The research discussed provides a clearer idea of how rituals have been used in therapy, but only in individual case studies. Specific empirical research is lacking to show how rituals are effective, their levels of effectiveness in the treatment of clients, empirical testing of prescription outcome, or even if everyday therapists are using them in their practice. Research shows that rituals are associated with relationship satisfaction and cohesiveness, identity, and that therapists have used rituals in their practice, but it is still unclear how they work in the therapeutic setting. Other researchers have developed ways of assessing rituals for families in therapy, but questions still remain about how they help. In order to examine these questions further, the current study narrowed the focus of rituals to a particular field of study, addictions counseling. In the empirical data on rituals, research has indicated that rituals provide a buffering effect against the difficulties of growing up in an alcoholic family. Because of this research and new ways of looking at addictions, rituals were examined in the context of therapy with drug and alcohol abuse.
Addiction

For years therapists and researchers have viewed addiction as a disease state, stating that addicts are victims and are forever addicts and powerless to overcome the illness (Thombs, 1999). Yet others believe this view takes away responsibility and accountability from the addicts’ actions (Milkman & Schaffer, 1985). Alternative theories have emerged, moving away from the disease/victim stance, and moving towards giving addicts full responsibility, placing them in complete control of their cravings and their recovery (Peele, 1985). It should be noted that the authors who advocate a social model of addiction as a contrast to the disease model did much of their work 15-20 years ago. The ideas were not widely accepted then but have generated promising new treatment models (Berg & Miller, 1992). Those who support alternative theories have stated that addiction is more a matter of subjective experience and a cognitive choice (Berg & Miller, 1992; Heather, Rollnick, & Winton, 1983; Peele & Brodsky, 1972).

Researchers emphasize that beliefs and expectancies are what influence the initial and continual use of addictive behavior (Brown, Goldman, Inn, & Anderson, 1980). Peele (1985) stated that experience maintains the use rather than the actual substance, further suggesting that individuals are quite capable of altering their cognition and environmental circumstances in order to redirect their urges. He gave the example of heroin users in recovery, finding that they preferred an injectable heroin substitute over a non-injectable heroin substitute, placing more value on the experience. The ritual associated with injection usage was just as important as the fix from the drug (Roman, Pinto, & Gay, 1973). Addiction is not simply a biological condition, but is “no different from all other human feelings and action in being subject to social and cognitive influences” (Peele,
Life style, emotional fulfillment, peer acceptance, and values are all reasons that begin and maintain addiction.

Addictions are used to satisfy aspects of life that the individuals cannot fill themselves (Peele, 1995). Skolnick (1979) suggested addiction is viewed as a relief or solution for pain, anxiety, and emotional losses. “All addictions accomplish something for the addict…. They are ways of coping with feelings and situations with which addicts cannot otherwise cope” (Peele, 1995, p. 146). Addiction is a way of adjusting to one’s environment, filling a need or a void. Even withdrawal symptoms cannot be completely explained by physiological reasons, but are increasingly explained as emotional stress (Skolnick, 1979) and as needs involving a person’s identity, beliefs, or social connectedness (Peele, 1985). When people participate in an addictive activity (e.g., drugs, gambling, or sex), they are trying to gain a specific effect and an affective goal. Addicts often believe the activity will make them something they are not: more assertive, more sexy, brave, or possessing some sort of power (Ellis & Velten, 1992). These desired effects turn coping mechanisms into destructive habitual behaviors because they are believed to dissipate the unwanted discomfort.

Studies of those who experiment with substances, but who do not become addicted, support the concept that addicts do have control (Peele & Brodsky, 1972). Individuals who use substances but do not become addicted have too many other valuable things that were not worth the risk of continual or habitual use. Addicts actively chose the timing, the setting, and the reaction of returning to the addictive behavior (Peele, 1995). Not only are the time and place calculated, but level of drug or alcohol use to reach a desired effect is also quite calculated. “Abusive substances do not hop into your
mouth, nose, or veins. Instead you choose to think about the positive feelings or relief you expect to get from them. You think about what you like to think about and do what you insist on doing: avoid pain and feel good” (Ellis & Velton, 1992, p. 130). Cognition leads to an affect, and affect leads to the substance abuse behavior (Pita, 1992); in other words a cognitive path of choice occurs in the decision process.

Liddle and Dakof (1995) have examined the use of family therapy and its role in recovery from addiction. Their research identified family therapy as an effective approach in the reduction of adolescent substance abuse. While they described few long term findings, they found no support that family therapy would not help in substance abuse reduction. Edwards and Steinglass (1995) also gave examples of research that support the use family therapy in addiction counseling. They found that although the research designs were weak and limited, family therapy would be appropriate for treatment in most cases.

With addiction viewed as a choice to fulfill needs or to reach a particular affective state, one might be able to see a similarity between reasons for addiction and reasons for using rituals. With this information and the development of using family therapy to treat addiction, the current study will examine addictions in the light of rituals and ritual behavior.

Rituals and Addiction/Drugs and Alcohol

Rappaport (1971) outlined six key aspects of rituals that are summed up by Roberts (1988). A ritual is (a) repetitive in content, form, and action; (b) action: a ritual is in the form of doing something active, (c) special or stylized behavior: it is more than the typical, mundane usage; (d) order: there is a start and a finish, with little room for
spontaneity; (e) evocative presentational style: there is a plan to get to a certain state of mind, and (f) collective dimension: a societal meaning is present (Shamai, 1995). Due to the ritualistic nature of drug usage, understanding the basic aspects of rituals can further our understanding of addiction. For example, addictions are (a) repetitive: by nature addictive drug use is a repeated behavior; (b) action: it is a physical act of gathering the substance, setting and choosing the environment, and partaking of the substance; (c) special behavior or stylization: the behavior is used to reach a specialized feeling or state of being that is not normally experienced by the individual; (d) order: the person begins with a focus on the desired outcome and ends with the altered state of mind; (e) evocative presentational style: the main reason for the use is to alter uncomfortable affect or situations that the individual chooses as a coping method. They are seeking to fulfill what they are missing in themselves that they cannot seem to find elsewhere; (f) collective dimensions: the social meaning is to be something they are not, to achieve a different image in society's eyes and/or their own eyes (Roberts, 1988; Shamai, 1995).

