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Beliefs of Board Certified Substance Abuse Counselors Regarding Selected Multiple Relationship Issues

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BELIEFS OF BOARD CERTIFIED SUBSTANCE ABUSE COUNSELORS REGARDING SELECTED MULTIPLE RELATIONSHIP ISSUES

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DEDICATION

I would like to dedicate this work to the Glory of God. I hope my work can always be a reflection of his.

To my husband, Dan Hollander who loves me and helps me grow more each day. You are my berserk. To a long good life.

To the generations of my family: Kenney, Schrock, Johnson, and Matthews. This degree is for all of you who had the capability to succeed in education, but did not have the opportunity. This doctorate is for us all.

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ABSTRACT

The purpose of this study was to increase understanding of beliefs of substance abuse counselors regarding multiple relationships. The association between beliefs and the variables of educational level, recovery status, experience, and supervision were explored.

Purposeful sampling and multiple criteria were used to select seven states of the 31 that responded to a request for information regarding licensure or certification in their state. Participants were chosen from the following seven states: Arizona, Illinois, Maine, Maryland (D.C.), Montana, North Carolina, and Wyoming. Twenty percent (20 %) of individuals from each of the seven states were selected to participate. Random sampling was utilized to select participants from each of the seven mailing lists. Participants were mailed a cover letter, demographic questionnaire, and a researcher-developed instrument entitled the Multiple Relationship Survey for Substance Abuse Counselors (MRS SAC). Of the 765 surveys that were assumed to have been delivered, 387 usable surveys were returned for a return rate of 50.6%.

Results of the study showed that two variables were indicative of a lower total score on the MRS SAC, which indicated participants viewed more items as ethically problematic. Non-recovering individuals obtained a lower total score on the MRS SAC and individuals currently receiving supervision obtained a lower total score.

This indicated non-recovering individuals and individuals receiving supervision found more multiple relationship behaviors to be ethically problematic than recovering individuals and individuals not receiving supervision. Highest degree obtained, experience prior to licensure, and supervision prior to licensure were not associated with lower total scores on the MRS SAC indicating these factors did not contribute to beliefs regarding multiple relationship behaviors. The results of this study have implications for substance abuse counselors, counselor educators, and national and state certification boards. Recommendations for further research were offered.

CHAPTER ONE

INTRODUCTION

This chapter will provide the introduction, conceptual framework, and importance of the study. The purpose of the study will be explained and limitations, delimitations, and assumptions of the study will be discussed. Definitions of important terms will be provided.

Background

In 2001, an estimated 16.6 million people in the United States were diagnosed with substance dependence (National Household Survey on Drug Abuse, 2002). The National Institute on Drug Abuse estimates the economic cost of illegal drug abuse is close to $161 billion (National Institute on Drug Abuse, 2002). Alcohol and drug abuse continue to have a negative affect on society through higher levels of unemployment, suicide, homicide, costs to industry, and additional costs to health care (Atwood & Chester, 1995). Substance abuse counselors are professionals at the forefront of treatment in this costly problem.

Among the issues experienced on a regular basis by all practicing mental health professionals are those concerning ethical practice. Although all counselors strive to practice in an ethical manner, different types of counselors are exposed to differing ethical issues. An ethical issue that has been extensively studied, has

generated controversy in the mental health professions, and is frequently cited as a concern of counselors, is multiple relationships (Pope & Vetter, 1992). Multiple relationships occur whenever a mental health professional has another, significantly different relationship with a help seeker (Remley & Herlihy, 2001). Multiple relationships involve violations of the therapeutic boundary. Addicted individuals seeking treatment are often characterized by maladaptive behaviors and difficulty with boundaries (Atwood & Chester, 1995). Many substance abuse counselors are themselves in recovery, which compounds the problems of boundary setting and multiple relationships within the substance abuse counseling context. Ethical concerns include the potential for counselors in recovery to encounter clients in the 12-step community, former clients becoming colleagues, and relapse potential for the counselor.

Although substance abuse counseling is a facet of mental health counseling, substance abuse counselors often encounter additional dilemmas related to recovery status, educational levels, supervision, and experience. Problems, especially those related to multiple relationships, are inherent in the substance abuse field and contribute substantially to the ethical dilemmas that a substance abuse counselor may face. It is difficult, however, to determine the extent to which these factors may influence the ethical beliefs of substance abuse counselors.

Several similarities emerge when substance abuse counseling is compared to mental health counseling. Mental health counselors work with a variety of clients from different socioeconomic and ethnic backgrounds who present with a wide range of concerns. Substance abuse counselors also work with diverse clientele, as

substance abuse affects all socioeconomic and ethnic backgrounds (Toriello, 1998). Mental health counselors and substance abuse counselors are employed in similar settings including hospitals, intensive outpatient treatment centers, and private practice. Ethical dilemmas are a common difficulty experienced in all treatment settings for all mental health professionals, including substance abuse counselors.

Substance abuse counseling differs in several ways from the general field of mental health counseling. Substance abuse counselors may come from a variety of backgrounds including social work, psychology, criminal justice, and counseling. Unlike other mental health professionals, substance abuse counseling professionals may have a degree in an unrelated field that does not require specific coursework in ethics (West, Mustaine, & Wyrick, 1999). This may contribute to a lack of knowledge related to ethics for some substance abuse counselors.

Another difference between substance abuse counseling and other types of mental health counseling is a lack of standardized requirements for becoming a substance abuse counselor. This may include variations in educational requirements (Page & Bailey, 1995). Generally, in the field of mental health counseling, specific standards have been implemented nationally to ensure competency. Practicing mental health counselors are master's-degreed clinicians who have passed a national exam and have completed a minimum number of supervised (post-master's degree) clinical hours.

In contrast, the process for credentialing substance abuse counselors varies by state. Some states provide a license to professionals who meet the requirements and other states provide certification. Credentialing involves varying levels of education,

experience and supervision within the field of substance abuse counseling. In some states, a bachelor's degree is required; other states require only a high school diploma or General Education Diploma (GED). Some states also utilize a tiered system based on education and experience to differentiate between beginning-level and advanced-level clinicians. These educational differences can lead to a lack of standard coursework or preparation in ethics (Dove, 1995). Without standardization of requirements to be certified or licensed, it is difficult to determine how much information substance abuse counselors receive related to ethics.

Another difference between substance abuse counseling and other types of professional counseling is the increased opportunity for substance abuse counselors to have interaction with clients outside of the therapy session (Doyle, 1997). Substance abuse counselors may also be asked to engage in multiple roles (e.g., counselor and liaison between treatment and incarceration).

The recovery status of a substance abuse counselor can contribute to ethical dilemmas. Multiple relationship concerns may be compounded by the counselor's previous personal experience as a client (being in recovery from abusing substances) and lack of formal preparation (Culbreth, 2000). This can create ethical dilemmas for the counselor in recovery on a number of levels. If a counselor is maintaining recovery through 12-step meetings in the community, encountering clients outside the therapeutic setting is likely at times, especially in rural areas. By contrast, mental health counselors rarely have the experience of incidental encounters with clients while seeking their own treatment.

Purpose of the Study

The purpose of this study was to increase understanding of beliefs of substance abuse counselors regarding multiple relationships. The relationship between beliefs and the variables of educational level, recovery status, experience, and supervision were explored. Board Certified Substance Abuse Counselors (BCSACs) in seven states across the United States were surveyed. Purposeful, proportional, random sampling was utilized. States with a large number of substance abuse counselors were selected to increase the number of potential participants. Random sampling was utilized to select participants from mailing lists purchased or obtained from seven states.

Research Question

The following research question was examined: What is the relationship of educational level, recovery status, experience, and supervision to beliefs regarding the ethics of selected multiple relationship issues among selected Board Certified Substance Abuse Counselors? This study examined how the variables of educational level, recovery status, experience, and supervision may relate to beliefs about multiple relationships among substance abuse counselors.

Conceptual Framework

The conceptual framework for this study was based on the boundaries that form the counseling relationship. For the purpose of this study, boundary was defined as a protective border that surrounds the therapeutic relationship and defines roles for

the counselor and client. Boundaries serve to protect the client who is vulnerable in the process of counseling and help define participants' roles in the helping relationship (Remley & Herlihy, 2001).

Boundaries provide the counselor with safe parameters within which to practice. Ethical issues often surround the areas of therapeutic boundaries and multiple relationships (Remley & Herlihy, 2001). There is considerable debate among counselors regarding the value of boundaries (Sonne, 1994; St. Germaine, 1993) and appropriateness of avoiding multiple relationships (Tomm, 1993; Zur, 2002).

Multiple relationships include sexual and non-sexual relationships with clients. Sexual relationships involve physical contact between a mental health professional and a current or former client. Non-sexual relationships include friendships, bartering, and other forms of social relationships. The potential harm to clients from sexual and non-sexual relationships has been discussed extensively (Pipes, 1997; Rinella & Gerstein, 1994; Smith, 1999; Smith & Fitzpatrick, 1995). The study examined non-sexual boundaries primarily, including bartering, gift giving, social relationships, and business or financial relationships.

Factors related to the counseling relationship and situational circumstances play an important role in how ethical dilemmas are viewed. Herlihy and Corey (1997) discussed factors that contribute to the complexity of multiple relationship dilemmas. "They are problematic for a number of reasons including that they can be difficult to recognize; they can be very harmful, but not in every instance; they are the subject of conflicting views; and they are not always avoidable" (Herlihy & Corey, 1997, p. 4). This study examined the beliefs of substance abuse counselors related to multiple

relationships and conflicting ethical situations faced by substance abuse counselors. Items were designed to assess the beliefs of participants regarding multiple relationship ethical dilemmas.

Importance of the Study

This study has implications for policy and practice in the field of substance abuse. This study provided the opportunity for an extensive review of state requirements across the nation while increasing awareness related to the diversity of minimum qualifications necessary to become a substance abuse counselor. Lack of standardization of requirements by state governing boards contributes to fluctuation in the quality of services provided to clients (West, Mustaine, & Wyrick, 1999). Services received by substance-abusing clientele may vary considerably based on the state where services are rendered. Lack of uniformity raises the question of whether the services received by clients of all socioeconomic and racial backgrounds, regardless of the state where they reside, is of adequate quality (S.E. Loftin, personal communication, June 11, 2003).

The results of this research might also be utilized to influence practice in the counseling field. Counselor educators, armed with increased knowledge of the factors that contribute to ethical beliefs, can address concerns that may influence ethical behavior. Education related to ethics decreases the potential of harm to clients and increases the opportunity for rapid recovery. Ethical behavior of practitioners also leads to more efficient services and less litigation by clients, thereby increasing cost effectiveness (S.E. Loftin, personal communication, June 11, 2003).

Results of the proposed research study may also increase awareness of ethical dilemmas experienced by substance abuse counselors. Increased awareness can lead to policy changes related to ethical codes of conduct on national and state levels to reflect dilemmas commonly experienced by practitioners.

Overview of Research

There is a notable lack of research in the area of ethics in substance abuse counseling. A detailed search of the literature revealed only 22 studies related to substance abuse counseling and factors that contribute to ethical decision-making. A significant amount of research (e.g., Bernsen, Tabachnick, & Pope, 1994; Borys & Pope, 1989; Gibson & Pope, 1993; Pope & Vetter, 1992) has examined multiple relationship beliefs and behaviors of mental health professionals including psychiatrists, psychologists, social workers, and counselors. Unfortunately, substance abuse counselors have often been included within the broader framework of the helping professions rather than being specifically targeted for research. Although substance abuse counseling is a smaller subset or specialization within the helping professions, its problems can be unique. Only three articles (St. Germaine, 1996, 1997; Toriello, 1998) were found that specifically addressed substance abuse counselors' ethical beliefs, behaviors, and practices. Doyle (1997) discussed ethics preparation related to substance abuse counseling. Three additional articles reviewing the implications of multiple relationships in substance abuse counseling include Chapman (1997), Doyle (1997), and Powell (1996).

The history of the profession of substance abuse counseling and initial requirements to become a substance abuse counselor have been discussed by White (2000a, 2000b). Certification and licensure of substance abuse counselors has also been reviewed in the literature (Page & Bailey, 1995; West, Mustaine, & Wyrick, 1999). Results have indicated that the amount of preparation and hours of experience required to become a substance abuse counselor vary based on the state providing credentialing (Page & Bailey).

Several studies related to substance abuse counselors have focused on supervision (Anderson, 2000; Culbreth, 1999; Culbreth & Borders, 1998; Evans & Hohenshil, 1997; Reeves, Culbreth, & Greene, 1997). Reeves, Culbreth and Greene examined the effects of sex, age, and educational level on the supervisory styles of substance abuse counselors. Culbreth found that supervisor qualifications can vary considerably in the supervision of substance abuse counselors. Educational differences between supervisor and supervisee as well as mismatches in recovery status were also examined as factors affecting supervision (Anderson). Research by Culbreth and Borders indicated that substance abuse counselors believed recovery status was a significant issue in the supervisory relationship. Supervision has been determined to contribute to the job satisfaction of substance abuse counselors (Evans & Hohenshil).

Recovery status effects have also been discussed in the literature (Culbreth, 2000; Dilts, Clark, & Harmon, 1996; Doyle, 1997; Shipko & Stout, 1992). A literature review conducted by Culbreth examined reccurring themes in previous literature related to recovery status. Culbreth found that clients do not perceive

differences in effectiveness based on the counselor's recovery status, and that there were no apparent differences in treatment outcomes between recovering and non-recovering counselors. Doyle reported that multiple relationships for substance abuse counselors pose an additional ethical challenge. The recovery status of many substance abuse counselors creates opportunities to form a relationship outside the counseling relationship.

Shipko and Stout (1992) researched the personality characteristics of recovering and non-recovering substance abuse counselors. Despite the potential differences, these researchers found no significant personality characteristic differences between recovering and non-recovering counselors. Unlike Shipko and Stout, Culbreth (2000) found personality and attitude differences between the two groups, with recovering counselors being less flexible and more concrete in thinking. One study has explored self-disclosure of recovery status by psychiatrists treating substance-abusing clientele (Dilts, Clark, & Harmon, 1997).

Assumptions of the Study

This study assumed that the researcher-developed survey instrument measured beliefs about multiple relationships. The measure relied on self-report and assumed participants responded honestly to the instrument.

Limitations and Delimitations

A limitation that may have weakened the internal validity of the study was the survey instrument employed. The survey was created to address concerns related to

substance abuse counselors. Reliability and validity were addressed through a pilot study. Reliability of the instrument was examined by the use of Cronbach's Alpha. Validity of the survey was examined through expert review and the pilot study. The survey was sent for review to three clinicians with substance abuse specialization. Pilot study participants were also requested to provide feedback related to survey items. Items were adjusted according to recommendations.

The wording of the demographic questions may also have been a limitation. A few participants reported having a significant number of years experience prior to becoming licensed or certified. It is possible recovering individuals perceived recovery experience as clinical experience.

Another potential limitation of the study was participants who responded to the survey may have been different from those who failed to respond to the survey. Accuracy of self-report data, although assumed to reflect honest responses, cannot be ensured.

Surveying Board Certified Substance Abuse Counselors (BCSACs) delimits generalizability. Non-certified substance abuse counselors may have responded differently. Substance abuse counselors were selected based on state licensure due to the variety of individual differences of counselors registered through national licensure organizations. Strict educational and clinical requirements of Nationally Certified Counselors (NCC) would have limited the survey group, thereby, eliminating substance abuse counselors not meeting NCC guidelines.

Participants were selected from seven specific states; thus, generalizability to other states and geographic regions may be limited. The sample was limited to seven

states due to the cost of purchasing mailing lists. Purposeful, proportional, random sampling was utilized. All 50 state licensure boards were mailed a request for information and 31 states responded. Purposeful sampling was used to select seven states of the 31 that responded to the request. States with a large number of substance abuse counselors were selected to increase the number of potential participants. Random sampling was utilized to select participants from mailing lists purchased or obtained from seven states.

Although states were requested to provide addresses specifically for substance abuse counselors, a few states did not separate the names of prevention specialists or judicial specialists. This may have caused the inclusion of participants who were not working as substance abuse counselors. Additionally, retired counselors and individuals not currently working in the field were not excluded since they continued to possess board certification.

Significantly more of the respondents (approximately two-thirds) possessed a master's degree or doctoral degree. This may have contributed to a disproportionate representation of substance abuse counselors with master's degrees. There may have been an under-representation of substance abuse counselors possessing a high school diploma, GED, associate degree, or bachelor's degree. Individuals with a master's degree or doctoral degree may have been more likely to respond to the survey.

Definition of Terms

The following definitions describe terminology frequently utilized throughout the study. Terms are defined as they will be used in this particular study.

Boundary	A protective border that surrounds the therapeutic relationship and defines roles for the counselor and client.
Boundary Violation	To disregard or breach a boundary.
Educational Level	The amount of formal education a substance abuse counselor has completed.
Ethics	Moral principles combined with practice utilized to provide guidelines for professional conduct.
Experience	Skills acquired through active clinical participation in substance abuse counseling.
Licensure/Certification	Recognition that a state-governed board provides to verify that a counselor has completed all the minimum state requirements necessary to become a substance abuse counselor.
Multiple Relationship	A relationship in which a counselor assumes one or more additional professional and/or non-professional roles simultaneously while treating a client.
Non-recovering	A term used to describe a counselor who has not sought treatment for an alcohol or drug addiction.

Recovering	A term used to describe a counselor who has sought treatment for an alcohol or drug addiction.
Substance Abuse Counselor	A clinician who is certified or licensed by a state governing board and treats substance-abusing individuals.
Supervision	Substance abuse counseling experience obtained while under the direct clinical guidance of another professional.

CHAPTER TWO

REVIEW OF THE LITERATURE

This chapter will provide a review of the literature related to the proposed study of Board Certified Substance Abuse Counselors' beliefs regarding multiple relationships. This chapter is organized in seven main sections: multiple relationships and ethics, ethical standards affecting substance abuse counselors, potential for harm, research on multiple relationships in the mental health profession, ethical issues and the substance abuse counselor, predictor variables, and a summary of the chapter.

Multiple Relationships and Ethics

Multiple relationships continue to be a recurring concern for mental health professionals (Gibson & Pope, 1993). For the purpose of this study, multiple relationship was defined as a relationship in which a counselor assumes one or more additional professional or non-professional roles simultaneously while treating a client. Multiple relationships include sexual relationships and non-sexual relationships. The study focused primarily on non-sexual multiple relationships.

Non-sexual multiple relationships may take the form of personal relationships or friendships, social interactions, business or financial relationships, supervisory or evaluative relationships, shared religious affiliation, and collegial or professional relationships with clients (Anderson & Kichener, 1996). Multiple relationships can be

intentional (e.g., serving as a client's counselor and supervisor) or unintentional (e.g., unexpectedly encountering a client in a self-help group a counselor is attending). Language related to non-sexual relationships tends to be ambiguous in ethics codes of mental health professionals; however, sexual relationships with current clients are clearly forbidden in all of these codes (Ebert, 1997; Freud & Krung, 2002; Sonne, 1994).

Several issues contribute to making multiple relationships problematic, including difficulty in recognizing a multiple relationship, the continuum of conflicting views about multiple relationships, and unavoidable multiple relationships (Herlihy & Corey, 1997). At times, it is difficult for the mental health professional to determine the appropriateness of a multiple relationship due to the multitude of variables involved. Issues related to rural areas and acquaintances who become clients are examples of ethical concerns faced by practicing mental health professionals.

Substance abuse counselors encounter the same difficulties as mental health counselors in relation to multiple relationships. However, additional variables contribute to the concerns faced by substance abuse counselors. These variables include clients and counselors attending the same 12-step meetings, former clients becoming colleagues, and substance abuse counselors who serve as counselor and liaison with the court system.

This study examined selected multiple relationship issues experienced by substance abuse counselors. The relationship of the variables of educational level, recovery status, experience, and supervision to substance abuse counselors' attitudes toward multiple relationships were examined.

Ethical Standards Affecting Substance Abuse Counselors

Professional associations, certifying agencies, and state licensure boards for counselors have specific regulations regarding multiple relationships. Although each organization individually defines what constitutes a multiple relationship, all professional counseling organizations consider sexual relationships with current clients as a violation of ethics. The codes of conduct to which counselors adhere are determined by their affiliation with professional associations and credentialing bodies. Three organizations with which substance abuse counselors are often affiliated are the American Counseling Association (ACA), the National Board for Certified Counselors (NBCC), and the National Association of Alcoholism and Drug Abuse Counselors (NAADAC). The ethical standards related to multiple relationships found in the codes of conduct of each of these professional associations are examined in the following sub-sections.