The process is an active approach of reaching a particular affective state and ridding themselves of undesirable feelings. So, if addiction can be viewed in terms of rituals and as ritualistic, then possibly rituals could be examined in the facilitation of addictions therapy.

Alcoholics Anonymous, or AA, uses ritualistic concepts and behaviors in their quest for sobriety: "Rituals of drinking are replaced with rituals that support sobriety" (Laird, 1984, p. 128). AA uses several rituals, mainly that of the "Twelve Steps." These 12 steps are ritualistic in the sense that the addict must repeat them regularly and participate in activities that symbolically represent a readiness for change. The steps
include: turning their life over to God, admitting and accepting one’s faults, taking responsibility for mistakes made towards others, and improving relationships with God and telling others about these same ideas (Pita, 1992).

Family therapy frameworks, such as strategic family therapy, often prescribe the use of rituals to “alter family structure” and increase healthy interactions (Stanton, 1981). This idea is supported in research that focuses on the effects of rituals in alcoholic families. For example, Wolin et al. (1979) studied the relationship between family rituals and alcohol transmission over family generations. Three family types were distinguished. Family type #1 ignored the alcoholic parent’s conduct during times of rituals and insisted on the parent’s involvement. Alcoholic interruptions of rituals occurred less frequently in this family type, and the “passing on” of alcoholism also occurred less frequently. In family type #2, rituals persisted while the alcoholic parent was present. The family members tried to ignore or “reject” the behavior, but simultaneously held strong resentment towards the alcoholic’s interference and low participation in the rituals. Family type #2 had higher alcoholic incidents than family type #1. Generations of type #2 families passed on the alcoholic trait more often than type #1 families. However, type #2 families passed on fewer alcoholic dependencies than family type #3. Family type #3 is characterized by major disruptions in family rituals by the alcoholic parent. The parent’s alcoholic behavior occurred more often and parental uninvolvment was more accepted by family members. Due to continual ritual interruption, family type #3 was more disturbed and affected by the alcoholism. The transmission of the alcoholic trait was more likely to be passed on in the type #3 family.
They concluded that rituals are linked to lower alcoholic abuse transference (Wolin et al.).

Transmission of alcohol addiction to the child is more prevalent in families where dinners, holidays, and celebrations are interrupted by heavy periods of parental drinking (Wolin et al., 1980). Wolin et al. (1980) also found that in families in which alcoholism was passed on to the next generation, the alcoholic parent’s participation in rituals changed from being involved to much less involvement. In families where alcoholism is not transmitted, there was little change in parental involvement in rituals, and drinking was kept somewhat separate from the ritualized event (Wolin et al.). Bennett et al. (1987) supported the idea that keeping alcoholism away from family rituals helps to keep stability in families and decreases chances of transmission of alcoholism. They also found that children of alcoholics who marry a spouse whose family has highly ritualized events will be less susceptible to alcoholism.

Fiese (1993) measured the relationship between alcoholic families and rituals, finding that alcoholic families had fewer rituals and less significance attached to what few rituals they did have. Adolescents in these families exhibited higher levels of anxiety and symptomatic disturbances. Hawkins’ (1997) research gives support for rituals as a stabilizing and protective factor against psychopathology in children of alcoholics. These findings suggested that family rituals and daily routines may account as a buffer for children of alcoholic parents. Since research suggests that rituals facilitate stability and lower transmission of alcohol in alcoholic families, there seems to be a basis for further research in using rituals in a therapeutic setting when counseling substance abusers.
Addictions Summary

Literature reveals that rituals are helpful in times of grief, transition, celebration, and sharing emotion. They help define roles in families and social groups, bring about greater relationships and identity, and help cope with life’s transitions. Therapists have theorized and given case examples of the effectiveness of rituals in therapy. Some research gives empirical support for the importance of family rituals, particularly in studies of alcoholism, where rituals serve as a buffer from the effects of alcoholic transmission in alcoholic families. As one looks at alcoholism and drug abuse, a ritualistic pattern of symbolism emerges. Addiction serves as a coping mechanism for the inability to deal with emotion, and is no different from any other feeling or environmental influence. So if addiction is a matter of coping and adjusting to one’s environment, and rituals are used to transition, adjust, and cope, then it seems appropriate that rituals could be further studied as an approach to use in substance abuse counseling.

In this study rituals are viewed as a potential source of personal and relational growth. Investigators previously have explored theorized ritual importance, empirical support for ritual use, and how rituals have been used in a therapeutic setting. But still there is little understanding of how rituals work in therapy, and there is a lack of empirical support of the process of prescribing rituals all the way to testing their effect on outcomes. In light of the alternative views on addiction, and the connection of addiction being a ritualistic behavior, in this study the use of rituals will be investigated in the context of addiction. In this exploratory study the usage of rituals in addictions counseling is examined. This study will allow the following research questions to be explored: (1) Are addictions therapists using rituals? (2) How do therapists determine
when to use rituals? (3) What type of rituals do they use? (4) How do therapists assess the effectiveness of rituals?
CHAPTER III

METHODS

Design

This was an exploratory study. Exploratory designs are done when researchers are not able to state specific hypotheses about the links between variables (Miller, 1986) or is unable to anticipate how participants will respond to a wide variety of answers (Dillman, 1978). Exploratory studies are also done to see if more in-depth studies are possible and needed (Miller, 1986).

Sample

The sample included outpatient substance abuse counselors from various mental health agencies in Northern Utah. Professional counselors at the following agencies agreed to participate: New Choices (Logan, Utah, \( n = 14 \)), Weber Human Services (Ogden, Utah, \( n = 6 \)), Columbia Ogden Regional Medical Center (Ogden, Utah, \( n = 4 \)), Davis Mental Health (Bountiful, Utah, \( n = 25 \)), and Valley Mental Health (Salt Lake

Table 1

Demographic Summary of Sample

<table>
<thead>
<tr>
<th>Demographic</th>
<th>Male (n = 11)</th>
<th>Female (n = 14)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>M  SD</td>
<td>M  SD</td>
</tr>
<tr>
<td>Age</td>
<td>44  7.14</td>
<td>46  6.24</td>
</tr>
<tr>
<td>Years in practice</td>
<td>11.7  7.30</td>
<td>15  6.37</td>
</tr>
</tbody>
</table>
City, Utah, n = 14). Table 1 shows that participants' average age was in their middle 40s, and that they had been professional counselors for about 12-15 years, on average. The sample included therapists from a variety of disciplines: social work, psychology, and marriage and family therapy (see Table 2). The education levels ranged from bachelor degrees to Ph.D. Therapists in a variety of disciplines reported a variety of theoretical

Table 2

Practice Characteristics of Counselors in the Sample (N = 25)

<table>
<thead>
<tr>
<th>Variable</th>
<th>Male (n = 11)</th>
<th>Female (n = 14)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>n</td>
<td>%</td>
</tr>
<tr>
<td>Education</td>
<td></td>
<td></td>
</tr>
<tr>
<td>LSAC</td>
<td>3</td>
<td>27</td>
</tr>
<tr>
<td>B.S.</td>
<td>2</td>
<td>18</td>
</tr>
<tr>
<td>MS</td>
<td>4</td>
<td>36</td>
</tr>
<tr>
<td>PH.D</td>
<td>1</td>
<td>9</td>
</tr>
<tr>
<td>Psy D.</td>
<td>1</td>
<td>9</td>
</tr>
<tr>
<td>Other</td>
<td>--</td>
<td>--</td>
</tr>
<tr>
<td>Discipline</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Social work</td>
<td>5</td>
<td>45</td>
</tr>
<tr>
<td>Psychology</td>
<td>4</td>
<td>36</td>
</tr>
<tr>
<td>Marriage &amp; family therapy</td>
<td>--</td>
<td>--</td>
</tr>
<tr>
<td>Other</td>
<td>--</td>
<td>--</td>
</tr>
<tr>
<td>Substance abuse</td>
<td>2</td>
<td>18</td>
</tr>
<tr>
<td>Theoretical model</td>
<td></td>
<td></td>
</tr>
<tr>
<td>12 Step</td>
<td>3</td>
<td>27</td>
</tr>
<tr>
<td>Psychodynamic</td>
<td>2</td>
<td>18</td>
</tr>
<tr>
<td>Substance abuse</td>
<td>1</td>
<td>9</td>
</tr>
<tr>
<td>Eclectic</td>
<td>1</td>
<td>9</td>
</tr>
<tr>
<td>Behavioral</td>
<td>1</td>
<td>9</td>
</tr>
<tr>
<td>Glasser</td>
<td>1</td>
<td>9</td>
</tr>
<tr>
<td>Cognitive/Behavioral</td>
<td>1</td>
<td>9</td>
</tr>
<tr>
<td>Brief therapy</td>
<td>--</td>
<td>--</td>
</tr>
<tr>
<td>No response</td>
<td>1</td>
<td>9</td>
</tr>
</tbody>
</table>
models in which they practiced from with the most common being the 12 step program, psychodynamic, and an eclectic approach.

Procedure

Supervisors were called and asked for permission to have questionnaires sent to their therapists. Upon agreement, a letter was sent to supervisors of each agency explaining the purpose and process of the study (see Appendix A) along with the questionnaire packets (see Appendix B). Packets given to each therapist included: an informed consent form conveying approval from the IRB (see Appendix A), a demographic sheet, an instrument (see Appendix B), and a self-addressed, stamped envelope. Therapists were asked to mail back their responses to the student researcher. When possible, the student researcher met with therapists in their staff meeting and gave the questionnaires, allowing for any questions to be answered. All agencies were sent a follow-up letter to each participant, about one-two weeks after the initial questionnaire was given, to remind them to return the questionnaire. After the reminder note, a second questionnaire was distributed to the therapists, in case the initial questionnaire was misplaced or lost. Of the 63 questionnaires sent out, a total of 25 responded (40% response rate). Human subjects approval was obtained from Utah State University (see Appendix A).

Measurement

A demographic sheet accompanied the questionnaire that consisted of four research questions with qualifying questions for each area of interest. The questionnaire consisted of open-ended questions. Open-ended questions are often used in exploratory
research to allow participants to express themselves without restriction and with more detail (Dillman, 1978). The purpose of an exploratory study is to obtain data that will be used to formulate a hypothesis for future research. In order to gain more insight and develop hypotheses, open-ended questions were used to allow for a larger variety of answers and/or explanation. Participants were instructed to write out their responses in paragraph form. Participants were asked to indicate their area of discipline.

At the beginning of each questionnaire a definition of rituals was given so therapists understood the context of the questionnaire. The first research question ("Are addictions therapists using rituals?") was addressed with the following question: A. "How often do you use rituals (percentage of clients and percentage of sessions)?" The second research question ("How do therapists determine when to use rituals?") was addressed with the following questions: A. "Please list the criteria you use when determining when to use rituals with clients" B. "Under what circumstances would you be most likely to use rituals?" The third research question ("What type of rituals do you use?") was addressed by: A. "Please list specific rituals you commonly use in therapy." The final research question ("How do therapists assess for effectiveness of rituals?") was explored by the following question: A. "How do you assess how effective your prescribed rituals have been?" The questionnaire concluded with an overall question: "Is there anything else you would like to say regarding your use of rituals in your therapy?"
CHAPTER IV
RESULTS

The purpose of this study was to explore and understand if and how therapists who treat alcohol and drug abusers use rituals in their treatment protocols. This section discusses the major findings of the study based on the four research questions presented earlier.