American Counseling Association

The American Counseling Association's (ACA) primary ethical standard related to multiple relationships states:

> Counselors are aware of their influential positions with respect to clients, and they avoid exploiting the trust and dependency of clients. Counselors make every effort to avoid multiple relationships with clients that could impair professional judgment or increase the risk of harm to clients. (Examples of such relationships include, but are not limited to, familial, social, financial, business, or close personal relationships with clients.) When a multiple relationship cannot be avoided, counselors take appropriate professional precautions such as informed consent, consultation, supervision, and documentation to ensure that judgment is not impaired and no exploitation occurs (American Counseling Association [ACA] Code of Ethics, Standard A.6.a.).

This standard specifically addresses multiple relationships that are deemed inappropriate. The code also specifies that professionals should avoid multiple

relationships when possible and recommends how a non-professional relationship should be addressed if the relationship is unavoidable. Personal needs of the counselor are also addressed: "In the counseling relationship, counselors are aware of the intimacy and responsibilities inherent in the counseling relationship, maintain respect for clients, and avoid actions that seek to meet their personal needs at the expense of clients" (ACA Code of Ethics, Standard A.5.a.). A related standard states, "Counselors do not accept as clients superiors or subordinates with whom they have administrative, supervisory, or evaluative relationships" (ACA Code of Ethics, Standard A.6.b.). The code discourages counselors from engaging in counseling relationships with individuals over whom the counselor may have supervisory power.

In regard to sexual relationships, counselors do not engage in sexual intimacies with current clients. "Counselors do not have any type of sexual intimacies with clients and do not counsel persons with whom they have had sexual relationships" (ACA Code of Ethics, Standard A.7.a.). Counselors are permitted to have a sexual relationship with former clients after a minimum of two years after termination, if certain conditions are met:

> Counselors do not engage in sexual intimacies with former clients within a minimum of two years after terminating the counseling relationship. Counselors who do engage in such relationship after two years following termination have the responsibility to examine and document thoroughly that such relations did not have an exploitative nature, based on factors such as duration of counseling, amount of time since counseling, termination circumstances, client's personal history and mental status, adverse impact on the client, and actions by the counselor suggesting a plan to initiate a sexual relationship with the client after termination (ACA Code of Ethics, Standard A.7.b.).

National Board for Certified Counselors

The National Board for Certified Counselors (NBCC) Code of Ethics contains a series of statements related to multiple relationships. The first concern addressed is relationships related to personal gain: "Certified counselors are aware of the intimacy in the counseling relationship and maintain respect for the client. Counselors must not engage in activities that seek to meet their personal or professional needs at the expense of the client" (National Board Certified Counselors [NBCC] Ethical Code, Section A.8.). This standard prohibits counselors from using the relationship for personal gain. Another standard addresses multiple relationships with an inherent power differential:

> Certified counselors who have an administrative, supervisory and/or evaluative relationship with individuals seeking counseling services must not serve as the counselor and should refer the individuals to other professionals. Exceptions are made only in instances where an individual's situation warrants counseling intervention and another alternative is unavailable. Multiple relationships that might impair the certified counselor's objectivity and professional judgment must be avoided and/or the counseling relationship terminated through referral to a competent professional (NBCC Ethical Code, Section B.9.).

The statement specifically addresses supervisory relationships but does not discuss personal relationships (e.g., treating friends or relatives). Sexual intimacy with a client is considered unethical; however, a counselor is permitted to engage in a sexual relationship after a minimum of two years after termination of the counseling relationship (NBCC Ethical Code, Standard A.10).

National Association of Alcoholism and Drug Abuse Counselors

The National Association of Alcoholism and Drug Abuse Counselors (NAADAC) is the largest national organization for alcoholism and drug abuse professionals (National Association of Alcoholism and Drug Abuse Counselors, 2002). This organization's ethical standards are specific to substance abuse counselors. "The NAADAC member shall not engage in professional relationships or commitments that conflict with family members, friends, close associates, or others whose welfare might be jeopardized by such a multiple relationship" (NAADAC Ethical Standards, Principle 9.b.). The NAADAC code delineates the types of prior relationships that may constitute a multiple relationship for the counselor. "The NAADAC member shall not exploit relationships with current or former clients for personal gain, including social or business relationships (NAADAC Ethical Standards, Principle 9.c.)." The principle addresses multiple relationships with individuals for whom it may be inappropriate to provide treatment. Regarding sexual relationships, Principle 9 also states the NAADAC member should not accept clients with whom the member has had a sexual relationship and the member is not to engage in sexual behavior with current or former clients (NAADAC Ethical Standards, Principle 9.d., e.). This principle differs from the ACA Code of Ethics and the NBCC Code of Ethics in that the NAADAC Ethical Standards prohibit the counselor from ever engaging in a sexual relationship with a former client.

The NAADAC Ethical Standards do not appear to be as comprehensive and detailed as the ACA Code of Ethics or the NBCC Ethical Code. The ACA Code of Ethics indicates how a counselor should proceed if a multiple relationship is

unavoidable. The NBCC Ethical Code addresses the counselor's power differential. Both of the aforementioned codes discuss potential harm to clients and make recommendations to the counselor. The NAADAC code does not address these concerns and fails to address issues that may be specific to the substance abuse counselor, such as sponsorship. Another difference between the ACA code and NBCC code and the NAADAC code is that NAADAC forbids sexual relationships with former clients. Both the ACA code and NBCC code permit sexual relationships with former clients after a minimum of two years, if certain conditions are met.

Potential for Harm

Considerable research has indicated the potential for harm to clients from multiple relationships (Pipes, 1997; Rinella & Gerstein, 1994; Smith, 1999; Smith & Fitzpatrick, 1995). Nonetheless, some writers believe it is unrealistic to avoid multiple relationships (Tomm, 1993; Zur, 2002). Multiple relationships may have a positive effect if both the counselor and client have entered the relationship with forethought and awareness. Tomm suggested that friendships can place the therapeutic relationship on a more equal level, so that clinicians are viewed as normal individuals and clients are seen as normal individuals with everyday problems.

In urban communities, counselors usually are able to avoid encountering clients outside the office by frequenting areas located away from their place of employment. However, it may be difficult to completely avoid multiple relationships in small or rural communities where individuals are likely to be served by the same

agencies and facilities (Pope & Vetter, 1992). It may be necessary for the counselor to engage in business or social relationships with the client.

Regardless of the precautions a counselor may take to avoid harm to the client, multiple relationships can cause disruption and harm for both the client and counselor. Smith (1999) discussed the harm to clients who have been engaged in sexual multiple relationships with their counselor. Clients may experience obsessive thoughts, self-doubt, mistrust, and confusion. Symptoms can include depression, suicidal thoughts, recurrent nightmares and flashbacks. Boundary violations may also exacerbate previous symptomology. Clients who seek further treatment from another clinician may expect special treatment or be apprehensive about further violation (Kaslow, 1998).

Multiple relationships with clients can lead to repercussions for a counselor, which can affect their clientele, reputation, and livelihood. A counselor who frequently engages in inappropriate multiple relationships may not be respected by other mental health professionals. Lack of respect in the community can limit referrals provided by clients and clinicians.

Potential harm to the clinician may include disciplinary action from one or more licensure boards in which the clinician holds membership. Disciplinary action can range from a written reprimand to expulsion or credential revocation, based on the infraction. One example of disciplinary action recently taken was expulsion of a member from the American Counseling Association due to a violation of ethical standards related to sexual intimacies and consultation ("Member Expelled from ACA," 2002).

Research on Multiple Relationships in the Mental Health Professions

Research examining multiple relationships in the mental health profession has included psychiatrists, psychologists, social workers, counselors, and substance abuse counselors. Professionals experience similar issues related to ethics as well as distinct differences based on the intricacies of the specific discipline. The following sections will review literature related to multiple relationships and mental health professionals in general and substance abuse counselors more specifically.

Psychiatrists

Psychiatrists, unlike other mental health professionals, interact in a doctor-patient role as well as a therapeutic role. This may provide the opportunity for additional ethical dilemmas. Literature related to psychiatrists has focused specifically on boundary violations including sexual misconduct (Garfinkel, Dorian, Sadavoy & Bagby, 1997; Gutheil & Gabbard, 1993) and personality traits related to boundary violations (Garfindel, Bagby, Waring, & Dorian, 1997). Additional research has discussed violations after termination of treatment (Malmquist & Notman, 2001) and benefits of boundary crossings (Rinella & Gerstein, 1994).

Gutheil and Gabbard (1993) reviewed literature related to boundaries and boundary violations in clinical practice related to sexual misconduct litigation. Examples of behavior related to misconduct including offering extended time for sessions and making exceptions regarding the place of the session, money, gifts, and additional services. Psychiatrist behavior that contributed to misconduct included wearing seductive clothing, using the client's first name, making inappropriate self-disclosure, and making contact during physical examinations. Other writers have

suggested difficulty with sexual and non-sexual multiple relationships related to finances, confidentiality, and pre-existing multiple relationships (Garfinkel, Dorian, Sadavoy, & Bagby, 1997). According to these authors, boundary crossings demonstrate inadequate training and lapses in judgment, which contribute to difficulty with non-sexual boundaries and make practitioners more likely to engage in multiple relationships.

A survey of boundary violations and personality traits among psychiatrists who had become sexually involved with clients was conducted by Garfinkel, Bagby, Waring, and Dorian (1997). Findings revealed that two of the psychiatrists whose licensure was revoked were identifiable at the beginning of residency as indicated by scores on a personality inventory demonstrating character pathology with antisocial attitudes and behaviors. The authors discussed further use of diagnostic inventories with psychiatrists in residency and made recommendations for supervision and counseling of these residents.

Psychiatrist and patient boundary issues after termination of the therapeutic relationship using the transference model of psychoanalysis have also been discussed in the literature. Malmquist and Notman (2001) suggested that using the transference experienced between client and psychiatrist during the therapeutic process as a basis for post-termination relationships can lead to confusion and adverse consequences for client and psychiatrist. Consequences may include litigation after the occurrence of post-treatment multiple relationships.

Benefits of non-sexual multiple relationships between psychiatrist and client have been explored (Rinella & Gerstein, 1994). Discussion included concerns related

to legal regulations and dual relationships and repercussions related to boundary violations. Issues surrounding strict boundaries in relation to non-sexual multiple relationships were explored and an example of a multiple relationship that was beneficial for both client and therapist was provided.

Psychologists

Psychologists have conducted extensive research related to ethics and continue to examine different aspects of multiple relationships. Research has examined ethical dilemmas experienced by psychologists (Pope & Vetter, 1992), the ethical code of conduct (Ebert, 1997; Sonne, 1994), models for ethical decision-making (Gottlieb, 1993; Rubin, 2000), and multiple relationships with students (Slimp & Burian, 1994). Different types of boundaries (Smith & Fitzpatrick, 1995) including sexual and nonsexual boundaries (Baer & Murdock, 1995; Gabbard, 1997; Lamb & Catanzaro, 1998) and post-therapy relationships (Anderson & Kichener, 1996; Lamb, Strand, Woodburn, Buchko, Lewis, & Kang, 1994; Pipes, 1997) have also been explored.

Research conducted by Pope and Vetter (1992) examined ethical dilemmas experienced by 679 members of the American Psychological Association. Participants indicated confidentiality (18%) was the leading category of ethical concerns. Multiple relationships were rated the second leading category (17%) out of 23 categories.

The utility of the American Psychological Association Code of Ethics for practicing psychologists has been explored in relation to multiple relationships. Prohibitions related to multiple relationships and constitutional problems with

multiple relationship restrictions have been discussed in the literature (Ebert, 1997). Ebert recommended publishing ethical decisions brought to the board for review to provide practitioners with explanations for prohibitions, a list of acts prohibited by the code, and an analytical model to assist with ethical decision-making.

Sonne (1994) discussed the lack of a precise definition of multiple relationships and when multiple relationships constitute unethical conduct according to the 1992 American Psychological Association Code of Ethics. The author recommended additions to the code of ethics including providing definitions within the code, providing guidance for dealing with multiple relationships, and specifying certain unethical multiple relationships. Sonne also suggested that the code forbid bartering for services and prevent psychologists from engaging in therapy with students or supervisees. The 2003 American Psychological Association Code of Ethics provides a definition of multiple relationships and offers instructions for the clinician after a multiple relationship has occurred (APA Code of Ethics, 2003, Section 3.05).

Rubin (2000) recommended utilizing the term "multiple dimensions of involvement" to discuss multiple relationships. Five principles to practice throughout the therapeutic relationship including beneficence, respect for client autonomy, therapist self-awareness, therapist self-interest, and openness to objective input were considered. Applications of the multiple dimensions of involvement model were also provided.

A decision-making model to avoid exploitive multiple relationships was examined utilizing a model with three dimensions: power, duration, and termination

(Gottlieb, 1993). Within each dimension are three levels the clinician uses to determine the level of engagement. Power levels include low, mid-range, and high, based on the strength of the power differential. Duration levels include brief, intermediate, and long based on the length of contact. Termination levels include specific, uncertain, and indefinite based on when termination is anticipated. The author recommended use of the decision-making model to complement ethical principles.

Multiple role relationships between interns and staff members or supervisors during internship have been considered. Slimp and Burian (1994) discussed several types of multiple relationships including sexual, social, therapy, and business. They recommended additional applied preparation in ethics, forming an ethics committee of interns and staff members at preparation sites, and employing an ethics consultant at preparation sites to encourage discussion and unbiased feedback.

Smith and Fitzpatrick (1995) reviewed literature related to theory and research on patient and therapist boundary issues. Types of boundary violations discussed included multiple relationships, nonerotic physical contact, inappropriate self-disclosure, and sexual contact. They noted that therapists' boundary crossings provide the opportunity for examination and discussion among clinicians. They recommended that any boundary crossing that occurs should be well documented.

A survey of 596 psychologists examined nonsexual boundary crossings and sexual boundary violations (Lamb & Catanzaro, 1998). It was found that 8% of the participants had engaged in at least one sexual boundary violation. Psychologists who had engaged in a sexual boundary violation reported significantly more nonsexual

boundary crossings than psychologists who did not engage in a sexual boundary violation.

Nonsexual relationships between psychologists and former clients have been explored. Pipes (1997) discussed psychologists' reservations about nonsexual relationships with former clients, including personal and intentional social interactions. He concluded that psychologists have an obligation toward former clients to provide the opportunity for the client to re-engage in therapy if necessary, to avoid exploitation, and to preserve transference.

Baer and Murdock (1995) conducted a survey of 223 American Psychological Association members to examine nonerotic multiple relationships and the effects of sex, theoretical orientation, and interpersonal boundaries. Male therapists rated nonerotic multiple relationships as more ethical than female therapists. Therapists with a psychodynamic/analytic theoretical orientation rated nonerotic multiple relationships as less ethical than therapists with other theoretical orientations. Therapists with higher stress ratings indicated nonerotic multiple relationships as more ethical than therapists with lower stress ratings. Sex, theoretical orientation, and level of stress were determined to contribute to perceptions of nonerotic multiple relationships among psychologists.

A survey of 348 psychologists (Lamb, Strand, Woodburn, Buchko, Lewis, & Kang, 1994) was conducted to examine sexual and business relationships between therapists and former clients. Results indicated that 6.5% of participants engaged in a post-termination sexual relationship with a client and 29% were involved in a business relationship with a former client. Participants indicated that circumstances

such as living in a rural community and the kind and nature of a business arrangement would influence their judgment of the appropriateness of business relationships.

Post-therapy relationships among psychologists have been explored. Anderson and Kichener (1996) asked psychologists to describe three instances of nonromantic/nonsexual relationships with former clients. Sixty-three (63) participants responded, with 15 reporting no encounters with post-therapy relationships. Critical incidents submitted by the remaining participants consisted of 91 critical incidents that were categorized into eight relationship categories: personal or friendship, social interactions and events, business or financial, collegial or professional, supervisory or evaluative, religious affiliation, collegial or professional plus social, and workplace. This study demonstrated that psychologists deal with a number of different nonromantic, nonsexual relationships with clients; there is little consensus among professionals about nonsexual relationships; and future revisions of the Ethics Code may warrant discussion related to nonsexual relationships with former clients.

Boundary violations and clinical errors have been examined in the literature. Gabbard (1997) examined 80 cases of sexual boundary violations among psychotherapists and discovered several common clinical errors that may have contributed to these violations. Contributing factors to boundary violations included self-disclosure, therapist isolation, and secrets in supervision.

Social Workers

Social workers also experience a myriad of ethical dilemmas. Literature has examined issues related to the social work Code of Ethics (Freud & Krung, 2002), boundary issues (Kagle & Giebelhausen, 1994; Reamer, 2003), and boundary

violations (Smith, 1999). Social work educators' beliefs regarding multiple relationships with students (Congress, 2001) have also been investigated.

Freud and Krung (2002) discussed ambiguity related to multiple relationship boundaries in the 1996 National Association of Social Workers Code of Ethics. They addressed the history of the Code of Ethics, the necessity of clear boundaries, and the meaning of multiple relationships. Boundary issues in clinical and non-clinical settings, in addition to sexual and non-sexual multiple relationships, were discussed. These authors recommended that terminology be modified, changing multiple relationships to more explicit terminology focusing on boundary management, and that criteria be included to assist with ethical decision-making.

Research related to social workers' multiple relationship concerns has been examined. Kagle and Giebelhausen (1994) discussed legal, ethical, and practice issues associated with multiple relationships and provided a case example. Their recommendations for further education of social work professionals included discussing multiple relationships during supervision and educating clients by distributing information about client rights and the professional ethics required of social workers.

Reamer (2003) offered the following recommendations for risk management of boundary issues in social work: being alert to possible conflicts of interest, informing clients and colleagues about potential conflicts, and consulting with colleagues. Additional recommendations included developing a plan of action to protect client and practitioner, documenting discussions, consulting, obtaining supervision, and monitoring implementation of the action plan.

Smith (1999) discussed deviation from practice as a potential area for boundary crossings, which could later lead to boundary violations. Consequences for boundary violations and subsequent treatment recommendations for violated clients were reviewed.

A survey of 87 deans of accredited Master's of Social Work programs was conducted to examine multiple relationships in academia (Congress, 2001). Participants were asked to respond to 25 items related to multiple relationships including sexual relationships, professional employment, non-professional employment, social-individual, social-group, therapeutic, and professional-collegial relationships. A total of 92% of participants believed it was ethical to hire a current or former student to work on a research project and 41.2% believed it was ethical to have dinner or a drink with a student. The majority of participants (98.9%) believed sexual relationships with current students were unethical.

Counselors

A considerable body of literature has been produced that addresses multiple relationship dilemmas for counselors. Research has focused on ethically controversial behaviors (Gibson & Pope, 1993), management of multiple relationships (St. Germaine, 1993), classifications of multiple relationships (Pearson & Piazza; 1997), relationships between counselor educators and students (Kolbert, Morgan, & Brendel, 2002; Thornton, 2003; Webb, 1997), ethical decision-making and counselor trainees (Dinger, 1997) sexual and nonsexual relationships (Thoreson, Shaughnessy, & Frazier, 1995; Thoreson, Shaughnessy, Heppner, & Cook, 1993), multiple relationships in rural counseling (Anderson, 1999; Brownlee, 1996), cultural issues

related to multiple relationships (Kaslow, 1998), benefits of multiple relationships (Tomm, 1993; Zur, 2002), and post-therapy relationships (Pritchett & Fall, 2001; Salisbury & Kinnier, 1996).

Gibson and Pope (1993) surveyed 579 licensed professional counselors for their opinions regarding 88 ethically controversial behaviors. At least 90% of participants viewed 21 of the 88 behaviors as unethical. Twenty-four percent (24%) of the items reported as unethical were related to sexual behavior with clients. Participants indicated that the most controversial areas were fee collection (42%) and dual (multiple) relationships (42%).

Problems associated with multiple relationships for counselors and clients and different types of multiple relationships were discussed by St. Germaine (1993). She suggested steps for managing multiple relationships which included setting boundaries, talking with the client about the relationship, seeking consultation, and making a referral.

Classification categories related to multiple relationships in counseling were offered by Pearson and Piazza (1997). Categories were circumstantial multiple roles, structured multiple professional roles, shifts in professional roles, personal and professional role conflicts, and the predatory professional. They recommended that the classification system be used to anticipate and manage risks associated with multiple relationships.

Kolbert, Morgan, and Brendel (2002) conducted a qualitative study of six faculty members and 16 master's level graduate students in a counselor preparation program. Participants were provided four scenarios and were requested to describe

their reactions to interactions between faculty and students in the scenarios. Results indicated that students had a more negative view of faculty-student multiple relationships. However, both students and faculty recognized the inherent power differential between the two groups and believed maintaining appropriate boundaries was the professor's responsibility. A study conducted by Thornton (2003) determined that social relationships between professors and students were perceived as more acceptable than business or romantic relationships. Multiple relationships between counselors and clients were perceived as less acceptable than relationships between professors and students and supervisors and supervisees.

Counselor preparation and boundary management related to multiple relationships have also been explored. According to Webb (1997), boundary violations can be minimized through helping counselors learn to internalize a professional/personal value system to regulate their needs. Webb recommended that preparation include using life experiences, modeling, incorporating an ethical perspective, and a focus on self-awareness.

Research conducted by Dinger (1997) examined ethical decision-making models and ethics education related to counselor trainees. Dinger (1997) analyzed 52 counselor trainees' responses related to ethical decision-making and ethics education. Results indicated that participants were able to correctly identify more ethical issues if they were trained in the Ethical Justification model or if they had completed an ethics class. Preparation with the A-B-C-D-E Worksheet (assessment, benefit, consequences and consultation, duty, and education worksheet) and no practicum

experience contributed to participants being less cautious about general and dual-role behaviors.

Thoreson, Shaughnessy, and Frazier (1995) conducted a national survey of 377 female counselors and Thoreson, Shaughnessy, Heppner, and Cook (1993) surveyed 366 male counselors to examine sexual contact during and after professional relationships. Few female participants (less than 1%) reported sexual contact with a current client, student, or supervisee. There were no significant differences between master's level and doctoral level counselors related to frequency of sexual contact with clients, students, or supervisees. However, participants with doctoral degrees were more likely than master's level counselors to have engaged in sexual contact with their own counselors, supervisors, or teachers during and after the professional relationship.

A similar percentage of male participants (1.7%) in Thoreson, Shaughnessy, Heppner, and Cook's (1993) study reported engaging in sexual contact with a current client. When the definition was modified to include students and supervisees after termination of the professional relationship, 16.9% of participants reported engaging in sexual contact. There were no significant differences between master's level counselors and doctoral level counselors.

Rural settings have been another area of focus (Anderson, 1999; Brownlee, 1996). Anderson asserted that rural communities increase the probability of poor boundaries due to the lack of professional resources in areas where the population is widely spread. Anderson offered recommendations for treatment of incestuous families and suggestions for maintaining confidentiality protocol in rural settings.

Brownlee (1996) discussed difficulties associated with non-sexual multiple relationships in rural settings, and identified contextual issues in rural settings. He recommended a review of ethical decision-making models for rural mental health professionals.

Kaslow (1998) reviewed multiple relationships and ethical concerns related to cultural contexts faced by counselors in mental health practice. To illustrate the point that there are differences in multiple relationships based on culture, examples were provided of confidentiality concerns based on culture and verbal and non-verbal greetings.

Tomm (1993) took an unusual approach, examining the benefits of multiple relationships for clients and practitioners. Benefits to the client, according to Tomm, include creating a sense of normalcy in the relationship, minimizing power differentials, and promoting positive interactions outside the counseling relationship. Practitioner benefits include enhancement of the therapeutic relationship and positive personal experiences.

Non-sexual multiple relationship benefits for the client have also been explored by Zur (2002). The author reported that familiarity between the client and counselor contributes to therapeutic effectiveness and lessens the likelihood of exploitation by the counselor. Familiarity with the counselor's personal background and values were viewed as helpful information that contributed to the transference and matching process for the client.

Pritchett and Fall (2001) examined post-termination non-sexual multiple relationships among counselors. Issues related to the ethical code of conduct,

consequences for post-termination non-sexual relationships, an ethical scenario, and ethical decision-making models were explored. To increase clarity for the counselor, recommendations included revision of ethical codes to include guidance on post-termination relationships.

A survey of 96 members of the American Mental Health Counselors Association was conducted to examine post-termination friendship between counselors and clients (Salisbury & Kinnier, 1996). These researchers found that 33% of participants believed post-termination sexual relationships might be acceptable five years after termination. However, 70% reported the belief that post-termination friendships were acceptable two years after termination, and 33% of participants reportedly had engaged in friendships with former clients.

Cross-discipline Studies

Several researchers have explored differences and similarities across different mental health disciplines. Borys and Pope (1989) studied multiple relationships related to psychologists, psychiatrists, and social workers. This study, with 4,800 participants, focused on nonsexual multiple relationships. The majority of participants believed dual role behaviors were unethical under most conditions and reported that they rarely or never engaged in dual role behaviors. Members of the professions (psychology, psychiatry, and social work) did not differ in their opinions regarding nonsexual dual professional roles. Bersen, Tabachnick, and Pope (1994) surveyed social workers' sexual attraction toward clients and compared the results to other mental health professionals. Results showed no differences among psychiatrists, psychologists, and social workers related to sexual attraction.

Ethical Issues and the Substance Abuse Counselor

Very few studies have specifically addressed ethical issues in substance abuse counseling (Chapman, 1997; Doyle, 1997; Powell, 1996; St. Germaine, 1996, 1997). These studies are discussed in the following section.

Borys (1994) addressed the importance of boundaries when working with clients diagnosed with various disorders, including substance abuse. Substance abusers bring maladaptive behaviors and defense mechanisms into counseling. Setting a structured boundary with a substance-abusing client may be a necessity to facilitate the groundwork for continued recovery.

A survey of 55 addiction counselor certification boards was conducted to determine the nature and frequency of ethical complaints (St. Germaine, 1997). Questions were asked regarding procedures and policies related to complaints and preparation requirements. Results of the study indicated that the most common complaints were sexual relationships with a current client, practicing while impaired, and practicing without a certificate.

St. Germaine (1996) surveyed 858 Certified Alcohol and Drug Counselors regarding their beliefs and behaviors related to ethics. The survey listed 27 statements related to ethical beliefs and 20 statements related to ethical behaviors. Participants were sent either the beliefs form or the behaviors form and were asked to rate the statements. Over two-thirds (68.9%) of the participants reported that they encountered clients outside of counseling daily, frequently, or sometimes. Participants also reported that they had engaged in the majority of multiple relationship behaviors listed (e.g. allowing a client to enroll in a class taught by the counselor, going out to

eat with a client after a session, providing individual therapy to a relative). St. Germaine then compared her results to a national study of psychologists, psychiatrists, and social workers, and concluded that there was no significant difference between substance abuse counselors and other mental health professionals related to multiple relationships.

Multiple relationships pose an additional ethical challenge for substance abuse counselors (Doyle, 1997). Due to the recovery status of many substance abuse counselors, the opportunity to form a relationship outside the counseling relationship is likely to occur. This is particularly true in rural settings where 12-step meetings are limited. The author asserted that ethics codes do not provide enough guidance on multiple relationships for substance abuse counselors in recovery.

Difficulties associated with multiple relationships in substance abuse counseling for client and counselor have been explored by Chapman (1997). Concerns related to clients included potential harm, the power differential, and confidentiality while engaged in a multiple relationship. Problems experienced by the counselor included diminished objectivity toward the client, loss of credibility, effects related to future clients, and ethical and legal concerns after termination.

Powell (1996) investigated multiple roles related to substance abuse counselors in recovery. Issues related to 12-step meeting attendance and power differentials related to multiple relationships were discussed. Seeking similar community resources that are shared by clients may increase the difficulty experienced by a substance abuse counselor attempting recovery. Recovering

counselors may feel uncomfortable with self-disclosure if clients are present, thereby jeopardizing their own social support in maintaining recovery.

Predictor Variables

A review of the literature indicated four variables (education, experience, supervision, and recovery status) that contribute to differences among substance abuse counselors and mental health professionals. The following section will discuss literature related to education, preparation and experience, supervision, and recovery status of substance abuse counselors.

Education

Substance abuse counselors come from a variety of backgrounds including social work, psychology, criminal justice, and counseling. Unlike other mental health professionals, substance abuse counselors may have a degree in an unrelated field or may not possess a college degree (West, Mustaine, & Wyrick, 1999). Many programs unrelated to counseling do not require specific coursework related to ethics, which contributes to a lack of knowledge of ethics among substance abuse counselors in the field.

In the field of mental health counseling, specific standards have been implemented nationally to ensure competency. Practicing mental health counselors are master's level clinicians who have passed a national exam and have completed a minimum number of supervised (post-master's degree) clinical hours. This researcher reviewed requirements to become a substance abuse counselor and received 31 (of the 50 states requested) substance abuse counselor application packets to determine each

state's requirements. A review of the applications indicated a lack of standardization for minimum educational requirements.

Licensure or certification of substance abuse counselors varies from state to state (Page & Bailey, 1995). In some states, a bachelor's degree is required; other states require only a high school diploma or GED. West, Mustaine and Wyrick (1999) compared 34 states' requirements to become a substance abuse counselor and found that only six states require a graduate degree to practice substance abuse counseling. These educational differences can lead to a lack of standard coursework/preparation in ethics (Dove, 1995). Inconsistency in education limits the counselor's level of skill, which could potentially cause harm to the client.

Toriello (1998) surveyed 227 substance abuse counselors related to sensitivity to ethical dilemmas and beliefs about preparation to help resolve ethical dilemmas. Results indicated a significant difference between the decisions related to ethics of substance abuse counselors with a graduate degree compared to substance abuse counselors with an associate degree or high school diploma. Counselors with an associate degree or high school diploma were described as more sensitive and found it more difficult to recognize to ethical dilemmas. There were no significant differences between groups inability to recognize ethical dilemmas.

Preparation and Experience

The preparation requirements for becoming a substance abuse counselor also differ between states. Although preparation is required, the amount of preparation and hours of experience may vary (Page & Bailey, 1995). The preparation usually requires the substance abuse counselor to have experience in a substance abuse

treatment setting prior to licensure/certification. Treatment settings typically include inpatient as well as outpatient settings. Work experience is often taken into consideration but no standard is set in relation to requirements for the preparation experience. Counselors in preparation may be paired with supervisors who possess different credentials and follow different ethics codes (West, Mustaine, & Wyrick, 1999). For example, a substance abuse counselor may be supervised by a social worker.

After a substance abuse counselor is certified, the licensing or certifying board usually requires continuing education credit hours. Additional preparation usually takes place in the form of seminars, lectures or workshops. Previous authors (West, Mustaine, & Wyrick, 2002) have recommended more research to investigate formal and informal types of counselor preparation, including workshops and seminars.

Supervision

Doyle (1997) discussed the need for continued supervision of substance abuse counselors due to the high potential for ethical and multiple relationship issues that present in the field. Doyle identified issues the code specifically does not address for recovering counselors. Supervision could be helpful for recovering counselors when faced with ethical dilemmas related to social relationships, sponsorship, and self-help group meetings.

The effects of sex, age, and educational level on the supervisory styles of substance abuse counselors were examined by Reeves, Culbreth, and Greene (1997). Results from the survey of 72 substance abuse counselor supervisors indicated that participants viewed themselves as interpersonally sensitive, with younger and

graduate level supervisors being more egalitarian in supervision. Younger supervisors (under age 50) were less likely to determine the direction of the discussion during supervision and did not require supervisees to stringently adhere to directives they provided. Older supervisors (age 50 and over) were less comfortable sharing their personal experiences as a counselor.

Educational differences between supervisor and supervisee as well as mismatches in recovery status have also been discussed (Anderson, 2000). Evidence has suggested substance abuse counselor supervisors oversee supervisees with varying levels of preparation and knowledge of therapeutic approaches. Research by Culbreth and Borders (1998) indicated substance abuse counselors believed recovery status was a significant issue in the supervisory relationship. Further research indicated a significant interaction between counselor and supervisor recovery status (Culbreth & Borders, 1999). The requirements regarding the qualifications of the individual providing supervision can also vary considerably (Culbreth, 1999).

Additional factors in the supervisory relationship may contribute to discussion related to ethics during the supervision process. Further research by West, Mustaine, and Wyrick (2002) debated findings related to factors contributing to the supervisory relationship including recovery status, formal and informal counselor preparation, and formal and informal supervisor preparation. States were selected to determine counselor qualifications, clinical qualifications, and client assessor qualifications. Of 42 states surveyed, 11 required graduate level preparation for clinical supervisors and only three states required academic preparation related to clinical supervision.

Additional findings suggested a lack of consistency in clinical experience and education required to provide supervision to substance abuse counselors.

Recovery Status

An additional difference between substance abuse counselors and mental health counselors is recovery status. Substance abuse counselors may have become interested in the field due to their own struggle to gain sobriety. Shipko and Stout (1992) researched the personality characteristics of recovering and non-recovering substance abuse counselors. Despite the potential differences, results of the study indicated no significant personality characteristic differences between recovering and non-recovering counselors. Literature related to self-disclosure and the treatment of substance abuse has been limited to self-disclosure by psychiatrists (Dilts, Clark, & Harmon, 1997).

A literature review conducted by Culbreth (2000) examined reoccurring themes in previous literature related to recovery status. Culbreth concluded that clients do not perceive differences in effectiveness based on the counselor's recovery status, and that there are no apparent differences in treatment outcomes between recovering and non-recovering counselors. The author recognized differences between how recovering and non-recovering counselors perceive and treat substance abuse problems. Unlike the findings of Shipko and Stout (1992), Culbreth indicated there are personality and attitude differences between the two groups. As a result of the extensive literature review, Culbreth asserted that recovering counselors are less flexible, more concrete in thinking, more rigid about the disease model of addiction, and less positive about the effectiveness of non-recovering counselors. Recovering

counselors are also less likely to view additional preparation as a priority or have a positive view about supervision.

Toriello (1998) examined the influence of educational level and recovery status on perceptions of ethical dilemmas among a total of 227 substance abuse counselors. Results from the study indicated no significant difference between recovering and non-recovering substance abuse counselors and the extent to which they recognize ethical dilemmas.

Summary

This chapter has examined the codes of ethics for members of the American Counseling Association, National Board Certified Counselors, and National Association of Alcoholism and Drug Abuse Counselors with respect to standards that address multiple relationships. Research has been reviewed regarding multiple relationships and mental health professionals in general and substance abuse counselors specifically. Although all mental health professionals face ethical dilemmas, substance abuse counselors face additional difficulties. Research has demonstrated that inconsistent licensure requirements and inadequate ethical conduct codes contribute to ineffective substance abuse counselor preparation related to multiple relationships. Differences related to substance abuse counselors were discussed including education, experience, supervision, and recovery status.

CHAPTER THREE

RESEARCH DESIGN

In this chapter, the research methods and design of the study are discussed. The chapter begins with an overview of the study. Research questions and hypotheses are presented and the variables are described. Participants and sampling procedures are discussed. Instrumentation, including the Demographic Questionnaire and the Multiple Relationship Survey for Substance Abuse Counselors (MRS SAC), is described along with instrument development procedures. Procedures for collecting and analyzing data are also discussed.

Overview of the Study

This study investigated the relationship of four factors (educational level, recovery status, experience, and supervision) to ethical beliefs related to multiple relationships of Board Certified Substance Abuse Counselors (BCSACs). A survey design was utilized to obtain information from substance abuse counselors regarding their beliefs about the ethics of selected multiple relationship issues.

Research Questions and Hypotheses

Research has indicated that educational level (Dove, 1995; Page & Bailey, 1995; Toriello, 1998; West, Mustaine, & Wyrick, 1999); recovery status (Culbreth,

2000; Dilts, Clark, & Harmon, 1997; Shipko & Stout, 1992; Toriello); experience (Dinger, 1997; Page & Bailey; West, Mustaine, & Wyrick, 1999, 2002); and supervision, (Anderson, 2002; Culbreth 1999; Culbreth & Borders, 1998, 1999; Doyle 1997; Reeves, Culbreth, & Greene, 1997; West, Mustaine, & Wyrick, 2002) each influence substance abuse counseling.

Educational level influences the degree of education a counselor has received related to ethics. Substance abuse counselors may possess a degree in an unrelated field or not possess a college degree (West, Mustaine, & Wyrick, 2002). Educational differences within the field can lead to a lack of standard coursework/preparation in ethics (Dove, 1995). Substance abuse counselors may lack the information necessary to evaluate ethical dilemmas, leading to an increased opportunity for multiple relationships.

Training plays an integral role in counselors' exposure to ethical dilemmas, thereby contributing to beliefs. Preparation to become a substance abuse counselor is required; however, the amount of preparation and hours of experience may vary (Page & Bailey, 1995). Substance abuse counselor boards may not require specific coursework related to ethics. Research has indicated substance abuse counselors who received training in ethics were able to identify more ethical issues (Dinger, 1997).

Supervision contributes to the feedback a counselor receives about ethical dilemmas which serves to help the counselor monitor ethical beliefs and behaviors. Continued supervision of substance abuse counselors is warranted due to the high potential for ethical and multiple relationships (Doyle, 1997). Qualifications to

provide supervision can vary considerably (Culbreth, 1999) and mismatches in recovery status have been raised as a concern (Anderson, 2000).

Recovery status has been shown to contribute to differences among substance abuse counselors, which may also influence ethical beliefs. Differences between how recovering and non-recovering substance abuse counselors treat substance abuse problems have been identified (Culbreth, 2000). Personality and attitude differences between recovering and non-recovering counselors have also been discussed (Shipko & Stout, 1992). These factors may contribute to differences in ethical beliefs among recovering and non-recovering counselors.

Research Question:

What is the relationship of educational level, recovery status, experience, and supervision to beliefs regarding the ethics of selected multiple relationship issues among Board Certified Substance Abuse Counselors (BCSACs)?

Hypotheses:

Hypothesis 1 was based on research related to education and ethics conducted by Toriello (1998). Toriello, in a survey related to substance counselors and sensitivity to ethical dilemmas and beliefs about training, determined that counselors with an associate degree or high school diploma were more ethically sensitive than counselors with higher degrees. Poor statistical interpretation may have contributed to Toriello's findings. Inconsistent findings in the research lead to the directional hypothesis.

Hypothesis 1

The overall mean score on the MRS SAC will be significantly lower for BCSACs with a bachelor's degree than the overall mean score on the MRS SAC for BCSACs with less than a bachelor's degree.

Research conducted by Culbreth (2000), Shipko and Stout (1992), and Toriello (1998) formed the basis for Hypothesis 2. Culbreth, based on an extensive literature review, suggested that significant personality and attitude differences exist between recovering counselors and non-recovering counselors. This contradicted earlier findings by Shipko and Stout that no significant differences in personality characteristics existed between the two groups. A survey study conducted by Toriello indicated no personality differences between recovering and non-recovering substance abuse counselors. Conflicting findings in previous research and lack of strong empirical evidence led to the directional hypothesis.

Hypothesis 2

The overall mean score on the MRS SAC will be significantly lower for non-recovering BCSACs than the overall mean score on the MRS SAC for recovering BCSACs.

Research related to experience has examined differences related to the number of hours required for eligibility to receive licensure/certification. Previous research has focused on variations in state requirements related to hours of experience prior to licensure/certification (Page & Bailey, 1995). Although limited research has been conducted in this area, it is plausible to suggest there are potential differences.

Hypothesis 3

The overall mean score on the MRS SAC will be significantly lower for BCSACs with experience prior to licensure/certification than the overall mean score on the MRS SAC for BCSACs with no experience prior to licensure/certification.

The need for continued supervision has been addressed in the literature (Doyle, 1997). Reeves, Culbreth, and Greene (1997) examined the effects of sex, age, and educational level on the supervisory styles of substance abuse counselors. Further research (West, Mustaine, & Wyrick, 2002) has examined factors contributing to the supervisory relationship including recovery status, formal and informal counselor training, and formal and informal supervisor training. Research has not examined the relationship between supervision prior to licensure/certification and ethics related to multiple relationships. However, it is reasonable to suggest that there may be differences based on supervision experience due to variability in supervisory training and recovery status differences.