Therapists Using Rituals with Drug and Alcohol Clients

The intent of the first research question was to determine the extent to which substance abuse therapists use rituals in their treatment of clients. Tables 3 and 4 show that a large portion of the therapists sampled do use rituals in their treatment. Table 3 shows that therapists report that they use rituals in about one of every five sessions (17%). They also report that they use rituals with one third of their clients. Using rituals appears to occur in select situations with specific types of clients. Table 4 shows the raw number of rituals used by the therapists in their treatment protocols.

Table 3
Percentage of Therapists Who Report Use of Rituals in Substance Abuse Treatment

<table>
<thead>
<tr>
<th>Variable</th>
<th>Range</th>
<th>M</th>
<th>SD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Percentage of sessions</td>
<td>1-95</td>
<td>17</td>
<td>4.10</td>
</tr>
<tr>
<td>Percentage of clients</td>
<td>0-100</td>
<td>33</td>
<td>5.70</td>
</tr>
</tbody>
</table>
Table 4

Frequency of Rituals Used in Therapists' Treatment Protocols.

<table>
<thead>
<tr>
<th>Number of rituals used</th>
<th>Frequency</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>7</td>
<td>28</td>
</tr>
<tr>
<td>1</td>
<td>2</td>
<td>8</td>
</tr>
<tr>
<td>2</td>
<td>2</td>
<td>8</td>
</tr>
<tr>
<td>3</td>
<td>2</td>
<td>8</td>
</tr>
<tr>
<td>4</td>
<td>4</td>
<td>16</td>
</tr>
<tr>
<td>5</td>
<td>1</td>
<td>4</td>
</tr>
<tr>
<td>6</td>
<td>3</td>
<td>12</td>
</tr>
<tr>
<td>7</td>
<td>2</td>
<td>8</td>
</tr>
<tr>
<td>8</td>
<td>1</td>
<td>4</td>
</tr>
<tr>
<td>9</td>
<td>1</td>
<td>4</td>
</tr>
</tbody>
</table>

Of the 25 respondents, seven report that they did not use any rituals. Of those respondents who stated they did not use rituals, commonalties in demographic backgrounds were examined. Three of the seven (42%) who did not use rituals received their training as clinical psychologists. In the total survey, there were only four psychologists, of which three reported they did not use rituals. Each of these three psychologists had been in practice for over 15 years. By contrast, the psychologist who reported using rituals had only been practicing for 3 years. The other two therapists who reported they did not use rituals were social workers. These two social workers also had been in practice for a relatively long time, 10 and 27 years, respectively.

Of the seven therapists who reported using no rituals, five had been in practice for 20 or more years. The other two had been in practice for 10-15 years. Those who were reported as not using rituals had a mean of 20.5 years of practicing, versus those who did
report using one or more rituals in therapy had a mean of 10.8 years in the mental health field.

The results show that in this small sample, 18 of the 25 therapists working with drug and alcohol clients used rituals as part of their treatment. Least likely to use rituals were psychologists, as well as those therapists who had been in practice for a greater number of years.

Determining When to Use Rituals

The intent of the second research question was to explore how therapists determine when to use rituals. Tables 5 and 6 give explanations of how therapists decide when to use rituals (Table 5) and under what circumstances therapists are most likely to implement rituals in their treatment (Table 6). Responses are similar for both tables with a difference of two categories.

Table 5 depicts the criteria therapists use when determining when to use rituals in their treatment with drug and alcohol clients. Although therapists gave more than just

Table 5

<table>
<thead>
<tr>
<th>Criteria used</th>
<th>Frequency</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Stuck (no progress in treatment)</td>
<td>6</td>
<td>24</td>
</tr>
<tr>
<td>Client’s cognitive level</td>
<td>5</td>
<td>20</td>
</tr>
<tr>
<td>Therapist’s perception</td>
<td>5</td>
<td>20</td>
</tr>
<tr>
<td>No response</td>
<td>4</td>
<td>16</td>
</tr>
<tr>
<td>Always use rituals</td>
<td>3</td>
<td>12</td>
</tr>
<tr>
<td>Never use rituals</td>
<td>2</td>
<td>08</td>
</tr>
</tbody>
</table>
one answer, their responses were examined based on observed patterns in the therapists’ responses. Four respondents did not answer this question. Two additional therapists reported that they never use rituals. Of the remaining 16 responses there were three clear groupings of criteria: stuck, therapist’s perception, and client cognition.

Six of therapists reported responses that were grouped into a category relating to the idea of being stuck or having some sort of an impasse in therapy. The key element related to lack of treatment progress. This included comments related to no progress in treatment after 3 months, other interventions had failed, client was on the verge of change but could not actually do it, or the therapists felt they “weren’t getting through” to the client.

In the second category, five therapists emphasized their perception of the client, rather than their lack of progress. Examples of these comments related to client openness, following through on assignments and general perceptions of compliance. Five other therapists referred to client’s cognition. This included elements such as “client is very concrete in their thinking,” “client is open-minded,” and cognitive ability or IQ.

It appears that these therapists used clinical criteria for deciding when to use rituals. Although two of the therapists claimed to never use rituals, 18 did use rituals and had criteria in mind for determining when to use them. Their criteria included: client is stuck, client’s cognitive ability, therapists perception of the situation, and some use them in all situations.

Table 6 depicts the particular circumstances where therapists would most likely implement rituals into their treatment with drug and alcohol clients. The patterns of responses were collapsed into categories shown. The categories of no response, never
Table 6

Circumstances When Therapists Are Most Likely to Use Rituals

<table>
<thead>
<tr>
<th>Type of circumstance</th>
<th>Frequency</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Emotionally stuck</td>
<td>10</td>
<td>40</td>
</tr>
<tr>
<td>Client’s cognitive ability</td>
<td>5</td>
<td>20</td>
</tr>
<tr>
<td>To replace behaviors</td>
<td>4</td>
<td>16</td>
</tr>
<tr>
<td>No response</td>
<td>3</td>
<td>12</td>
</tr>
<tr>
<td>Never use rituals</td>
<td>3</td>
<td>12</td>
</tr>
</tbody>
</table>

use rituals, client’s cognitive ability, and emotionally stuck are the same as in Table 5. The difference with Table 6 is that the category of replacing old behaviors was added and the category of therapist’s perception was dropped.