Hypothesis 4

The overall mean score on the MRS SAC will be significantly lower for BCSACs who received supervision prior to licensure/certification than the overall mean score on the MRS SAC for BCSACs who did not receive supervision prior to licensure/certification.

Hypothesis 5

The overall mean score on the MRS SAC will be significantly lower for BCSACs who currently receive supervision than the overall mean score on the MRS SAC for BCSACs who do not receive current supervision.

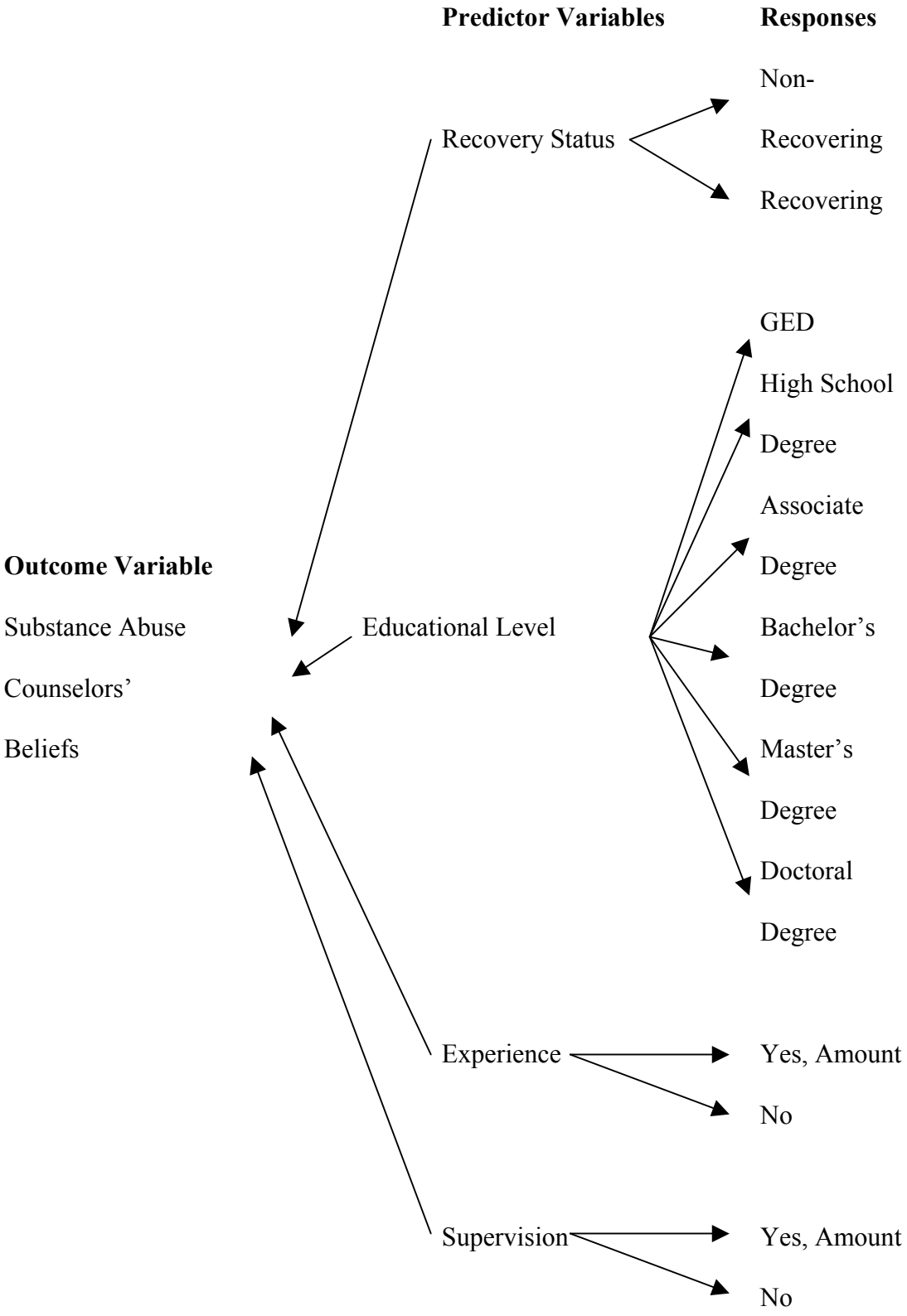
Data Collection Procedures

This study examined four predictor variables and one outcome variable. The first predictor variable examined was the recovery status of the participant. Participants were asked to identify themselves as non-recovering or recovering, and if recovering, to state the number of years they have been in recovery. The second predictor variable was educational level, with six response choices ranging from General Education Diploma (GED) through doctoral degree. The third predictor variable was experience, which requested participants to report years of post-licensure/certification experience as a counselor and if they gained experience in the substance abuse counseling field prior to licensure/certification and the number of years of experience. The fourth predictor variable was length of supervision; participants were asked to report if they received clinical supervision prior to licensure and the number of years of supervision. Participants also reported if they are currently receiving clinical supervision. The outcome variable in the study was ethical beliefs related to selected multiple relationship issues as measured by the MRS SAC, which is an instrument developed by this researcher. Table 1 demonstrates the variables in table form. In addition, Figure 1 illustrates the nature of the variables.

Table 1. Variables and Potential Responses

Outcome Variable	Predictor Variables	Responses
Substance Abuse Counselors' Beliefs	Recovery Status	Non-Recovering, Recovering
	Educational Level	GED, High School Degree, Associate Degree, Bachelor's Degree, Master's Degree, Doctoral Degree
	Experience	Yes/ No, Amount
	Supervision	Yes/ No, Amount

Figure 1. Outcome Variable and Predictor Variables.



Participants

The population of interest for this study was Board Certified Substance Abuse Counselors in the United States. The sample was comprised of licensed/certified substance abuse counselors in seven selected states. The participants were selected from lists supplied by state boards that responded to a request for information about licensing/certification requirements in their state. Purposeful, proportional, random sampling was utilized. All 50 state licensure boards were mailed a request for information and 31 states responded. Purposeful sampling was used to select seven states of the 31 that responded to the request. States with a large number of substance abuse counselors were selected to increase the number of potential participants. Random sampling was utilized to select participants from mailing lists purchased or obtained from seven states.

States were selected based on several criteria, including minimum educational requirements and the number of years or hours of experience required for licensure/certification, to ensure maximum variability across the states selected. The number and type of licensure/certification tiers utilized in each state were also utilized to select states.

The researcher purchased mailing lists of BCSACs from the seven state boards selected. Boards were requested to provide mailing lists of licensed/certified substance abuse counselors in their state. Boards provided lists of names and addresses with no demographic information (age, gender, race, or ethnicity). Therefore, it was not be possible to stratify the sample based on age, gender, race, or ethnicity. Twenty percent (20%) of individuals from each of the seven states were

selected to participate. A survey packet was sent to 787 randomly selected individuals.

Instrumentation

A demographic questionnaire was developed based on variables examined in previous research related to substance abuse counselors including recovery status, educational level, supervision, and experience (see Figure 1). Questions related to sex and race or ethnicity were included to provide additional information about the sample. Participants were requested to check responses as well as provide numerical information.

A researcher-developed instrument, entitled The Multiple Relationship Survey for Substance Abuse Counselors (MRS SAC), was utilized to investigate the beliefs of BCSACs regarding multiple relationships. An investigation yielded no instrument that addressed multiple relationships specifically for substance abuse counselors. The MRS SAC was developed through adaptation of items in the Borys and Pope (1989) instrument and the Gibson and Pope (1993) instrument, in addition to information in the literature that indicated specific problem areas for substance abuse counselors (Doyle, 1997) and non-sexual relationship concerns (Pritchett & Fall, 2001). Consultation with another substance abuse practitioner in the field also contributed to item development. A panel of three experts reviewed the MRS SAC and answered specific questions regarding the instrument (see Appendix E). After receiving feedback from each expert, the instrument was revised accordingly. Table 2 displays research supporting specific items.

Table 2. Research Supporting Item Development

Research	Item and Item Numbers
Borys & Pope (1989)	1. Accept a gift worth less than $10 2. Go out to eat with a client after outpatient group 10. Provide non-substance related counseling to a client's family member 12. Hire a client to babysit your children 17. Barter with a client for services 24. Become involved in a romantic or sexual relationship with a client
Doyle (1997)	3. Attend the same 12-step meeting as a current client 6. Serve as a client's 12-step program sponsor 7. Keep quiet about a client's relapse to other treatment team members 8. Disclose one client's progress to another client

Table 2 (continued). Research Supporting Item Development

Research	Item and Item Numbers
Doyle (1997)	9. Decline to write a job recommendation letter for a client 13. Talk about a client's therapy issues to colleagues outside the treatment facility 18. Avoid self-disclosing personal information to a client 19. Disclose treatment information to a client's sponsor 22. Tell a client that you will not write a letter for the client to receive child custody
Gibson & Pope (1993)	4. Refuse to give a client a ride in your car 5. Lend a client cigarettes or a small amount of money (under $10) 16. Disclose a client's HIV status in a group counseling setting

Table 2 (continued). Research Supporting Item Development

Research	Item and Item Numbers
Gibson & Pope (1993)	21. Touch a client when the client has not requested it 23. Borrow money from a client 25. Decline to provide treatment to a friend's family member
Pritchett & Fall (2001)	11. Avoid attending the same religious or social activity as a client 14. Offer privileges or preferential treatment to a favorite client such as shortening the length of treatment 15. Avoid a friendship with a client's family member 20. Go into a business partnership with a former client

Reliability of the MRS SAC was also examined by the use of Cronbach's Alpha to determine the internal consistency for each subscale. Validity of the MRS SAC was examined through content and construct validity. Content validity for the

survey was determined through a review by three individuals who have expertise in substance abuse counseling. The experts selected to examine the MRS SAC were requested to provide feedback about the appropriateness and content of items and their subscales. Construct validity for the MRS SAC and the demographic questionnaire were established through expert and peer scrutiny of question composition and variable definition.

A pilot study was conducted to determine the reliability and validity of the MRS SAC. The pilot study utilized substance abuse counselors located in two local treatment centers. Items were adjusted based on results of the pilot study and other measures.

Participants were asked to rate 25 statements related to multiple relationships using a Likert-type scale where 1= never ethical, 2= ethical under rare conditions, 3= ethical under some conditions, 4= ethical under most conditions, 5= always ethical. Unrated statements were treated as non-responses. The five subscales contained in the instrument related to multiple relationships included social/sexual involvements, financial involvements, personal/professional relationships, dual professional relationships, and boundaries of confidentiality. Three of the subscales, social/sexual involvements, financial involvements, and dual professional roles, were chosen based on factors previously identified by Borys and Pope (1989). Two additional subscales (personal/professional relationships and boundaries of confidentiality) were developed based on substance abuse counselor themes identified in the literature. Table 3 displays the survey subscales and items.

Table 3. Multiple Relationship Survey for Substance Abuse Counselors

Subscale	Item Number and Item
Social /Sexual Involvements	Six statements will assess beliefs related to social/sexual involvements with clients outside the counseling relationship. Participants will rate statements according to the following scale: 1= Never ethical, 2= Ethical under rare conditions, 3= Ethical under some conditions, 4= Ethical under most conditions, 5= Always ethical. 2. Go out to eat with a client after outpatient group 3. Attend the same 12-step meeting as a current client 11. Avoid attending the same religious or social activity as a client 15. Avoid a friendship with a client's family member 21. Touch a client when the client has not requested it

Table 3 (continued). Multiple Relationship Survey for Substance Abuse Counselors

Subscale	Item Number and Item
Social /Sexual Involvements	24. Become involved in a romantic or sexual relationship with a client
Financial Involvements	Five statements will assess beliefs related to financial involvements. Participants will rate statements according to the following scale: 1= Never ethical, 2= Ethical under rare conditions, 3= Ethical under some conditions, 4= Ethical under most conditions, 5= Always ethical. 1. Accept a gift worth less than $10 5. Lend a client cigarettes or a small amount of money (under $10) 17. Barter with a client for services 20. Go into a business partnership with a former client

Table 3 (continued). Multiple Relationship Survey for Substance Abuse Counselors

Subscale	Item Number and Item
Financial Involvements	23. Borrow money from a client
Personal/Professional Relationships	Five statements will assess beliefs related to personal/professional relationships. Participants will rate statements according to the following scale: 1= Never ethical, 2= Ethical under rare conditions, 3= Ethical under some conditions, 4= Ethical under most conditions, 5= Always ethical. 4. Refuse to give a client a ride in your car 6. Serve as a client's 12-step sponsor 12. Hire a client to babysit your children 14. Offer privileges or preferential treatment to a favorite client such as shortening the length of treatment 18. Avoid self-disclosing personal information

Table 3 (continued). Multiple Relationship Survey for Substance Abuse Counselors

Subscale	Item Number and Item
Dual Professional Relationships	Four statements will assess beliefs related to dual professional relationships. Participants will rate statements according to the following scale: 1= Never ethical, 2= Ethical under rare conditions, 3= Ethical under some conditions, 4= Ethical under most conditions, 5= Always ethical. 9. Decline to write a job recommendation for a client 10. Provide non-substance related counseling to a client's family member 22. Tell a client that you will not write a letter for the client to receive child custody 25. Decline to provide treatment to a friend's family member

Table 3 (continued). Multiple Relationship Survey for Substance Abuse Counselors

Subscale	Item Number and Item
Boundaries of Confidentiality	Five statements will assess beliefs related to confidentiality concerns. Participants will rate statements according to following scale: 1= Never ethical, 2= Ethical under rare conditions, 3= Ethical under some conditions, 4= Ethical under most conditions, 5= Always ethical. 7. Keep quiet about a client's relapse to other treatment team members 8. Disclose one client's progress to another client 13. Talk about a client's therapy issues to colleagues outside the treatment facility 16. Disclose a client's HIV status in a group counseling setting 19. Disclose treatment information to a client's sponsor

Participants were sent a packet containing a cover letter and consent form (see Appendix B), the demographic questionnaire (see Appendix C), and MRS SAC (see Appendix D). An addressed prepaid return envelope and pen were provided in the packet to increase the return rate. The participants were assured of confidentiality and were informed that no sensitive material related to actual behaviors with clients would be requested. To minimize cost and prevent secondary participation, coding was utilized to track completed packets. Numbers were assigned to each participant and were tracked to determine individuals who did not respond. Three weeks after the initial mailing, a reminder card was sent to individuals from the first mailing, who did not respond.

Data Analysis

Statistical procedures were utilized to examine the following five hypotheses as related to results according to the MRS SAC. The first four hypotheses were generated based on a review of the literature prior to conducting the study. The final hypothesis was developed during data entry.

Hypothesis 1

The overall mean score on the MRS SAC will be significantly lower for BCSACs with a bachelor's degree than the overall mean score on the MRS SAC for BCSACs with less than a bachelor's degree.

Hypothesis 2

The overall mean score for on the MRS SAC will be significantly lower for non-recovering BCSACs than the overall mean score on the MRS SAC for recovering BCSACs.

Hypothesis 3

The overall mean score on the MRS SAC will be significantly lower for BCSACs with experience prior to licensure/certification than the overall mean score on the MRS SAC for BCSACs with no experience prior to licensure/certification.

Hypothesis 4

The overall mean score on the MRS SAC will be significantly lower for BCSACs who received supervision prior to licensure/certification than the overall mean score on the MRS SAC for BCSACs who did not receive supervision prior to licensure/certification.

Hypothesis 5

The overall mean score on the MRS SAC will be significantly lower for BCSACs who currently receive supervision than the overall mean score on the MRS SAC for BCSACs who do not receive current supervision.

Data obtained from the demographic questionnaire and MRS SAC was analyzed in two steps. First, descriptive statistics summarized the sample related to sex and race or ethnicity. Also, frequency data were compiled to examine alcohol or drug recovery status, educational level, post-licensure/certification experience, experience prior to licensure/certification, clinical supervision prior to licensure/certification, and current supervision.

The second step of data analysis explored information obtained from the MRS SAC. Descriptive statistics were compiled for individual items including the percentage of participants' response to items and means and standard deviations for each item. Frequency distributions for each item were examined and a visual comparison of each item was conducted. Due to the negative skew of most items, a total score was compiled for each participant. The Kolmogorov-Smirnov was conducted and indicated further analyses should be examined through non-parametric tests. Each hypothesis was tested individually with a Kruskal-Wallis test. A Pearson correlation was conducted on the continuous variable years in recovery.

The third step of data analysis was concluded by examining subscales of the MRS SAC. A Cronbach's Alpha was conducted on each subscale to examine subscale reliability. Descriptive statistics were calculated to determine the mean and standard deviation of each subscale.

CHAPTER FOUR

RESULTS

In this chapter, the results of the study are presented. Sampling procedures are described and demographic characteristics of the participants are discussed. Results of statistical procedures utilized to examine the data and test the hypotheses are presented.

The purpose of this study was to increase understanding of beliefs of substance abuse counselors regarding multiple relationships. The relationship between beliefs and the variables of educational level, recovery status, experience, and supervision were explored.

Characteristics of the Sample

Purposeful sampling was used to select seven states of the 31 that responded to a request for information regarding licensure or certification in their state. State selection was based on several criteria including geographic location, number of substance abuse counselors in the state, number of levels of certification, and minimum educational requirements. States with a large number of substance abuse counselors were selected to increase the number of potential participants. Participants were chosen from the following seven states: Arizona, Illinois, Maine, Maryland (D.C.), Montana, North Carolina, and Wyoming. The cost of obtaining mailing lists

from each state was also a consideration in state selection. States were requested to provide mailing lists of their licensed or certified substance abuse counselors. Prevention specialists, judicial counselors, and substance abuse counselor trainees were excluded from the study.

Twenty percent (20 %) of individuals from each of the seven states were selected to participate. Random sampling was utilized to select participants from each of the seven mailing lists. Of the 787 surveys mailed, 21 were returned to sender due to incorrect addresses and one survey was destroyed in the mail. Thus, 765 surveys were assumed to have been delivered. A total of 392 completed surveys were returned, five of which were discarded due to lack of sufficient questions answered on the survey or incomplete information and 373 were not returned. Therefore, 387 were utilized for data analysis with a usable return rate of 50.6%.

Demographic Data

Descriptive statistics were obtained for gender, racial/ethnic category, alcohol or drug recovery status, highest degree obtained, years of post-licensure/certification experience, experience in the substance abuse counseling field prior to licensure/certification, previous clinical supervision, and current clinical supervision. Frequencies and percentages of participants for each of these demographic variables are reported in narratives and tables below.

Sex

Participants were requested to state their gender. Results indicated 144 participants (37.2%) were male and 239 participants (61.8%) were female. Four

participants (1.0%) did not respond. Table 4 displays the frequency distribution of participants by sex.

Table 4. Frequency Distribution of Participants by Sex

Characteristic	Frequency	Percent
Sex		
Male	144	37.2%
Female	239	61.8%
No Response	4	1.0%
Total	N= 387	100.0%

Racial/Ethnic Category

Participants were requested to provide information regarding their racial/ethnic category. Three hundred twenty-nine participants (85.5%) reported White, forty-two participants (10.9%) reported Black or African American, seven participants (1.8%) reported Hispanic, five participants (1.3%) reported American Indian or Alaska Native, one participant (0.3%) reported Asian, one participant (0.3%) reported Biracial/Multiracial, and no participants (0.0%) reported Native Hawaiian or Other Pacific Islander. Two participants (0.5%) did not respond. Table 5 displays frequency and percentage data for racial/ethnic category.

Table 5. Racial/Ethnic Category

Characteristic	Frequency	Percent
Racial/Ethnic Category		
American Indian or Alaska Native	5	1.3%
Asian	1	0.3%
Biracial/Multiracial	1	0.3%
Black or African American	42	10.9%
Hispanic	7	1.8%
Native Hawaiian or Other Pacific Islander	0	0.0%
White	329	85.5%
No Response	2	0.5%
Total	N= 387	100.0%

Alcohol or Drug Recovery Status

Participants were asked to provide information regarding their recovery status. One hundred sixty-eight participants (43.4%) reported that they were recovering from drugs or alcohol and the number of years in recovery (M= 19.44 years, SD= 6.61 years). Two hundred eighteen participants (56.3%) reported being non-recovering individuals. One participant (0.3%) did not respond. Table 6 displays frequency and percentage data for recovering and non-recovering participants.