Three respondents did not answer this question. Three additional therapists reported that they do not use rituals. Of the remaining 19 responses, there were three clear groupings of criteria. The first grouping of responses related to the ideas of being emotionally stuck or having an impasse in therapy; this answer was given by 10 of the 25 therapists as being the time they would use rituals. This included circumstances related to unresolved feelings, saying goodbye, relapse, unable to let go, and being stuck on particular issues.

The second category related to client’s cognitive ability. This category included circumstances related to a client’s concrete thinking, client thinking about doing certain things, incorporating what the client has thought, client is ready or that the client was more feeling than logical.

The final category related to replacing old behaviors. This included circumstances related to: using a different response pattern, creating structure to promote
consistency in daily functioning, install positive rituals such as exercise, reading, meetings, and so forth, to replace avoidance behaviors, and comments such as replacing old behaviors with positive changes.

Of the 19 therapists who reported using rituals, seven reported that the circumstance they most likely use rituals is when clients are emotionally stuck. It is these situations where the client maintains unresolved emotions or is unable to move forward. Twenty percent of the therapists reported the circumstance they are most likely to use rituals is dependent on their client’s cognitive ability. Four of the therapists use rituals when they want to approach replacing an old behavior. These respondents reported that they used rituals when a new pattern or restructuring was necessary.

In addition to having methods of deciding when to use rituals, therapists used particular situations or circumstances to facilitate the decision. It appears that therapists go through a method of assessment to determine implementation of rituals. The most common, or highest reported circumstance to indicate a time to use rituals is when the client is emotionally stuck.

Types of Rituals Used

The third research question was to determine what types of rituals drug and alcohol therapists reported using. Table 7 displays the variety of types of rituals used by the therapists and frequencies of each ritual used. Thirty-five different rituals were reported by the therapists. The particular rituals used most often were no-send letters,
Table 7

Frequency of Types of Rituals Used

<table>
<thead>
<tr>
<th>Type of ritual</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>No send letters</td>
<td>16</td>
</tr>
<tr>
<td>Destruction of item (burning, flushing, burying)</td>
<td>14</td>
</tr>
<tr>
<td>Daily interaction</td>
<td>7</td>
</tr>
<tr>
<td>Positive affirmation</td>
<td>6</td>
</tr>
<tr>
<td>Imagery/desensitization</td>
<td>5</td>
</tr>
<tr>
<td>Make/create memorials</td>
<td>5</td>
</tr>
<tr>
<td>Poetry/drawing</td>
<td>4</td>
</tr>
<tr>
<td>Phone call/visit</td>
<td>3</td>
</tr>
<tr>
<td>None</td>
<td>3</td>
</tr>
<tr>
<td>Dear John letter to drugs</td>
<td>2</td>
</tr>
<tr>
<td>Want ad for higher power</td>
<td>2</td>
</tr>
<tr>
<td>Planting a tree</td>
<td>2</td>
</tr>
<tr>
<td>Journal</td>
<td>2</td>
</tr>
<tr>
<td>History book</td>
<td>2</td>
</tr>
<tr>
<td>Thinking errors</td>
<td>2</td>
</tr>
<tr>
<td>Transition ceremony</td>
<td>2</td>
</tr>
<tr>
<td>Stone throwing</td>
<td>2</td>
</tr>
<tr>
<td>Identify self as addict</td>
<td>1</td>
</tr>
<tr>
<td>Role play</td>
<td>1</td>
</tr>
<tr>
<td>Balloon</td>
<td>1</td>
</tr>
<tr>
<td>Holidays</td>
<td>1</td>
</tr>
<tr>
<td>Poster (&quot;stuff of my being&quot;)</td>
<td>1</td>
</tr>
<tr>
<td>Prayer</td>
<td>1</td>
</tr>
<tr>
<td>Step work</td>
<td>1</td>
</tr>
<tr>
<td>Attend meetings</td>
<td>1</td>
</tr>
<tr>
<td>Restructure emotional response</td>
<td>1</td>
</tr>
<tr>
<td>Instill hope</td>
<td>1</td>
</tr>
<tr>
<td>Empty chair</td>
<td>1</td>
</tr>
<tr>
<td>Celebrate sad occasions</td>
<td>1</td>
</tr>
<tr>
<td>Declaration of independence</td>
<td>1</td>
</tr>
<tr>
<td>Awareness of bigger picture</td>
<td>1</td>
</tr>
<tr>
<td>Scream into pillow</td>
<td>1</td>
</tr>
<tr>
<td>Homework</td>
<td>1</td>
</tr>
<tr>
<td>Go on a trip</td>
<td>1</td>
</tr>
<tr>
<td>Religious holiday</td>
<td>1</td>
</tr>
<tr>
<td>Make new friend</td>
<td>1</td>
</tr>
</tbody>
</table>
destruction of items, daily interactions, positive affirmations, imagery/desensitization, and creating memorials.

The 27 different ritual types were collapsed into smaller categories relating to emotional catharsis, mental process, increase in structure, and homework. Seven of the remaining rituals listed were not placed in any category, due to not enough information regarding the therapist's intent of use of the ritual. These seven uncategorized answers included transition ceremony, stone throwing, balloon, holidays, celebrate sad occasions, scream into pillow, religious holiday, and instill hope.

The category of emotional catharsis relates to rituals that help break or work through stuck emotions through some sort of artistic method. Some examples are creating memorials, poetry, drawing, and role playing. The category of mental process refers to altering the client's thoughts or mental state in some way. Some examples of this type of ritual include imagery, desensitization, thinking error, and so forth. The category of increase structure included rituals that add more to a schedule and leave less time for destructive behaviors. Examples include attending meetings, step work, prayer, and so forth. The final category of homework involves rituals that require work outside the therapeutic setting. Examples that relate to this are planting a tree, going on a trip, making a new friend, and so forth.

Therapists appear to use a wide variety of rituals in their treatment strategies with drug and alcohol clients. The most common rituals are those associated with emotional catharsis, especially that of writing letters or destroying significant items. While there are several different categories and many different types of individual rituals, they all seem to be implemented for the improvement of the client's condition.
Assessment of Ritual Effectiveness

The intent of the final research question was to determine if therapists had a way to assess the effectiveness of the rituals they assigned to their clients. Table 8 shows six categories of assessment. As with the other questions, four respondents did not answer the question. Two additional therapists reported “no,” that they did not assess the effectiveness of rituals. Of the remaining 19 responses, there were four clear groupings of assessment approaches.

Table 8
Frequency of Ritual Assessment Type

<table>
<thead>
<tr>
<th>Assessment type</th>
<th>Frequency</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Client report</td>
<td>6</td>
<td>24</td>
</tr>
<tr>
<td>Therapist's judgment</td>
<td>5</td>
<td>20</td>
</tr>
<tr>
<td>Observed improvement</td>
<td>5</td>
<td>20</td>
</tr>
<tr>
<td>Follow through</td>
<td>3</td>
<td>12</td>
</tr>
<tr>
<td>No response</td>
<td>4</td>
<td>16</td>
</tr>
<tr>
<td>None</td>
<td>2</td>
<td>08</td>
</tr>
</tbody>
</table>

The first grouping of responses related to client report of a client’s progress. The key element focuses on client response or report. This included comments referring to feedback from patients, client report after treatment, and clients reporting ability to move on.

The second pattern of responses related to therapist’s judgment. In this category therapists reported they assessed rituals through methods of common sense, discussions, and the overall direction of therapy. One therapist responded with “always” on
assessment, but did not provide information on how he/she actually did it. Responses in
the category were quite vague.

The third grouping of responses related to the ideas of there being some observed
improvement in the client’s progress. This included statements such as a shift in
emotional state and interactions, reduction of relapse, and behavior change increase. The
key elements were related to treatment progress and shifts.

The last grouping of responses related to follow through, with the key element
being the client’s willingness to try the prescribed ritual. This included comments related
to putting the talk into walk, follow through and adding pieces, and so forth.

Of the therapists who use rituals and reported having a method to assess their
effectiveness, six used the client’s report as their only criteria. Five reported they used
observed improvement in their client to assess ritual effectiveness. This group judged
success of their ritual prescription by noticing reduction of relapses, change in behavior,
or shifts in their emotional state. Another five reported using their own judgment to
determine the success of a ritual prescription. This group reported using common sense,
observation, or looking at overall direction of therapy. And finally, three reported that they judged the effectiveness of a ritual by the client’s follow through on the assigned
task.

It appears that therapists do have ways of assessing the effectiveness of the rituals
they prescribe to their clients. The most common way of assessment is that of client
report.
General Observations

The final section of the questionnaire gave therapists a chance to respond on anything else they wanted to say concerning rituals. Only 11 of the therapists chose to write in this section. Five of the 11 therapists made comments that expressed the importance of rituals, but at the same time expressed the importance of respecting the client's own creativity, suggestions, and/or comfort level with the ritual. This grouping related to comments such as "there is a tremendous strength in using rituals," "it can introduce clients to techniques they can use on their own," and "when a patient has mentioned using a ritual before, it opens the door to using this as a tool, the atmosphere should be conducive to promote expected outcomes."

Four of the 11 commented on having some sort of problem or concern with using rituals. Their concerns were either of dislike of rituals or guilt for not using them appropriately. Comments relating to this category included: "I probably should use more of these interventions.,” "I was not trained in ritual use and have no great affection for them," and "if I could find a better way to monitor them I would probably use rituals."

The remaining two responses centered on helping the client recognize his/her pattern of destructive rituals and replacing them with healthier rituals. Comments in this category related to: understanding that all substance abuse individuals have their own using rituals and assisting clients in recognizing their ritual (cycle of addiction) opens the door for beginning a new ritual or regime; and people get caught in using rituals or relapse cycles--one important part of therapy is to identify these patterns and replace the old rituals or patterns with new ones.
Results from this sample suggest that some therapists in the drug and alcohol field use rituals in the treatment of clients. These findings are consistent with the existing literature found on rituals and addiction (Laird, 1984; Peele 1985, 1995; Shamai, 1995). The literature indicates that addictions counselors have been using methods from 12-step programs to replace drinking rituals with more healthy rituals (Laird, 1984).

In the field of marriage and family therapy, ritual use in the therapeutic process has existed for many years (Selvini-Palazzoli, Boscolo, Cecchin, & Prata, 1977; van der Hart, 1983). The Milan group used ritualized prescriptions to alter interactions (Stanton, 1981), while some types of paradoxes have been used since the 1960s and 1970s (Haley, 1987; Stanton, 1981). While rituals have been discussed for quite some time, literature on their use in treatment has only focused on rituals for about the last 12 years (Imber-Black, Roberts, & Whiting, 1988). The study of rituals comes from family science tradition and has been incorporated into MFT for many years. Imber-Black et al. (1988) edited what is considered the seminal discussion on rituals. Since that time the use of rituals in therapy has become more widespread in all mental health treatment professions.

It seems that some therapists are using rituals in addictions counseling. Those that are not using rituals in their treatment plans have been in practice longer than those therapists who do use rituals. This makes sense as rituals and their uses have not been in the general literature of treatment options until the last 10-15 years. In addition, most of
the literature on rituals comes from the marriage and family therapy and social work journals. Thus it appears that psychologists and therapists practicing for longer periods of time are less likely to use rituals. This raises concern that practicing therapists may not be keeping up with treatment literature or pursuing continuing education once they leave graduate school.