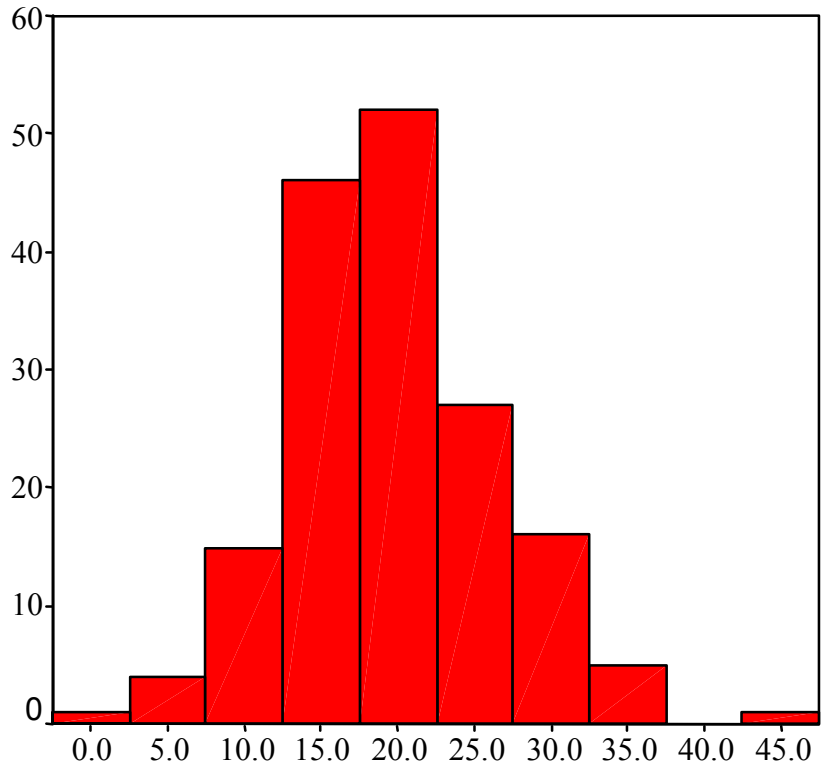
Table 6. Recovery Status

Characteristic	Frequency	Percent
Recovery Status		
Recovering	168	43.4%
Non-Recovering	218	56.3%
No Response	1	0.3%
Total	N= 387	100.0%

Years in Recovery

Those participants who reported being in recovery (N= 168) provided numeric information regarding number of years in recovery. The longest period in recovery was 45 years and the shortest was two years in recovery (M= 19.44 years, SD= 6.61 years). Graph 1 displays frequency data for number of years in recovery.

Graph 1. Number of Years in Recovery



Educational Level

Participants were requested to report their highest educational degree completed. Two participants (0.5%) reported GED. Fifteen participants (3.9%) reported high school diploma. Thirty participants (7.8%) reported associate degree. Eighty-two participants (21.2%) reported bachelor's degree. Two hundred forty-two participants (62.5%) reported master's degree. Fourteen participants (3.6%) reported doctoral degree. Two participants (0.5%) did not respond. Table 7 depicts educational

level. The majority of participants possessed a master's degree (62.5%) and only 21.2% possessed a bachelor's degree.

Table 7. Educational Level

Characteristic	Frequency	Percent
Educational Level		
GED	2	0.5%
High School Diploma	15	3.9%
Associate Degree	30	7.8%
Bachelor's Degree	82	21.2%
Master's Degree	242	62.5%
Doctoral Degree	14	3.6%
No Response	2	0.5%
Total	N= 387	100.0%

Table 8 depicts educational level and recovery status. Individuals in recovery possessed fewer master's degrees than non-recovering counselors and more bachelor's degrees, associate degrees, and high school diplomas than non-recovering counselors.

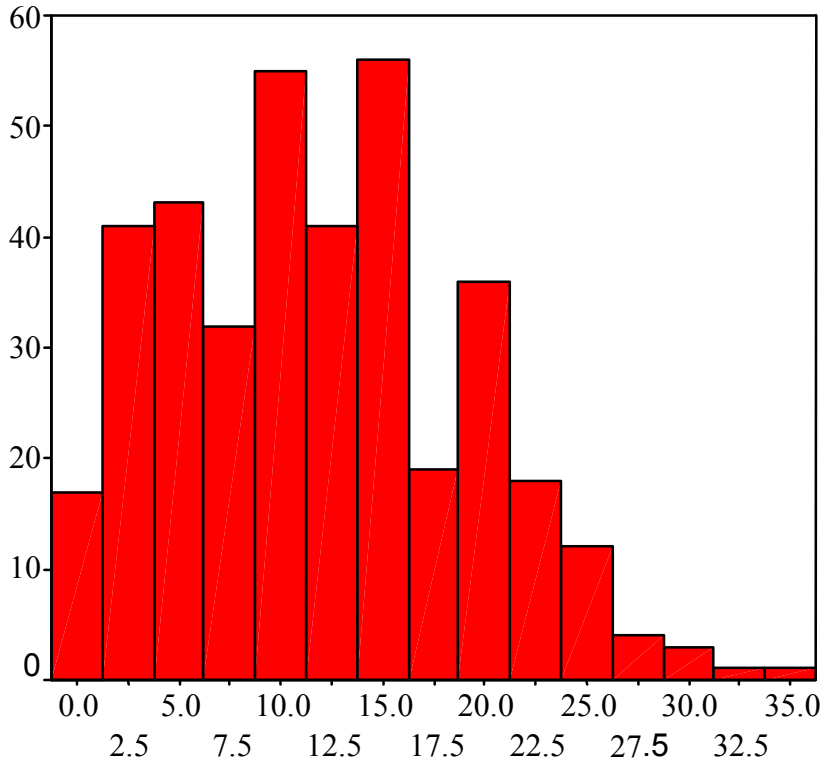
Table 8. Educational Level and Recovery Status

Characteristics	Recovering	%	Non-Recovering	%
Educational Level				
GED	2	1.1%	0	0%
High School Diploma	14	8.4%	1	.5%
Associate Degree	22	13.2%	8	3.7%
Bachelor's Degree	39	23.4%	42	19.3%
Master's Degree	85	50.9%	157	72.3%
Doctoral Degree	5	3.0%	9	4.1%
Totals	*n*= 167	100%	*n* =217	100%

Years of Post-Licensure/Certification Experience

Participants were asked, "How many years of post-licensure/certification experience do you have as a counselor?" Three hundred seventy-nine participants responded (97.9%) and eight (2.1%) did not respond. Participants provided numeric information regarding years of experience with a high of 35 years and a low of zero years (M= 11.85, SD= 7.16). Graph 2 provides frequency data for number of years of experience. The data appears to be moderately positively skewed for years of post-licensure experience.

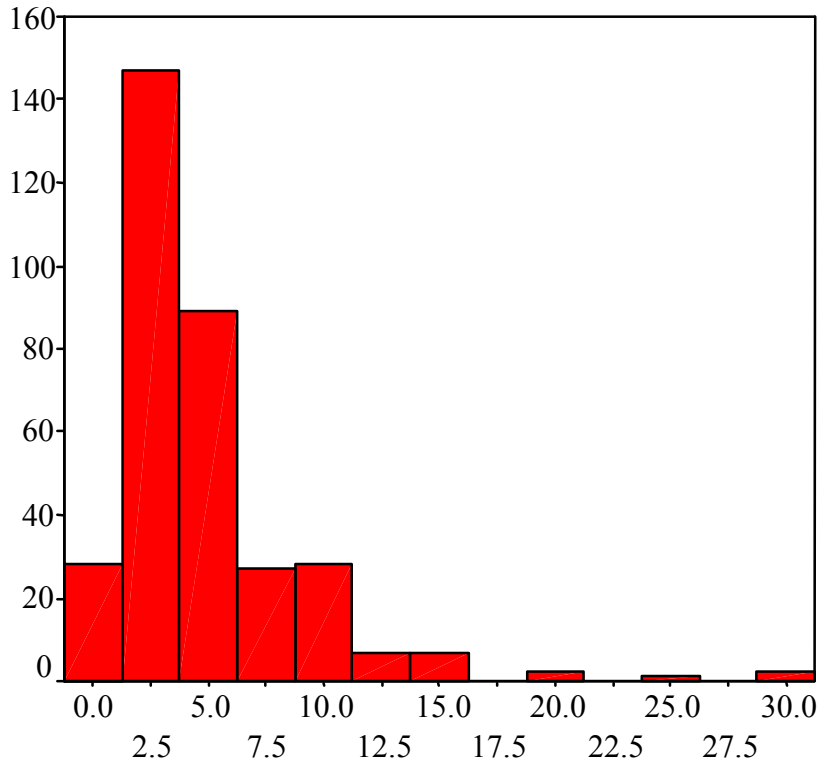
Graph 2. Years of Post-Licensure Experience



Experience Prior to Licensure/Certification

Participants were requested to respond to the question, "Did you gain experience in the substance abuse counseling field prior to licensure/certification?" Thirty-six participants (9.3%) responded they did not obtain prior experience. Three hundred forty-nine participants (90.2%) reported prior experience with a high of 29 years of experience and a low of six months (M= 4.76 years, SD= 4.01). Two participants (0.5%) did not respond. Graph 3 depicts frequency data for number of years of experience prior to licensure. The data appears to be sharply positively skewed.

Graph 3. Years of Experience Prior to Licensure

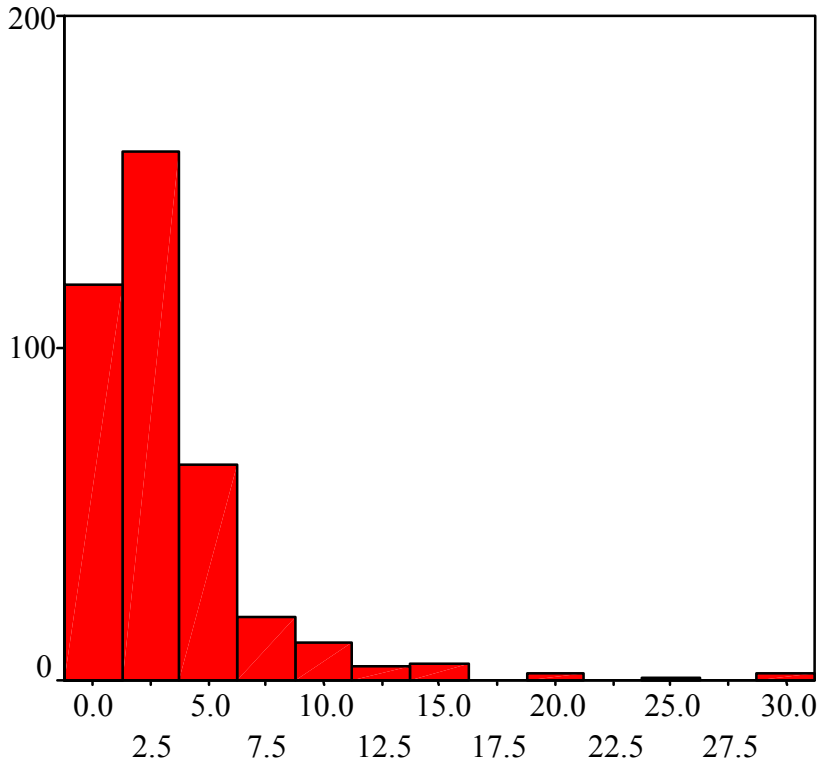


Clinical Supervision Prior to Licensure/Certification

Participants were asked to respond to the question, "Did you receive clinical supervision of your work as a substance abuse counselor prior to licensure/certification?" Forty-eight participants (12.4%) responded they did not receive prior supervision. Three hundred thirty-seven participants (87.1%) responded they did receive prior supervision with a high of 30 years of supervision and a low of six months (M= 3.86 years, SD= 3.87). Two participants (0.5%) did not respond.

Graph 4 depicts frequency data for number of years of prior supervision demonstrating a severely positive skew.

Graph 4. Years of Prior Supervision



Current Clinical Supervision

Participants were asked to respond to the question, "Are you currently receiving clinical supervision of your work as a substance abuse counselor (i.e. staffing cases, discussing clients)?" One hundred thirty-one participants (33.9%) reported they were not currently receiving supervision. Two hundred forty-eight participants (64.1%) responded they were currently receiving supervision. Eight

participants (2.1%) did not respond. Table 9 displays frequency and percentage data for participants currently receiving and not receiving supervision.

Table 9. Participants Currently Receiving Supervision

Characteristic	Frequency	Percent
Current Supervision		
Yes	248	64.1%
No	131	33.9%
No Response	8	2.1%
Total	N= 387	100.0%

Multiple Relationship Survey for Substance Abuse Counselors

Participants were requested to complete the Multiple Relationship Survey for Substance Abuse Counselors (MRS SAC; Appendix D) to examine beliefs related to ethics of selected multiple relationship issues. Participants were asked to rate 25 statements related to multiple relationships using a Likert-type scale where 1= never ethical, 2= ethical under rare conditions, 3= ethical under some conditions, 4= ethical under most conditions, 5= always ethical. Of the 25 items, 18 items were presented as positive statements and seven items were presented as negative statements. Upon data analysis, the seven negatively worded statements items were reverse scored (i.e. 1=5, 2=4, 3=3).

Individual Item Analyses

Descriptive Statistics for Individual Items

Table 10 displays each item and the percentage of participants who responded to each rating. The sample appeared to have greater variation in responses for items 1, 3, 4, 9, 10, 11, 15, 18, 22, and 25. These items addressed accepting a gift worth less than $10, attending the same 12-step meeting as a current client, refusing to give a client a ride in your car, declining to write a job recommendation letter for a client, providing non-substance abuse related counseling to a client's family member, avoiding attending the same religious or social activity as a client, avoiding a friendship with a client's family member, avoiding self-disclosing personal information, telling a client that you will not write a letter for the client to receive child custody, and declining to provide treatment to a friend's family member. This may indicate that, among this sample of participants, there was a lack of consensus regarding the extent to which the described behaviors are considered to be ethical.

Table 11 displays the means and standard deviations for each item of the MRS SAC. Mean scores suggested that participants rated several behaviors as being ethical under some or most conditions. Items 4, 11, 15, 18, 22, and 25 all with mean rating between 3.0 (ethical under some conditions) and 4.0 (ethical under most conditions. Items addressed refusing to give a client a ride in your car, avoid attending the same religious or social activity as a client, avoid a friendship with a client's family member, avoid self-disclosing personal information, tell a client that you will not write a letter for the client to receive child custody, and decline to provide treatment to a friend's family member. These were all reverse scored items. Mean scores also

suggested that participants generally believed that some behaviors are never or only rarely ethical. These behaviors, with mean scores less than 2.0, included going out to eat with a client after outpatient group, lending a client cigarettes or a small amount of money, serving as a client's 12-step program sponsor, keeping quiet about a client's relapse to other treatment team members, disclosing one client's progress to another client, hiring a client to babysit your children, talking about a client's therapy issues to colleagues outside the treatment facility, offering privileges or preferential treatment to a favorite client such as shortening the length of treatment, disclosing a client's HIV status in a group counseling setting, bartering with a client for services, disclosing treatment information to a client's sponsor, going into a business partnership with a former client, touching a client when the client has not requested it, borrowing money from a client, and becoming involved in a romantic or sexual relationship with a client.

Items related to Social/Sexual Involvements, Financial Involvements, Personal/Professional Relationships, and Boundaries of Confidentiality appeared overall as more ethically problematic to participants. Dual Professional Relationships were areas where participants responded to items as less ethically problematic.

Table 10. Percentage of Participants Response to Items

Item	Rating					
	1	2	3	4	5	NR
	%	%	%	%	%	%
1. Accept a gift worth less than $10	31.3	22.7	31.5	9.0	4.4	1.0
2. Go out to eat with a client after outpatient group	75.2	12.4	7.2	1.0	3.4	.8
3. Attend the same 12-step meeting as a current client	29.5	22.7	31.8	10.6	6.2	1.3
4. Refuse to give a client a ride in your car	8.8	14.5	27.6	23.5	24.8	.8
5. Lend a client cigarettes or a small amount of money (under $10)	63.3	20.7	10.1	1.8	3.6	.5
6. Serve as a client's 12-step program sponsor	87.6	4.4	2.6	.3	4.7	.3
7. Keep quiet about a client's relapse to other treatment team members	80.1	8.0	3.6	1.3	6.7	.3
8. Disclose one client's progress to another client	87.6	4.4	2.1	.5	5.4	0

Rating Codes: 1= Never ethical, 2= Ethical under rare conditions, 3= Ethical under some conditions, 4= Ethical under most conditions, 5= Always ethical, NR= No response.

Table 10 (continued). Percentage of Participants Response to Items

Item	Rating					
	1	2	3	4	5	NR
	%	%	%	%	%	%
9. Decline to write a job recommendation letter for a client	9.0	12.9	31.5	17.1	28.9	.5
10. Provide non-substance abuse related counseling to a client's family member	37.2	22.0	26.4	8.3	5.7	.5
11. Avoid attending the same religious or social activity as a client	7.2	11.6	36.7	23.8	20.2	.5
12. Hire a client to babysit your children	88.4	4.9	1.3	.5	4.7	.3
13. Talk about a client's therapy issues to colleagues outside the treatment facility	64.3	16.3	12.9	1.8	3.9	.3

Rating Codes: 1= Never ethical, 2= Ethical under rare conditions, 3= Ethical under some conditions, 4= Ethical under most conditions, 5= Always ethical, NR= No response.

Table 10 (continued). Percentage of Participants Response to Items

Item	Rating					
	1	2	3	4	5	NR
	%	%	%	%	%	%
14. Offer privileges or preferential treatment to a favorite client such as shortening the length of treatment	90.4	4.1	.5	.5	4.1	.3
15. Avoid a friendship with a client's family member	8.8	10.3	15.5	17.1	48.1	.3
16. Disclose a client's HIV status in a group counseling setting	90.2	3.4	.8	.3	4.9	.5
17. Barter with a client for services	65.9	17.8	8.3	1.6	5.2	1.3
18. Avoid self-disclosing personal information	2.3	11.9	37.7	28.7	19.1	.3
19. Disclose treatment information to a client's sponsor	68.7	15.2	0.3	1.6	3.4	.8

Rating Codes: 1= Never ethical, 2= Ethical under rare conditions, 3= Ethical under some conditions, 4= Ethical under most conditions, 5= Always ethical, NR= No response.

Table 10 (continued). Percentage of Participants Response to Items

Item	Rating					
	1	2	3	4	5	NR
	%	%	%	%	%	%
20. Go into a business partnership with a former client	73.9	13.4	7.5	1.3	3.4	.5
21. Touch a client when the client has not requested it	63.8	19.6	11.4	1.0	3.6	.5
22. Tell a client that you will not write a letter for the client to receive child custody	8.0	13.7	42.6	15.2	19.1	1.3
23. Borrow money from a client	94.1	1.0	0	.3	4.4	.3
24. Become involved in a romantic or sexual relationship with a client	94.6	.8	.3	0	4.1	.3
25. Decline to provide treatment to a friend's family member	9.8	11.4	25.8	24.8	27.4	.8

Rating Codes: 1= Never ethical, 2= Ethical under rare conditions, 3= Ethical under some conditions, 4= Ethical under most conditions, 5= Always ethical, NR= No response.

Table 11. Mean and Standard Deviation for Items

Item	Mean	Standard Deviation
1. Accept a gift worth less than $10	2.32	1.14
2. Go out to eat with a client after outpatient group	1.44	.93
3. Attend the same 12-step meeting as a current client	2.43	1.20
4. Refuse to give a client a ride in your car	3.41	1.25
5. Lend a client cigarettes or a small amount of money (under $10)	1.61	.99
6. Serve as a client's 12-step program sponsor	1.29	.91
7. Keep quiet about a client's relapse to other treatment team members	1.46	1.10
8. Disclose one client's progress to another client	1.32	.97
9. Decline to write a job recommendation for a client	3.44	1.28

Rating Codes: 1= Never ethical, 2= Ethical under rare conditions, 3= Ethical under some conditions, 4= Ethical under most conditions, 5= Always ethical, NR= No response.

Table 11 (continued). Mean and Standard Deviation for Items

Item	Mean	Standard Deviation
10. Provide non-substance abuse related counseling to a client's family member	2.23	1.20
11. Avoid attending the same religious or social activity as a client	3.38	1.15
12. Hire a client to babysit your children	1.28	.91
13. Talk about a client's therapy issues to colleagues outside the treatment facility	1.64	1.04
14. Offer privileges or preferential treatment to a favorite client such as shortening the length of treatment	1.23	.85
15. Avoid a friendship with a client's family member	3.85	1.35
16. Disclose a client's HIV status in a group counseling setting	1.25	.90
17. Barter with a client for services	1.60	1.06

Rating Codes: 1= Never ethical, 2= Ethical under rare conditions, 3= Ethical under some conditions, 4= Ethical under most conditions, 5= Always ethical, NR= No response.

Table 11 (continued). Mean and Standard Deviation for Items

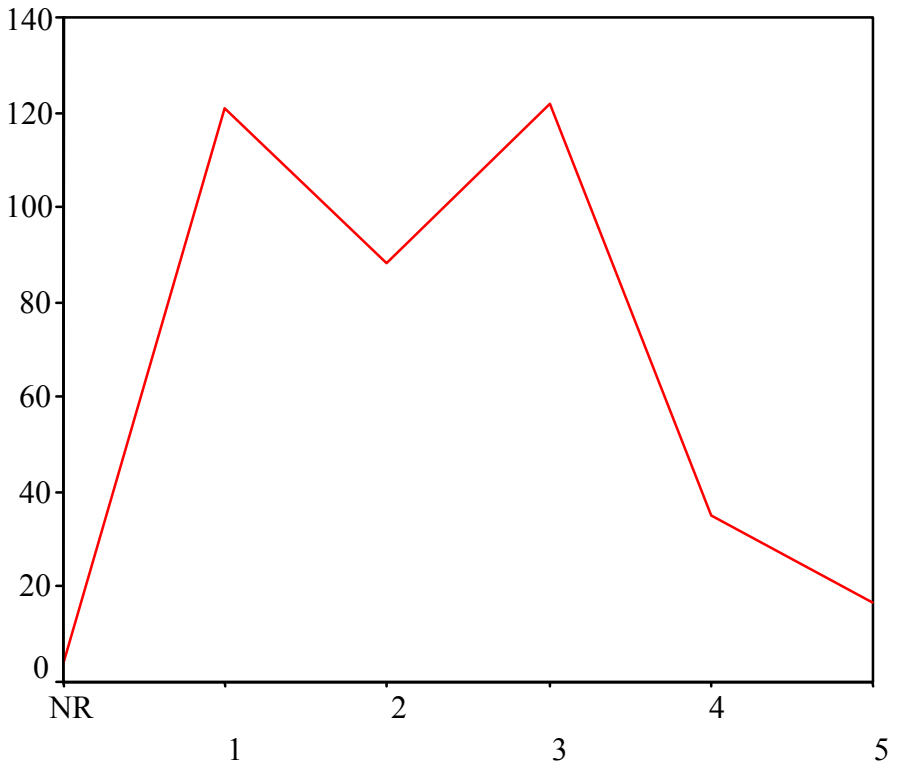
Item	Mean	Standard Deviation
18. Avoid self-disclosing personal information to a client	3.51	1.01
19. Disclose treatment information to a client's sponsor	1.54	.98
20. Go into a business partnership with a former client	1.46	.94
21. Touch a client when the client has not requested it	1.60	.98
22. Tell a client that you will not write a letter for the client to receive child custody	3.24	1.16
23. Borrow money from a client	1.19	.84
24. Become involved in a romantic or sexual relationship with a client	1.18	.81
25. Decline to provide treatment to a friend's family member	3.49	1.28

Rating Codes: 1= Never ethical, 2= Ethical under rare conditions, 3= Ethical under some conditions, 4= Ethical under most conditions, 5= Always ethical, NR= No response.

Frequency Distributions for Individual Items

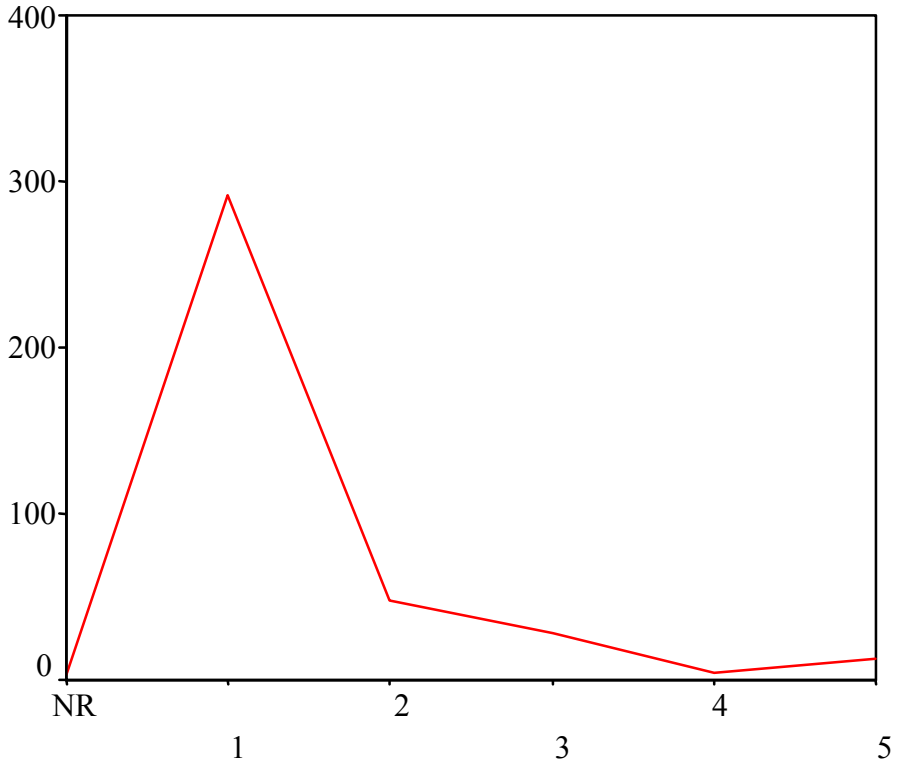
Frequency distributions were examined for each item of the MRS SAC. Line graphs were generated to visually compare the items and examine the shape of item distributions. Preliminary analyses indicated 16 items were positively skewed toward never ethical. The nine remaining items appeared somewhat more normally distributed. Item 1 and Item 2 represent the two types of distributions identified. Graph 5 depicts the frequency distribution for Item 1, "Accept a gift worth less than $10." There is a significant variation between individuals who rated accepting a gift as never ethical and ethical under some conditions versus the number of individuals who rated the item as ethical under rare conditions. Graph 6 depicts the positively skewed frequency distribution for Item 2, "Go out to eat with a client after outpatient counseling group." There appeared to be a consensus among individuals who rated the item as never ethical with a sharp decline related to ethical under rare conditions.

Graph 5. Frequency Distribution for Item 1



Graph 5. Rating Codes: 1= Never ethical, 2= Ethical under rare conditions, 3= Ethical under some conditions, 4= Ethical under most conditions, 5= Always ethical, NR= No response.

Graph 6. Frequency Distribution for Item 2



Graph 6. Rating Codes: 1= Never ethical, 2= Ethical under rare conditions, 3= Ethical under some conditions, 4= Ethical under most conditions, 5= Always ethical, NR= No response.

Due to the substantial number of positively skewed items, a total score was compiled for each participant to assist with analysis of the data. To verify the distribution of the total score, a Kolmogorov-Smirnov test was conducted. Results indicated the variable total score was not normally distributed at a two-tailed

significance of .000. The Kolmogorov-Smirnov indicated further analyses should be conducted through non-parametric tests. Results are displayed in Tables 12.

Table 12. One-Sample Kolmogorov-Smirnov Test

	Mean	Standard Deviation
Total Score	45.46	13.60
Kolmogorov-Smirnov Z	.000*	
Assumption Significance (two-tailed)		

*p<.05

Research Hypotheses

For the purposes of this study, five research hypotheses were examined. The following section describes the results of statistical analyses employed to test each hypothesis.

Hypothesis 1

Hypothesis 1 stated that the overall mean score on the MRS SAC will be significantly lower for BCSACs with a bachelor's degree than the overall mean score on the MRS SAC for BCSACs with less than a bachelor's degree.

Individuals were grouped into two categories based on degree completed. Individuals with GED, high school diploma, associate degree, and bachelor's degree were grouped in the first category. Individuals with a master's degree or doctoral degree were grouped into the second category. A Kruskal-Wallis test was conducted

to examine educational level and total score on the MRS SAC. No significant difference was found ($H(2)= .092$, $p > .05$), indicating that the groups did not differ significantly from each other. Participants with a bachelor's level degree or lower averaged a mean rank of 195.42, while participants with a master's level degree or higher averaged a mean rank of 191.78. Educational level did not influence total score on the MRS SAC. Results are displayed in Tables 13 and 14.

Table 13. Mean Ranks for Educational Level

Characteristic	N	Mean Rank
Degree Status		
Bachelor's or Degree or Lower	129	195.42
Master's Degree or Higher	256	191.78
Total	385	

Table 14. Kruskal-Wallis Test Statistic for Educational Level

Chi-Square	df	Asymp. Sig.
.092	1	.762

*p<.05

Hypothesis 2

Hypothesis 2 stated that the overall mean score on the MRS SAC will be significantly lower for non-recovering BCSACs than the overall mean score on the MRS SAC for recovering BCSACs.

Individuals were grouped into two categories based on alcohol and drug recovery status. Individuals who reported being in recovery were grouped in the first category and individuals who reported being non-recovering were grouped into the second category. A Kruskal-Wallis test was conducted to examine recovery status and total score on the MRS SAC. A significant result was found ($H(2)= 5.170$, $p < .05$), indicating that the groups differed significantly from each other. Recovering participants averaged a mean rank of 208.20, while non-recovering participants averaged a mean rank of 182.17. Non-recovering participants scored lower on the MRS SAC than recovering participants. A lower total score indicated participants viewed more items as ethically problematic. Results are displayed in Tables 15 and 16.

Table 15. Mean Ranks for Recovery Status

Characteristic	N	Mean Rank
Recovery Status		
Recovering	168	208.20
Non-recovering	218	182.17
Total	386	

Table 16. Kruskal-Wallis Test Statistic for Recovery Status

Chi-Square	df	Asymp. Sig.
5.170	1	.023*

*p<.05

Years in Recovery

A Pearson correlation was conducted to examine the relationship between years in recovery and total score on the MRS SAC. Results indicated a weak correlation that was not statistically significant ($r(2)= -.101$, $p > .05$). The results are displayed in table 17.

Table 17. Correlations for Years in Recovery and Total Score

	Pearson Correlation	Significance (2-tailed)
Years in Recovery and Total Score	-.101	.195

*p<.05

Hypothesis 3

Hypothesis 3 stated that the overall mean score on the MRS SAC will be significantly lower for BCSACs with experience prior to licensure/certification than the overall mean score on the MRS SAC for BCSACs with no experience prior to licensure/certification.

Individuals were grouped into two categories based on experience prior to licensure/certification. Individuals without prior experience degree were grouped in

the first category and individuals with experience were grouped into the second category. A Kruskal-Wallis test was conducted to examine experience prior to licensure/certification and total score on the MRS SAC. No significant difference was found ($H(2)= .328$, $p > .05$), indicating that the groups did not differ significantly from each other. Participants without experience prior to licensure/certification averaged a mean rank of 182.89, while participants with prior experience averaged a mean rank of 194.04. Experience prior to licensure/certification did not influence total score on the MRS SAC. Results are displayed in Tables 18 and 19.

Table 18. Mean Ranks for Experience

Characteristic	N	Mean Rank
Prior Experience		
No	36	182.89
Yes	349	194.04
Total	385	

Table 19. Kruskal-Wallis Test Statistic for Educational Level

Chi-Square	df	Asymp. Sig.
.328	1	.567

*p<.05

Hypothesis 4

Hypothesis 4 stated that the overall mean score on the MRS SAC will be significantly lower for BCSACs who received supervision prior to licensure/certification than the overall mean score on the MRS SAC for BCSACs who did not receive supervision prior to licensure/certification.

Individuals were grouped into two categories based on receiving supervision prior to licensure/certification. Individuals with supervision prior to licensure/certification were grouped in the first category and individuals without supervision prior to licensure/certification were grouped into the second category. A Kruskal-Wallis test was conducted to examine supervision prior to licensure/certification and total score on the MRS SAC. No significant difference was found ($H(2)= .595$, $p > .05$), indicating that the groups did not differ significantly from each other. Participants who did not receive supervision prior to licensure/certification averaged a mean rank of 181.42, while participants with supervision prior to licensure/certification averaged a mean rank of 194.65. Supervision prior to licensure/certification did not influence total score on the MRS SAC. Results are displayed in Tables 20 and 21.

Table 20. Mean Ranks for Prior Supervision

Characteristic	N	Mean Rank
Prior Supervision		
No	48	181.42
Yes	337	194.65
Total	385	

Table 21. Kruskal-Wallis Test Statistic for Prior Supervision

Chi-Square	df	Asymp. Sig.
.595	1	.440

*p<.05

Hypothesis 5

Hypothesis 5 stated that the overall mean score on the MRS SAC will be significantly lower for BCSACs who currently receive supervision than the overall mean score on the MRS SAC for BCSACs who do not receive current supervision.

Individuals were grouped into two categories based on currently receiving supervision. Individuals who reported currently receiving supervision were grouped in the first category and individuals who were not currently receiving supervision were grouped into the second category. A Kruskal-Wallis test was conducted to examine current supervision and total score on the MRS SAC. A significant result

was found ($H(2)= 5.866$, $p < .05$), indicating that the groups differed significantly from each other. Participants not currently receiving supervision averaged a mean rank of 208.74, while participants currently receiving supervision averaged a mean rank of 180.10. Participants currently receiving supervision scored lower on the MRS SAC than participants not currently receiving supervision. A lower total score indicated participants viewed more items as ethically problematic. Results are displayed in Tables 22 and 23.

Table 22. Mean Ranks for Current Supervision

Characteristic	N	Mean Rank
Current Supervision		
No	131	208.74
Yes	248	180.10
Total	379	

Table 23. Kruskal-Wallis Test Statistic for Current Supervision

Chi-Square	df	Asymp. Sig.
5.866	1	.015*

*p<.05

Multiple Relationship Survey for Substance Abuse Counselor Subscales

Subscale Reliability Testing

The five subscales contained in the MRS SAC related to multiple relationships included social/sexual involvements, financial involvements, personal/professional relationships, dual professional relationships, and boundaries of confidentiality. Three of the subscales, social/sexual involvements, financial involvements, and dual professional roles, were chosen based on factors previously identified by Borys and Pope (1989). Two additional subscales (personal/professional relationships and boundaries of confidentiality) were developed based on substance abuse counselor themes identified in the literature.

Cronbach's Alpha reliability testing was employed to examine the reliability of each subscale. Subscale 1 was related to Social/Sexual Involvements and included items 2, 3, 11, 15, 21, and 24. These items addressed going out to eat with a client after outpatient group, attending the same 12-step meeting as a current client, avoid attending the same religious or social activity as a client, avoiding a friendship with a client's family member, touching a client when the client has not requested it, and becoming involved in a romantic or sexual relationship with a client. Reliability testing for Subscale 1 indicated an alpha of .53 with all items. When reverse-scored items were deleted (items 11 and 15), the alpha level rose to .72.

Subscale 2, Financial Involvements, included items 1, 5, 17, 20, and 23. These items addressed accepting a gift worth less than $10, lending a client cigarettes or a small amount of money, bartering with a client for services, going into a business partnership with a former client, and borrowing money from a client. Alpha testing

for this subscale indicated an alpha of .81 when all items were included in the scale. No items in this subscale were reverse-scored.

Subscale 3 included Personal/Professional Relationships and consisted of items 4, 6, 12, 14, and 18. These items addressed refusing to give a client cigarettes or a small amount of money, serving as a client's 12-step program sponsor, hiring a client to babysit your children, offering privileges or preferential treatment to a favorite client such as shortening the length of treatment, and avoid self-disclosing personal information. Reliability testing for this subscale indicated an alpha of .58 when all items were included. When reverse-scored items were excluded (items 4 and 18), the alpha level rose to .91.

Subscale 4 was related to Dual Professional Relationships and included items 9, 10, 22, and 25. These items addressed declining to write a job recommendation letter for a client, providing non-substance abuse related counseling to a client's family member, telling a client that you will not write a letter for the client to receive child custody, and declining to provide treatment to a friend's family member. Reliability testing for Subscale 4 indicated an alpha level of .43 when all items were included. Three items (9, 22, and 25) were reverse-scored. When only the reverse-scored items were included, the alpha level rose to .63.

Subscale 5, Boundaries of Confidentiality, consisted of items 7, 8, 13, 16, and 19. These items addressed keeping quiet about a client's relapse to other treatment team members, disclosing one client's progress to another client, talking about a client's therapy issues to colleagues outside the treatment facility, disclosing a client's HIV status in a group counseling setting, and disclosing treatment information to a

client's sponsor. The Cronbach's Alpha test for this subscale indicated an alpha level of .87 with all items included. No items in this subscale were reverse-scored.

Reliability testing of each subscale indicated that reverse-scored items contributed to poor internal consistency. In subscales with reverse-scored items, the alpha level increased when those items were excluded. Subscales without reverse-scored items appeared to have higher internal consistency. This may be indicative the concepts that were reverse-scored were unimportant to the subscales or created a response bias.

Subscale Descriptive Statistics

Due to the use of non-parametric statistics, a factor analysis or correlations of items would have been inappropriate to examine subscales. To provide descriptive information regarding the subscales, means and standard deviations were calculated for each of the subscales.

Table 24. Means and Standard Deviations for Subscales

Subscale	Mean	Standard Deviation
Social/Sexual Involvements	1.89	.60
Financial Involvements	1.62	.76
Personal/Professional Relationships	1.77	.61
Dual Professional Relationships	2.49	.76
Boundaries of Confidentiality	1.44	.81

Information obtained regarding means and standard deviations indicated participants viewed Boundaries of Confidentiality as less ethically problematic than the other subscales. Dual Professional Relationships and Social/Sexual Involvements were viewed as more ethically problematic for participants.

Summary

Results of the study showed that two variables were indicative of a lower total score on the MRS SAC, which indicated participants viewed more items as ethically problematic. Non-recovering individuals obtained a lower total score on the MRS SAC and individuals currently receiving supervision obtained a lower total score. Highest degree obtained, experience prior to licensure, and supervision prior to licensure were not associated with lower total scores on the MRS SAC.

CHAPTER FIVE

DISCUSSION

In this chapter, the results of this study are discussed. The purpose of the study, methods, and hypotheses are restated. Findings of the study are discussed and limitations are reviewed. Implications for the substance abuse counseling field and further recommendations are offered.

The purpose of this study was to increase understanding of beliefs of substance abuse counselors regarding multiple relationships. The relationship between beliefs and the variables of educational level, recovery status, experience, and supervision were explored.

Purposeful sampling was used to select seven states of the 31 that responded to a request for information regarding licensure or certification in their state. Participants were chosen from the following seven states: Arizona, Illinois, Maine, Maryland (D.C.), Montana, North Carolina, and Wyoming. Twenty percent (20 %) of individuals from each of the seven states were selected to participate. Random sampling was utilized to select participants from each of the seven mailing lists. Of the 765 surveys delivered, 387 were utilized for data analysis with a usable return rate of 50.6%.

Discussion of Findings

The following hypotheses were examined for the purpose of this study.

Hypothesis 1

The overall mean score on the MRS SAC will be significantly lower for BCSACs with a bachelor's degree than the overall mean score on the MRS SAC for BCSACs with less than a bachelor's degree. Hypothesis 1 was not supported.

Hypothesis 1 was based on research related to education and ethics conducted by Toriello (1998). Toriello surveyed 227 substance abuse counselors related to sensitivity to ethical dilemmas and beliefs about preparation to help resolve ethical dilemmas. Results indicated that counselors with an associate degree or high school diploma were more ethically sensitive than counselors with higher degrees.