Determining When to Use Rituals

Not only is it important to understand what therapists do in therapy, but it also is important to understand why and how they decide to use the methods they use. The general format of therapy consists of clinicians gathering information, developing a hypothesis, and then making decisions about their client’s treatment (Turk, Salovey, & Prentice, 1988). Treatment plans are based on the therapist’s training and theoretical model, therapeutic experiences, intuition, and common sense (Garb, 1998). After the primary assessment, therapists are given new information from their tested hypotheses and observations of the client. The hope is that they will use this new information to alter and improve treatment plans for their clients (Turk et al., 1988). Based on the results of the present study, there is some evidence that clinicians are doing this.

In the current study it was found that in addition to using rituals, therapists used clinical criteria for determining when to implement rituals in their treatment. The most common reason given for using rituals was when a client was stuck, or stopped in treatment progress or emotional progress. If a client is unable to move past grief, relapsing, or is on the verge of change, some therapists responded by implementing some type of ritual. It is not surprising that “being stuck” was the most common reason for
deciding to use rituals, because much of the literature discusses the use of rituals in moving beyond feelings of being stuck (Imber-Black, 1988).

Therapists also seemed to decide on ritual implementation based on the client’s cognitive ability, or the client’s ability to comprehend or not. Literature suggests that rituals can be used to create an experience that is easier than giving a direct instruction (Selvini-Palazzoli et al., 1978; Stanton, 1981). This supports the findings that therapists use rituals depending on a client’s ability.

Therapists also used their own perception as a way of deciding when to implement ritual use. Therapists gauged the clients’ readiness for rituals by their follow through with other therapeutic assignments. And lastly, therapists used rituals in situations where a particular behavior needed to be replaced with a healthier behavior. Replacement of an old, unhealthy behavior suggested to therapists that ritual implementation was necessary. This too matches the literature stating that rituals are useful in interrupting patterns (Selvini-Palazzoli et al., 1978) and in breaking up dysfunctional behaviors (Wolin & Bennett, 1984).

The majority of the responses supported Hecker and Schindler’s (1994) findings that few therapists based their decision directly on relating to a particular theory or model. It is possible that they indirectly used their theories to aid their decision in ritual use but no specific references were indicated.

Therapists seemed to make their clinical decisions of implementing rituals based on the clinical situation and not necessarily theory. The situations in which therapists were most likely to assign rituals occur when a client’s progress was stuck and there was an impasse in therapy. Therapists also implemented rituals in treatment based on the
client's cognitive ability, their own perception of client readiness, and the need to replace destructive behaviors with healthier behaviors.

Types of Rituals Used

Therapists reported using a wide variety of rituals in their treatment with drug and alcohol abusing clients. The variety of rituals comes from the diversity of clients and their individual issues. In addition to evolving issues adding to ritual diversity, a large part is played by the variety of the therapists' theoretical backgrounds (Whiting, 1988).

The most common rituals used in this study were methods of dealing with the emotional needs of the client, rather than changing or altering behaviors. The two most common rituals used were letter writing and destruction of an item of significance. These rituals are often used in treatment for healing and moving past events that have kept clients from progressing to a better life. The rationale for such rituals is to represent letting go of past pain, memories, grudges, hurts, and so forth, and symbolizes ending the past to move forward (Whiting). The current study supports the literature that suggests addiction is a way of coping with these above-mentioned feelings (Peele, 1995) as suggested by the rituals the therapists are prescribing to their clients.

The 35 rituals mentioned by therapists were placed into four categories: emotional catharsis, mental process, increase in structure, and homework. The emotional catharsis category represents artistic rituals that help facilitate the healing process and encourages moving forward. These types of rituals are quite helpful, as addiction is viewed as a way of coping with difficult emotions. The mental process category represents rituals that facilitate a change in thinking patterns or altering cognition in some way. Literature
supports the use of these rituals, suggesting that addiction is a cognitive choice, and that individuals are capable of altering their cognition in order to redirect their urges (Peele, 1985).

The third and fourth categories, increase structure and homework, deal with behavior-changing rituals. These healthy rituals are prescribed to replace destructive patterns of behavior. The use of this type of ritual is supported in the literature, which states that positive rituals facilitate lower levels of alcohol transmission (Wolin et al., 1979; Wolin et al., 1980).

Substance abuse therapists used a variety of different rituals. The most common rituals used were those that help with the healing process and move the client beyond emotional stagnation. Therapists also prescribed rituals that helped replace cognition and behaviors that maintained addiction.

Assessment of Ritual Effectiveness

About 75% of therapists reporting using rituals, and the same percentage reported using a method of assessing the ritual’s effectiveness. The most common method of ritual assessment was based on how the client described the outcome of the ritual experience. Therapists also described their assessment tools as their own perception, basing the ritual’s effectiveness on common sense, or how they observed the situation. Other therapists reported that assessment was based on the client’s improvement or lack of relapse. Some therapists determined effectiveness purely on client’s follow through, rather than on how the ritual affected them.
While therapists in the current study had ways of assessing ritual effectiveness, their methods lacked measurable detail and tended to be quite vague. This would support the literature findings that assessments do occur, but there continues to be a lack of empirical methods to directly assess the effects of prescribed rituals on clients (Hecker & Schindler, 1994). Literature on ritual assessment has suggested using reflexive questions to assess current family rituals or observations and documentation in the therapy setting (Roberts, 1988). Others suggest assessment of ritual use through clinical observation (Wolin & Bennett, 1984). There is even an empirical assessment typology that determines a family's level of ritualization within a theoretical framework (Hecker & Schindler, 1994). Yet there is clearly a lack of measurable and empirical tools for assessing the outcome of prescribed rituals in therapy, particularly in addiction cases. This is consistent with the philosophy expressed by many therapists, that therapy is an art and not conducive to outcome studies (Miller, Duncan, & Hubble, 1997). This is historically true of the fields of marriage and family therapy and social work (Pinsof & Wynne, 1995).

Therapists do have methods of assessing the rituals prescribed to clients. These methods are mainly based on client report, therapist's perception of the outcome, client improvement or lack thereof, and client follow through. Responses were based on clinical observational methods.

Most therapists did use rituals, but for most there was not a systematic way to assess, prescribe, or evaluate their use. Most therapists gave value to the use of rituals but did not provide theory behind their implementation. While little consistency was
found between the different types of rituals used in the area of substance abuse, there are commonalities in circumstances when they are used.

Limitations of the Study

The major limitation of this study was the small and unrepresentative sample size. Such a small sample makes the results difficult to claim high levels of stability or accuracy. In addition to size, the sample was not representative of substance abuse counselors. The number of disciplines was limited, with the majority of participants being social workers. This poses a problem in that the results cannot be generalized to all mental health professionals. It also limited the information we could have received, especially from fields that are more strongly introduced to rituals, such as marriage and family therapists.

Recommendations

Future research on this subject is much needed, especially to increase the empirical findings on rituals in therapy. First of all researchers should use larger samples with a wider diversity of practitioners. Future investigators may want to focus on the purpose behind the rituals and why therapists are using the rituals they use. Along the same lines, emphasis should be placed on defining theory and how this affects a therapist’s decision to implement rituals.

More research on how rituals are being used in therapy is needed. As this is done, further research can investigate empirical tests on the effectiveness of rituals. Better assessment tools are needed, both for implementation and assessment of effectiveness.
More focus is needed on the effectiveness of rituals with substance abuse clients, how they work, and how well or not they work. These types of studies can help facilitate the better use of rituals and give alternative treatment for substance abuse clients.
REFERENCES


APPENDICES
Appendix A. Letters
MEMORANDUM

TO: Scot Allgood
    Becky Thomas

FROM: True Rubal, IRB Administrator

SUBJECT: Ritual Use in Substance Abuse

Your proposal has been reviewed by the Institutional Review Board and is approved under exemption #2.

× There is no more than minimal risk to the subjects.
   There is greater than minimal risk to the subjects.

This approval applies only to the proposal currently on file. Any change affecting human subjects must be approved by the Board prior to implementation. All approved proposals are subject to continuing review at least annually, which may include the examination of records connected with the project. Injuries or any unanticipated problems involving risk to subjects or to others must be reported immediately to the Chair of the Institutional Review Board.

Prior to involving human subjects, properly executed informed consent must be obtained from each subject or from an authorized representative, and documentation of informed consent must be kept on file for at least three years after the project ends. Each subject must be furnished with a copy of the informed consent document for their personal records.

The research activities listed below are exempt from IRB review based on the Department of Health and Human Services (DHHS) regulations for the protection of human research subjects, 45 CFR Part 46, as amended to include provisions of the Federal Policy for the Protection of Human Subjects, June 18, 1991.

2. Research involving the use of educational tests (cognitive, diagnostic, aptitude, achievement), survey procedures, interview procedures or observation of public behavior, unless: (a) information obtained is recorded in such a manner that human subjects can be identified, directly or through the identifiers linked to the subjects; and (b) any disclosure of human subjects' responses outside the research could reasonably place the subjects at risk of criminal or civil liability or be damaging to the subjects' financial standing, employability, or reputation.
Rituals have emerged as an important aspect of therapeutic progress and growth. Despite the significance of rituals within the therapeutic process, relatively little empirical research has been done on how rituals are used in therapy. Much of the rituals literature focuses on theory or case-by-case examples, rather than giving empirical support for how they work and how they are used. This study will examine the use of rituals in substance abuse counseling. Questionnaires will be given to supervisors, then handed to participating therapists, who will then mail the demographics sheet and questionnaire, in a pre self-addressed and stamped envelope, back to the student researcher.

Your participation is voluntary and you can choose to withdraw at any time. Deciding not to participate will not have any negative consequences. However, in order for the results to represent substance abuse counselors, it is important that each questionnaire be completed and returned. The information you provide will be used to better understand how rituals are used in therapy.

You may be assured of complete confidentiality. Please do not put your name on the questionnaire unless you agree to be interviewed further on your responses. Agency name is asked for mailing purposes only. The questionnaires will be kept in a locked facility, where only Becky Thomas and Dr. Allgood will have access to the information contained in the questionnaires. The questionnaire will be kept on file for the duration of the research project and will be destroyed upon completion. Returning the questionnaire will constitute your informed consent, The Institutional Review Board for the protection of human subjects of Utah State University has reviewed and approved this research project.

Your contribution to this effort is greatly appreciated. If you would like a summary of results, please print your name and address on the back of the return envelope not on the questionnaire. We will see that this gets to you. We would be happy to answer any questions you might have. This is part of a masters thesis project and you are welcome to contact either one of us. Becky can be reached by phone at (801) 544-1890. Scot Allgood can be reached by email at allgood@cc.usu.edu or by phone at (435) 753-5895.

Thank you for your assistance.

Sincerely,

Becky L. Thomas
Student Researcher

Scot M. Allgood, Ph.D.
Associate Professor

MFT Program, Family Life Center
Phone: (435) 753-2632
Fax: (435) 753-0371
Appendix B. Questionnaire
RITUALS AND ADDICTION

QUESTIONNAIRE

For purposes of this study a ritual is defined as: A prescribed behavior used to accomplish specific means; it is symbolic representation of beliefs and emotions. In therapy, rituals are used for purposes of creating new meanings, transitions, grieving, healing, coping, and defining identity. Examples of grieving rituals in therapy are: memorials, writing letters, freezing, or flushing items of significance such as rings, clothing, pictures, or any other memory. Examples of healing rituals: planting a tree, burning or burying items of emotional significance. Based on these definitions, please answer the questions as completely and elaborately as possible.

1. How often do you use rituals in therapy?
   - Percentage of sessions? _______________________
   - Percentage of clients? _______________________

2. Please list the criteria you use to determine when to use rituals with clients.

3. Under what circumstances would you be most likely to use rituals (what reasons or situations)?
4. Please list specific rituals you commonly use in therapy?

5. How do you assess how effective your prescribed rituals have been?

6. Is there anything else you would like to say regarding your use of rituals in your therapy?

If you would be willing to be interviewed so we can follow up on some of these ideas please leave your name and phone number on this form. __________________________