The results of this study did not support Toriello's findings. Educational degree did not affect participant responses to the MRS SAC. However, these findings may have been affected by the number of participants who possessed a master's degree or higher. There were significantly fewer participants who possessed a bachelor's degree in this study. It is possible that individuals with a bachelor's degree or less were less likely to participate in this research.

Hypothesis 2

The overall mean score on the MRS SAC will be significantly lower for non-recovering BCSACs than the overall mean score on the MRS SAC for recovering BCSACs. Hypothesis 2 was supported.

Research conducted by Culbreth (2000), Shipko and Stout (1992), and Toriello (1998) formed the basis for Hypothesis 2. Culbreth, based on an extensive

literature review, suggested that significant personality and attitude differences exist between recovering counselors and non-recovering counselors. Culbreth asserted that recovering counselors are less flexible, more concrete in thinking, more rigid about the disease model of addiction, and less positive about the effectiveness of non-recovering counselors. This contradicted earlier findings by Shipko and Stout that no significant differences in personality characteristics existed between the two groups. A survey study conducted by Toriello indicated no personality differences between recovering and non-recovering substance abuse counselors.

This study supported the research conducted by Culbreth who found differences between recovering and non-recovering counselors. Non-recovering substance abuse counselors found more multiple relationship behaviors to be ethically problematic as indicated by their responses to the questionnaire. It is plausible to suggest these differences may be related to personality differences between recovering and non-recovering substance abuse counselors. Beliefs regarding recovery, flexibility, and concrete thinking may be factors that contribute to beliefs regarding multiple relationship behaviors.

Hypothesis 3

The overall mean score on the MRS SAC will be significantly lower for BCSACs with experience prior to licensure/certification than the overall mean score on the MRS SAC for BCSACs with no experience prior to licensure/certification. Hypothesis 3 was not supported.

Research related to experience has examined differences in the number of hours required for eligibility to receive licensure/certification. Previous research has

focused on variations in state requirements related to hours of experience prior to licensure/certification (Page & Bailey, 1995). The current study indicated there were no differences between counselors with prior experience and counselors without prior experience.

Although this hypothesis was not supported, it is difficult to ascertain the role experience may play in ethical beliefs. It is possible that recovering counselors may have considered years of recovery experience to be clinical experience. Research has examined variations in experience requirements but not the implications of fewer hours of experience on ethical beliefs.

Hypothesis 4

The overall mean score on the MRS SAC will be significantly lower for BCSACs who received supervision prior to licensure/certification than the overall mean score on the MRS SAC for BCSACs who did not receive supervision prior to licensure/certification. Hypothesis 4 was not supported.

Hypothesis 5

The overall mean score on the MRS SAC will be significantly lower for BCSACs who currently receive supervision than the overall mean score on the MRS SAC for BCSACs who do not receive current supervision. Hypothesis 5 was supported.

Response to Items

Percentages of participants' response to items were explored and means and standard deviations for each subscale were developed. Results indicated the means for items 2, 5, 6, 7, 8, 12, 13, 14, 16, 17, 19, 20, 21, 23, and 24 fell between 1.0 (never

ethical) and 2.0 (ethical under rare conditions). Means below 2.0 indicated a consensus among participants that the items presented were ethical only under rare conditions. The remaining items, 1, 3, 4, 9, 10, 11, 15, 18, 22, and 25, ranged between 2 and 3. Means above 2 indicated a consensus among participants the items presented were ethical under some conditions or ethical under most conditions.

Analysis of the means and standard deviation of subscales indicated that items comprising the Boundaries of Confidentiality were generally viewed as never ethical or ethical under rare conditions. Social/Sexual Involvements and Dual Professional Relationships were viewed as ethical under some conditions, ethical under most conditions, or always ethical. It is plausible to suggest that strict confidentiality laws governing the release of information to other individuals contributed to the consensus of participants that violating boundaries of confidentiality is rarely ethical. Additionally, social involvements and dual professional relationships are less regulated by the profession and may contribute to more ethical conflict among professionals.

Summary of Findings

The need for continued supervision has been addressed in the literature (Doyle, 1997). Further research (West, Mustaine, & Wyrick, 2002) has examined factors contributing to the supervisory relationship including recovery status, formal and informal counselor training, and formal and informal supervisor training. Of 42 states surveyed, 11 required graduate level preparation for clinical supervisors and only three states required academic preparation related to clinical supervision.

Previous literature has not specifically examined supervision and multiple relationship beliefs.

The current study found current supervision contributed to views regarding ethical dilemmas while previous supervision prior to certification or licensure did not influence total score on the MRS SAC. These results indicate that current supervision influences beliefs regarding the extent to which multiple relationship behaviors are ethical, while previous supervision does not influence beliefs. It is plausible to suggest that though current supervision, substance abuse counselors maintain awareness of ethical dilemmas. Heightened awareness of ethical concerns may lead to concern about whether multiple relationship behaviors are ethical. Interaction with peers and regular consultation provide an arena for discussion of ethical concerns and the challenging of beliefs related to ethics.

Instrument Subscales

Instrument Development

A literature review indicated no available instruments to specifically examine multiple relationships among substance abuse counselors. The MRS SAC was developed to examine the beliefs of Board Certified Substance Abuse Counselors regarding multiple relationships. The instrument was developed based on the literature (Borys & Pope, 1989; Doyle, 1997; Gibson & Pope, 1993; Pritchett & Fall, 2001) and consultation with a substance abuse practitioner.

The development of the MRS SAC led to several interesting findings related to the specific instrument. Upon examination of the distribution of the items, it

became apparent the distributions were positively skewed. This contributed to the use of non-parametric statistics to analyze the data. Although subscales were initially developed, it became difficult to examine the subscales due to the use of non-parametric statistics. Due to the distribution of the data, using correlational analyses or a factor analysis would have been inappropriate. These barriers contributed to difficulty comparing the subscales and determining the relationship between the items.

Analysis of Reliability

Analysis of the reliability of the MRS SAC subscales was examined by conducting Cronbach's Alpha on each subscale. Alpha levels ranged between .91 and .63 when reverse-scored items were excluded. The reverse-scored items appeared to weaken the reliability when the items were included in the reliability testing. The items were initially included in the survey to prevent response bias. It is plausible to suggest the concepts related to the reverse-score items were unimportant to the subscales or the items may have inadvertently created a response set bias among participants. The double negative wording may also have created confusion among the participants. In the future, discarding the reverse-score items used in the MRS SAC may be appropriate.

Limitations

A limitation that may have weakened the internal validity of the study was the survey instrument employed. The survey was created to address concerns related to substance abuse counselors. Reliability of the instrument was examined by the use of

Cronbach's Alpha. Validity of the survey was examined through expert review and the pilot study. The survey was sent for review to three clinicians with substance abuse specialization. Pilot study participants were also requested to provide feedback related to survey items. Items were adjusted according to recommendations.

The reverse-scored items of the MRS SAC may have been a limitation. The double negative wording may have confused participants or have inadvertently contributed to response bias.

The wording of the demographic questions may also have been a limitation. A few participants responded having a significant number of years experience prior to becoming licensed or certified. It is possible recovering individuals perceived recovery experience as clinical experience.

Another potential limitation of the study was that participants who responded to the survey may have been different from those who failed to respond to the survey. Accuracy of self-report data, although assumed to reflect honest responses, cannot be ensured.

Although states were requested to provide addresses specifically for substance abuse counselors, a few states did not separate the names of prevention specialists or judicial specialists. This may have caused the inclusion of participants who were not working as substance abuse counselors. Additionally, retired counselors and individuals not currently working in the field were not excluded because they continued to possess board certification.

A significant percentage of the respondents (approximately two-thirds) possessed a master's degree or higher. This may have contributed to a

disproportionate representation of substance abuse counselors with advanced degrees. There may have been an under-representation of substance abuse counselors possessing a high school diploma, GED, associate degree, or bachelor's degree. Individuals with a master's degree or doctoral degree may have been more likely to respond to the survey.

Implications and Recommendations

Findings from this study have implications for substance abuse counselors and counselor educators. Additional implications include engagement from national and state boards. The following sections will address each entity.

Substance Abuse Counselors

Information obtained from the research conducted indicates recovery status and current supervision influence beliefs regarding multiple relationships. The results from this study support the professional literature that recommends continued supervision (Doyle, 1997). Results also support the professional literature that has found differences between recovering and non-recovering counselors (West, Mustaine, & Wyrick, 2002).

Due to the potential for ethical dilemmas to arise for individuals in the substance abuse field, it is important for supervision to continue after licensure/certification has been obtained. Additional risks for potential ethical dilemmas exist for counselors in recovery due to related personal issues and seeking similar resources for recovery. Continued supervision provides the opportunity for support and consultation when ethical dilemmas arise.

Counselor Educators

Counselor educators often serve as an educational resource for professionals entering the helping professions. By providing opportunities to discuss multiple relationships, educators can model the necessity for further debate regarding ethical dilemmas in the workplace. Discussing how to proceed when a multiple relationship is unavoidable and encouraging practitioners to explore personal issues could be beneficial for recovering counselors who may possess issues similar to their clientele.

Discussing different types of supervision in the classroom, including group supervision, peer consultation, and individual supervision, allows students to examine supervision alternatives post-licensure/certification. Recommending and emphasizing the benefits of continued supervision may encourage more counselors to engage in voluntary supervision post-licensure/certification. Counselor educators can play an integral role by emphasizing the contributions of supervision to professional development.

National Board

The National Association of Alcoholism and Drug Abuse Counselors (NAADAC) provides substance abuse counselors with ethical standards for the profession. The ethical standards provide a basic template for ethical conduct and briefly address client and interpersonal relationships. However, the standards fail to provide information regarding sponsorship, recovery status, or using similar client community resources. The current standards fail to discuss how to proceed when a multiple relationship dilemma is presented.

Unlike the American Counseling Association, the NAADAC does not appear to provide set national standards for all states to follow. While some states adhere to the NAADAC guidelines for education and number of years of experience, others do not. This discrepancy prevents the field from advancing and becoming a more unified profession. A stronger governing board could assist with the development of national minimum requirements for each state. This could also encourage the development of licensure for each state versus the current separation between certification and licensure between states.

The NAADAC provides ethical standards for substance abuse counselors but does not provide recommendations for addressing unavoidable multiple relationships. More succinct ethical standards offering recommendations for recovering counselors could be invaluable to practicing professionals. Guidelines and examples for ethical conduct would provide a valuable resource for individuals faced with multiple relationship dilemmas.

Additional implementation of national requirements to become certified as a substance abuse counselor are warranted. Currently, all states do not adhere to NAADAC guidelines or require substance abuse counselors to obtain membership to the national organization. The national board providing uniformity of the requirements to become certified or licensed initiates additional quality assurance and counselor competency within the substance abuse counseling profession.

State Boards

Each state board governs the requirements to become licensed/certified as a substance abuse counselor in its state. Consequently, there are no set requirements for

licensure/certification across the United States. This lack of cohesion contributes to minimal educational and experience requirements. All states do not require coursework or training in ethics, and supervision varies depending on the state requirements.

Lack of consistency prevents practitioners from obtaining standardized coursework and supervision regarding ethical practices. Although results of the current study did not indicate education was a factor in ethical beliefs, basic knowledge regarding multiple relationships is fundamental to practice. Providing mandatory educational requirements in ethics is necessary to protect clients as well as practitioners.

Due to the results of the current study, state boards' recommendations for supervision post licensure/certification would be valuable. Substance abuse counselors engaged in current supervision were more ethically concerned than their cohorts. The recommendation of continued supervision would assist with the development of continued discussion and competency related to ethics. Recommendations from the board for members to continue individual and peer consultation groups would be ideal for practicing substance abuse counselors.

The importance of competency and ethics is paramount in the substance abuse counseling profession. One college level ethics course prior to receiving licensure/certification would be beneficial to all individuals entering the field. To maintain competency and continued focus on ethics, the requirement of a minimum of three continuing education units of ethics training per calendar year is recommended. Training should include instruction regarding models of ethical

decision-making, potential ethical dilemmas faced by clinicians, and peer consultation regarding ethical dilemmas.

Recommendations for Further Research

The current study initially identified significant variations among the states to become certified or licensed as a substance abuse counselor. Due to the inconsistency of minimum requirements to become certified/licensed and the lack of uniformity among states, future research in this area is warranted. Additional research should examine each state's requirements to become a certified/licensed substance abuse counselor. Examining variations between state requirements related to education, practical experience, and supervision would be beneficial to assist with the development of minimum requirements for each state.

Previous research has emphasized differences among recovering and non-recovering substance abuse counselors (Culbreth, 2000; Shipko & Stout; 1992). The current study supported that there are differences between recovering and non-recovering counselors related to ethical beliefs regarding multiple relationships. Due to these differences, additional research focusing on recovering individuals and ethical dilemmas should be conducted. Research related to recovering individuals' perceptions of ethical dilemmas could provide valuable information to training facilities and supervisors providing training for substance abuse counselors.

Conclusion

This study examined the relationship of educational level, recovery status, experience, and supervision to beliefs regarding the ethics of selected multiple relationship issues among Board Certified Substance Abuse Counselors. Results of the study indicated recovery status and current supervision were indicative of a lower total score on the MRS SAC. Non-recovering substance abuse counselors and counselors receiving current supervision viewed more dual relationship behaviors as ethically problematic. Highest degree obtained, experience prior to licensure, and supervision prior to licensure were not associated with lower total scores on the MRS SAC.

The hypotheses were discussed and the survey instrument was evaluated. The results of this study have implications for substance abuse counselors, counselor educators, and national and state certification boards. Recommendations for further research were offered.

CHAPTER SIX

MANUSCRIPT FOR SUBMISSION

Beliefs of Board Certified Substance Abuse Counselors

Regarding Selected Multiple Relationship Issues

For Submission To The Journal of Mental Health Counseling

Ethical issues surrounding dual or multiple relationships have generated considerable controversy among mental health professionals and are frequently cited as a concern of counselors (Herlihy & Corey, 1997; Pope & Vetter, 1992). Multiple relationships, which violate the therapeutic boundary, occur whenever a mental health professional has another, significantly different relationship with a help seeker (Herlihy & Corey; Remley & Herlihy, 2001).

Substance abuse counselors, along with other mental health professionals, have an ethical obligation to avoid dual or multiple relationships that could impair professional judgment or jeopardize the welfare of clients (American Counseling Association, 1995; National Association of Alcoholism and Drug Abuse Counselors, 1995; National Board for Certified Counselors, 2000). Multiple relationships may be difficult to avoid, however, when counselors share "small worlds" with their clients (Herlihy & Watson, 2002; Remley & Herlihy, 2001). Compared with other mental

health counselors, substance abuse counselors have more opportunities to interact with clients outside of the therapy session (Doyle, 1997). Those substance abuse counselors who are themselves in recovery face some unique problems (Powell, 1997), including the potential to encounter clients in the 12-step community, former clients becoming colleagues, and relapse potential for the counselor. The ability of substance abuse counselors to appropriately address these unique ethical dilemmas related to multiple relationships may be influenced by their education, experience, and prior or current supervision of their clinical work (Dove, 1995; Doyle, 1997; West, Mustaine, & Wyrick, 1999).

Substance abuse counselors may come from a variety of backgrounds including social work, psychology, criminal justice, and counseling. They may have a degree in an unrelated field that does not require specific coursework in ethics (West, Mustaine, & Wyrick, 1999). Although other types of mental health counselors are master's degreed clinicians who have passed a national or state exam and have completed a minimum number of supervised (post-master's degree) clinical hours, there is a lack of standardized requirements for becoming a substance abuse counselor. This may include variations from state to state in educational, credentialing, and supervised experience requirements (Page & Bailey, 1995). Some states provide a license to professionals who meet the requirements and other states provide certification. In some states, a bachelor's degree is required; other states require only a high school diploma or General Education Diploma (GED). Some states also utilize a tiered system based on education and experience to differentiate between beginning-level and advanced-level clinicians.

These educational differences can lead to a lack of standard coursework or preparation in ethics (Culbreth, 2000; Dove, 1995). Substance abuse counselor certification boards may not require specific preparation related to ethics, which may contribute to a lack of knowledge related to ethics for some substance abuse counselors.

Doyle (1997) suggested that substance abuse counselors could benefit from continued supervision due to the high potential for ethical and multiple relationship issues to be present in the field. Doyle further suggested that supervision could be helpful for recovering counselors when faced with ethical dilemmas related to social relationships, sponsorship, and self-help group meetings. West, Mustaine and Wyrick (2002) and Culbreth (1999), found a lack of consistency in clinical experience and education required to provide supervision to substance abuse counselors. Educational differences between supervisor and supervisee as well as mismatches in recovery status also have been examined as factors affecting supervision (Anderson, 2000). Research by Culbreth and Borders (1998) indicated that substance abuse counselors believed recovery status was a significant issue in the supervisory relationship.

Despite these concerns, there is a notable dearth of research that has investigated ethics in the specific field of substance abuse counseling. Although a significant amount of research (e.g., Bernsen, Tabachnick, & Pope, 1994; Borys & Pope, 1989; Gibson & Pope, 1993; Pope & Vetter, 1992) has examined multiple relationship beliefs and behaviors of mental health professionals (including psychiatrists, psychologists, social workers, and counselors), substance abuse counselors, have been included within the broader framework of the helping

professions rather than being specifically targeted for research. Although substance abuse counseling is a smaller subset or specialization within the helping professions, its problems can be unique.

A literature search found only three articles (St. Germaine, 1996, 1997; Toriello, 1998) that specifically addressed substance abuse counselors' ethical beliefs, behaviors, and practices. Toriello (1998) surveyed 227 substance abuse counselors related to sensitivity to ethical dilemmas and beliefs about preparation to help resolve ethical dilemmas. Toriello found a significant difference between the decisions related to ethics of substance abuse counselors with a graduate degree compared to those of substance abuse counselors with an associate degree or high school diploma. Results indicated that counselors with an associate degree or high school diploma were more ethically sensitive than counselors with higher degrees.

St. Germaine (1996) surveyed 858 Certified Alcohol and Drug Counselors regarding their beliefs and behaviors related to ethics. The survey listed 27 statements related to ethical beliefs and 20 statements related to ethical behaviors. Participants were sent either the beliefs form or the behaviors form and were asked to rate the statements. Over two-thirds (68.9%) of the participants reported that they encountered clients outside of counseling daily, frequently, or sometimes. Participants also reported that they had engaged in the majority of multiple relationship behaviors listed (e.g., allowing a client to enroll in a class taught by the counselor, going out to eat with a client after a session, providing individual therapy to a relative).

In a follow-up study, a survey of 55 addiction counselor certification boards was conducted to determine the nature and frequency of ethical complaints (St.

Germaine, 1997). Questions were asked regarding procedures and policies related to complaints and preparation requirements. Results of the study indicated that the most common complaints were sexual relationships with a current client, practicing while impaired, and practicing without a certificate.

Given the paucity of research regarding ethical beliefs of substance abuse counselors despite the unique multiple relationship dilemmas these counselors confront, this research study was intended to investigate beliefs of substance abuse counselors regarding multiple relationships. The relationship between beliefs of Board Certified Substance Abuse Counselors and the predictor variables of educational level, recovery status, experience, and supervision was explored. A survey instrument was developed and administered, and data were analyzed to test five hypotheses related to the relationship between ethical beliefs and the predictor variables.

Method

Participants and Procedures

Purposeful, proportional, random sampling was utilized to obtain a sample of Board Certified Substance Abuse Counselors. All 50 state licensure boards were mailed a request for information about licensing/certification requirements in their states; 31 states responded. Purposeful sampling was used to select seven states of the 31 that responded to the request. States were selected based on several criteria, including having a large number of substance abuse counselors (to increase the number of potential participants), minimum educational requirements, the number of years or hours of experience required for licensure/certification, and number and type

of licensure/certification tiers utilized, to ensure maximum variability. Participants were chosen from the following seven states: Arizona, Illinois, Maine, Maryland (D.C.), Montana, North Carolina, and Wyoming.

The researcher obtained mailing lists of BCSACs from the seven state boards. Boards provided lists of names and addresses with no demographic information (age, gender, race, or ethnicity). Therefore, it was not possible to stratify the sample based on age, gender, race, or ethnicity. Prevention specialists, judicial counselors, and substance abuse counselor trainees were unable to be excluded from the study.

Twenty percent (20 %) of individuals from each of the seven states were selected by random sampling to participate in the study. Of 765 surveys that could be assumed to have been delivered, 387 usable surveys were returned for a return rate of 50.6%.

Instrumentation

A demographic questionnaire was developed based on variables examined in previous research related to substance abuse counselors. These variables included recovery status, educational level, supervision, and experience. Questions related to sex and race or ethnicity were included to further describe the sample. Participants were requested to check responses as well as provide numerical information.

A researcher-developed instrument, entitled The Multiple Relationship Survey for Substance Abuse Counselors (MRS SAC), was utilized to investigate the beliefs of BCSACs regarding multiple relationships. An investigation yielded no instrument that addressed multiple relationships specifically for substance abuse counselors. The MRS SAC was developed through adaptation of items in instruments published by

Borys and Pope (1989), Gibson and Pope (1993), and Pritchett and Fall (2001). Additional items were added based on information in the literature that indicated specific problem areas for substance abuse counselors (Doyle, 1997). Consultation with another substance abuse practitioner in the field also contributed to item development.

Validity of the MRS SAC was examined through content and construct validity. Content validity for the survey was determined through a review by three individuals with expertise in substance abuse counseling. The experts examined the MRS SAC and provided feedback about the appropriateness and content of items. Construct validity for the MRS SAC and the demographic questionnaire were established through expert and peer scrutiny of question composition and variable definition. A pilot study of the MRS SAC was conducted utilizing substance abuse counselors located in two area treatment centers. Items were adjusted based on results of the pilot study. Reliability of the MRS SAC was examined by the use of Cronbach's Alpha to determine the internal consistency of the instrument. Reliability testing indicated an alpha level of .88 for the MRS SAC.

Results

Demographic Data

Descriptive statistics were obtained for gender, racial/ethnic category, alcohol or drug recovery status, highest degree obtained, years of post-licensure/certification experience, experience in the substance abuse counseling field prior to licensure/certification, previous clinical supervision, and current clinical supervision.

Frequencies and percentages of participants for each of these demographic variables are as follows.

Sex: Of the 387 participants, 144 (37.2%) were male and 239 (61.8%) were female. Four participants (1.0%) did not respond.

Racial/Ethnic Category: Three hundred twenty-nine participants (85.5%) were White, forty-two participants (10.9%) were Black or African American, seven participants (1.8%) were Hispanic, five participants (1.3%) were American Indian or Alaska Native, one participant (0.3%) was Asian, and one participant (0.3%) was Biracial/Multiracial. Two participants (0.5%) did not respond.

Alcohol or Drug Recovery Status: One hundred sixty-eight participants (43.4%) reported that they were recovering from drugs or alcohol (M= 19.44 years, SD= 6.61 years). Two hundred eighteen participants (56.3%) reported being non-recovering individuals. One participant (0.3%) did not respond.

Years in Recovery: Those participants who reported being in recovery (N= 168) provided numeric information regarding number of years in recovery. The longest period in recovery was 45 years and the shortest was two years in recovery (M= 19.44 years, SD= 6.61 years).

Educational Level: Participants were requested to report their highest educational degree completed. Two participants (0.5%) had completed the GED, 15 participants (3.9%) had earned a high school diploma, 30 participants (7.8%) held an associate degree and 82 participants (21.2%) had received a bachelor's degree. Two hundred forty-two (242) participants (62.5%) held a master's degree, 14 participants (3.6%) had earned a doctoral degree. Two participants (0.5%) did not respond. Thus, the

majority of participants possessed a master's degree (62.5%) and only 21.2% possessed a bachelor's degree. Individuals in recovery possessed fewer master's degrees than non-recovering counselors and more bachelor's degrees, associate degrees, and high school diplomas than non-recovering counselors.

Years of Post-Licensure/Certification Experience: Participants were asked, "How many years of post-licensure/certification experience do you have as a counselor?" Three hundred seventy-nine (379) participants responded (97.9%) and eight (2.1%) did not respond. Participants provided numeric information regarding years of experience with a high of 35 years and a low of zero years (M= 11.85 years, SD= 7.16 years). The data appeared to be moderately positively skewed for years of post-licensure experience.

Experience Prior to Licensure/Certification: Participants were requested to respond to the question, "Did you gain experience in the substance abuse counseling field prior to licensure/certification?" Thirty-six participants (9.3%) responded they did not obtain prior experience. Three hundred forty-nine participants (90.2%) reported prior experience with a high of 29 years of experience and a low of six months (M= 4.76, SD= 4.01). Two participants (0.5%) did not respond. The data appeared to be sharply positively skewed.

Clinical Supervision Prior to Licensure/Certification: Participants were asked to respond to the question, "Did you receive clinical supervision of your work as a substance abuse counselor prior to licensure/certification?" Forty-eight participants (12.4%) responded they did not receive prior supervision. Three hundred thirty-seven participants (87.1%) responded they did receive prior supervision with a high of 30

years of supervision and a low of six months (M= 3.86 years, SD= 3.87 years). Two participants (0.5%) did not respond.

Current Clinical Supervision: Participants were asked to respond to the question, "Are you currently receiving clinical supervision of your work as a substance abuse counselor (i.e. staffing cases, discussing clients)?" One hundred thirty-one participants (33.9%) reported they were not currently receiving supervision. Two hundred forty-eight participants (64.1%) responded they were currently receiving supervision. Eight participants (2.1%) did not respond.

Multiple Relationship Survey for Substance Abuse Counselors

Participants were requested to complete the Multiple Relationship Survey for Substance Abuse Counselors (MRS SAC) to examine beliefs related to ethics of selected multiple relationship issues. Participants were asked to rate 25 statements related to multiple relationships using a Likert-type scale where 1= never ethical, 2= ethical under rare conditions, 3= ethical under some conditions, 4= ethical under most conditions, 5= always ethical. Of the 25 items, 18 items were presented as positive statements and seven items were presented as negative statements. For data analysis purposes, the seven negatively worded statements items were reverse scored (i.e. 1=5, 2=4, 3=3).

[Insert Table 1 about here.]

Table 1. Mean and Standard Deviation for Items

Item	Mean	Standard Deviation
1. Accept a gift worth less than $10	2.32	1.14
2. Go out to eat with a client after outpatient group	1.44	.93
3. Attend the same 12-step meeting as a current client	2.43	1.20
4. Refuse to give a client a ride in your car	3.41	1.25
5. Lend a client cigarettes or a small amount of money (under $10)	1.61	.99
6. Serve as a client's 12-step program sponsor	1.29	.91
7. Keep quiet about a client's relapse to other treatment team members	1.46	1.10
8. Disclose one client's progress to another client	1.32	.97
9. Decline to write a job recommendation for a client	3.44	1.28

Rating Codes: 1= Never ethical, 2= Ethical under rare conditions, 3= Ethical under some conditions, 4= Ethical under most conditions, 5= Always ethical, NR= No response.

Table 1 (continued). Mean and Standard Deviation for Items

Item	Mean	Standard Deviation
10. Provide non-substance abuse related counseling to a client's family member	2.23	1.20
11. Avoid attending the same religious or social activity as a client	3.38	1.15
12. Hire a client to babysit your children	1.28	.91
13. Talk about a client's therapy issues to colleagues outside the treatment facility	1.64	1.04
14. Offer privileges or preferential treatment to a favorite client such as shortening the length of treatment	1.23	.85
15. Avoid a friendship with a client's family member	3.85	1.35
16. Disclose a client's HIV status in a group counseling setting	1.25	.90
17. Barter with a client for services	1.60	1.06

Rating Codes: 1= Never ethical, 2= Ethical under rare conditions, 3= Ethical under some conditions, 4= Ethical under most conditions, 5= Always ethical, NR= No response.

Table 1 (continued). Mean and Standard Deviation for Items

Item	Mean	Standard Deviation
18. Avoid self-disclosing personal information to a client	3.51	1.01
19. Disclose treatment information to a client's sponsor	1.54	.98
20. Go into a business partnership with a former client	1.46	.94
21. Touch a client when the client has not requested it	1.60	.98
22. Tell a client that you will not write a letter for the client to receive child custody	3.24	1.16
23. Borrow money from a client	1.19	.84
24. Become involved in a romantic or sexual relationship with a client	1.18	.81
25. Decline to provide treatment to a friend's family member	3.49	1.28

Rating Codes: 1= Never ethical, 2= Ethical under rare conditions, 3= Ethical under some conditions, 4= Ethical under most conditions, 5= Always ethical, NR= No response.

Table 1 displays the means and standard deviations for each item of the MRS SAC. Mean scores, after correcting for reverse-scored items, suggested that participants, overall, believed that most of the behaviors listed were never or only rarely ethical. The sample appeared to have greater variation in responses for items that addressed accepting a gift worth less than $10, attending the same 12-step meeting as a current client, refusing to give a client a ride in your car, declining to write a job recommendation letter for a client, providing non-substance abuse related counseling to a client's family member, avoiding attending the same religious or social activity as a client, avoiding a friendship with a client's family member, avoiding self-disclosing personal information, telling a client that you will not write a letter for the client to receive child custody, and declining to provide treatment to a friend's family member. This may indicate that, among this sample of participants, there was a lack of consensus regarding the extent to which the described behaviors are considered to be ethical.

Frequency distributions were examined for each item of the MRS SAC. Line graphs were generated to visually compare the items and examine the shape of item distributions. Preliminary analyses indicated that 16 items were positively skewed toward never ethical. The nine remaining items appeared more normally distributed.

Due to the substantial number of positively skewed items, a total score was compiled for each participant to assist with analysis of the data. To verify the distribution of the total score, a Kolmogorov-Smirnov test was conducted. Results indicated the variable total score was not normally distributed at a two-tailed

significance of .000. The Kolmogorov-Smirnov indicated further analyses should be conducted through non-parametric tests (see Table 2).

Table 2. One-Sample Kolmogorov-Smirnov Test

	Mean	Standard Deviation
Total Score	45.46	13.60
Kolmogorov-Smirnov Z	.000*	
Assumption Significance (two-tailed)		

*p<.05

Results of Hypothesis Testing

Five research hypotheses were examined. The first hypothesis stated whether counselors with graduate degrees would rate multiple relationship behaviors as less ethical than would counselors with less formal education. Hypothesis 1 stated that the overall mean score on the MRS SAC will be significantly lower for BCSACs with a bachelor's degree than the overall mean score on the MRS SAC for BCSACs with less than a bachelor's degree.

Individuals were grouped into two categories based on degree completed. Individuals with GED, high school diploma, associate degree, and bachelor's degree were grouped in the first category. Individuals with a master's degree or doctoral degree were grouped into the second category. A Kruskal-Wallis test was conducted to examine educational level and total score on the MRS SAC. No significant difference was found ($H(2)= .092$, $p > .05$), indicating that the groups did not differ

significantly from each other. Participants with a bachelor's level degree or lower averaged a mean rank of 195.42, while participants with a master's level degree or higher averaged a mean rank of 191.78. Thus, educational level was not found to influence total score on the MRS SAC.

The second hypothesis tested whether recovery status was related to ethical beliefs. Hypothesis 2 stated that the overall mean score on the MRS SAC will be significantly lower for non-recovering BCSACs than the overall mean score on the MRS SAC for recovering BCSACs.

Individuals were grouped into two categories based on alcohol and drug recovery status: those who reported being in recovery (N= 168), and those who reported being non-recovering (N= 218) were grouped into the second category. A Kruskal-Wallis test was conducted to examine recovery status and total score on the MRS SAC. A significant result was found ($H(2)= 5.170, p < .05$), indicating that the groups differed significantly from each other. Recovering participants averaged a mean rank of 208.20, while non-recovering participants averaged a mean rank of 182.17. Non-recovering participants scored lower on the MRS SAC than recovering participants. A lower total score indicated participants viewed more items as ethically problematic. Results are displayed in Tables 3 and 4.

Table 3. Mean Ranks for Recovery Status

Characteristic	N	Mean Rank
Recovery Status		
Recovering	168	208.20
Non-recovering	218	182.17
Total	386	

Table 4. Kruskal-Wallis Test Statistic for Recovery Status

Chi-Square	df	Asymp. Sig.
5.170	1	.023*

*p<.05

The third hypothesis tested whether experience was related to ethical beliefs. Hypothesis 3 stated that the overall mean score on the MRS SAC will be significantly lower for BCSACs with experience prior to licensure/certification than the overall mean score on the MRS SAC for BCSACs with no experience prior to licensure/certification.

Individuals were grouped into two categories based on experience prior to licensure/certification. Individuals without prior experience degree were grouped in the first category (N= 36) and individuals with experience were grouped into the second category (N= 349). A Kruskal-Wallis test was conducted to examine experience prior to licensure/certification and total score on the MRS SAC. No

significant difference was found ($H(2)= .328$, $p > .05$), indicating that the groups did not differ significantly from each other. Participants without experience prior to licensure/certification averaged a mean rank of 182.89, while participants with prior experience averaged a mean rank of 194.04. Experience prior to licensure/certification did not influence total score on the MRS SAC.

The fourth hypothesis tested whether supervision was related to ethical beliefs. Hypothesis 4 stated that the overall mean score on the MRS SAC will be significantly lower for BCSACs who received supervision prior to licensure/certification than the overall mean score on the MRS SAC for BCSACs who did not receive supervision prior to licensure/certification.

Individuals were grouped into two categories based on receiving supervision prior to licensure/certification. Individuals with supervision prior to licensure/certification were grouped in the first category (N= 337) and individuals without supervision prior to licensure/certification were grouped into the second category (N= 48). A Kruskal-Wallis test was conducted to examine supervision prior to licensure/certification and total score on the MRS SAC. No significant difference was found ($H(2)= .595$, $p > .05$), indicating that the groups did not differ significantly from each other. Participants who did not receive supervision prior to licensure/certification averaged a mean rank of 181.42, while participants with supervision prior to licensure/certification averaged a mean rank of 194.65. Supervision prior to licensure/certification did not influence total score on the MRS SAC.

The final hypothesis tested whether current supervision was related to ethical beliefs. Hypothesis 5 stated that the overall mean score on the MRS SAC will be significantly lower for BCSACs who currently receive supervision than the overall mean score on the MRS SAC for BCSACs who do not receive current supervision.

Individuals were grouped into two categories based on currently receiving supervision. Individuals who reported currently receiving supervision were grouped in the first category (N= 248) and individuals who were not currently receiving supervision were grouped into the second category (N= 131). A Kruskal-Wallis test was conducted to examine current supervision and total score on the MRS SAC. A significant result was found ($H(2)= 5.866$, $p < .05$), indicating that the groups differed significantly from each other. Participants not currently receiving supervision averaged a mean rank of 208.74, while participants currently receiving supervision averaged a mean rank of 180.10. Participants currently receiving supervision scored lower on the MRS SAC than participants not currently receiving supervision. A lower total score indicated participants viewed more items as ethically problematic. Results are displayed in Tables 5 and 6.

Table 5. Mean Ranks for Current Supervision

Characteristic	N	Mean Rank
Current Supervision		
No	131	208.74
Yes	248	180.10
Total	379	

Table 6. Kruskal-Wallis Test Statistic for Current Supervision

Chi-Square	df	Asymp. Sig.
5.866	1	.015*

*p<.05

Discussion

The first hypothesis, that the overall mean score for each item on the MRS SAC will be significantly lower for BCSACs with a bachelor's degree than the overall mean score on each item on the MRS SAC for BCSACs with less than a bachelor's degree, was not supported. In an earlier study, Toriello (1998) surveyed 227 substance abuse counselors' sensitivity to ethical dilemmas and beliefs about preparation to help resolve ethical dilemmas. Results indicated that counselors with an associate degree or high school diploma were more ethically sensitive than counselors with higher degrees. The results of this study did not support Toriello's

findings in that educational degree did not influence participant responses to the MRS SAC. However, in the present study, a large number of participants possessed a master's degree or higher; there were significantly fewer participants who possessed a bachelor's degree in this study.

The second hypothesis, that the overall mean score on the MRS SAC will be significantly lower for non-recovering BCSACs than the overall mean score for each item on the MRS SAC for recovering BCSACs, was supported. This result supports the findings of Culbreth (2000), who found differences between recovering and non-recovering counselors. In the present study, non-recovering substance abuse counselors found more multiple relationship behaviors to be more ethically problematic as indicated by their responses to the questionnaire. It is plausible to suggest that personality differences related to recovery including flexibility and concrete thinking may be factors that contribute to beliefs regarding multiple relationship behaviors.

The third hypothesis, that the overall mean score on the MRS SAC will be significantly lower for BCSACs with experience prior to licensure/certification than the overall mean score on the MRS SAC for BCSACs with no experience prior to licensure/certification, was not supported. Research related to experience has examined differences in the number of hours required for eligibility to receive licensure/certification. Previous research has focused on variations in state requirements related to hours of experience prior to licensure/certification (Page & Bailey, 1995). The current study indicated there were no differences between counselors with prior experience and counselors without prior experience. Although

this hypothesis was not supported, it is difficult to ascertain the role that experience may play in ethical beliefs. It is possible that recovering counselors may have considered years of recovery experience to be clinical experience. Research has examined variations in experience requirements but not the implications of fewer hours of experience on ethical beliefs.

The fourth hypothesis, that the overall mean score on the MRS SAC will be significantly lower for BCSACs who received supervision prior to licensure/certification than the overall mean score on the MRS SAC for BCSACs who did not receive supervision prior to licensure/certification, was not supported. However, the fifth hypothesis, that the overall mean score on the MRS SAC will be significantly lower for BCSACs who were currently receiving supervision than the overall mean score on the MRS SAC for BCSACs who were not receiving current supervision, was supported. The need for continued supervision has been addressed in the literature (Doyle, 1997) but the relationship between supervision and beliefs about multiple relationships has not been examined previously.

The current study found current supervision contributed to views regarding ethical dilemmas while previous supervision prior to certification or licensure did not influence total score on the MRS SAC. These results indicate that current supervision influences beliefs regarding the extent to which multiple relationship behaviors are ethical, while previous supervision does not influence beliefs. It is plausible to suggest that substance abuse counselors maintain awareness of ethical dilemmas through current supervision. Heightened awareness of ethical concerns may lead to concern about whether multiple relationship behaviors are ethical. Interaction with

peers and regular consultation provide an arena for discussion of ethical concerns and the challenging of beliefs related to ethics.

Limitations

A limitation that may have weakened the internal validity of the study was the survey instrument employed. The survey was created to address concerns related to substance abuse counselors. Reliability of the instrument was examined by the use of Cronbach's Alpha. Validity of the survey was examined through expert review and the pilot study. The survey was sent for review to three clinicians with substance abuse specialization. Pilot study participants were also requested to provide feedback related to survey items. Items were adjusted according to recommendations.

The wording of the demographic questions may also have been a limitation. A few participants responded having a significant number of years experience prior to becoming licensed or certified. It is possible recovering individuals perceived recovery experience as clinical experience.

Another potential limitation of the study was that participants who responded to the survey may have been different from those who failed to respond to the survey. Accuracy of self-report data, although assumed to reflect honest responses, cannot be ensured.

Although states were requested to provide addresses specifically for substance abuse counselors, a few states did not separate the names of prevention specialists or judicial specialists. This may have caused the inclusion of participants who were not working as substance abuse counselors. Additionally, retired counselors and

individuals not currently working in the field were not excluded because they continued to possess board certification.

A significant percentage of the respondents (approximately two-thirds) possessed a master's degree or higher. This may have contributed to a disproportionate representation of substance abuse counselors with advanced degrees. There may have been an under-representation of substance abuse counselors possessing a high school diploma, GED, associate degree, or bachelor's degree. Individuals with a master's degree or doctoral degree may have been more likely to respond to the survey.

Recommendations

Findings from this study have implications for substance abuse counselors, counselor educators, and national and state substance abuse counselor certification boards. Results from this study indicated that recovery status and current supervision influence beliefs regarding multiple relationships. The results support the need for continued supervision as has been recommended by Doyle (1997).

The potential for ethical dilemmas to arise for individuals in the substance abuse field underscores the need for supervision to continue after licensure/certification has been obtained. Additional risks for potential ethical dilemmas exist for counselors in recovery due to related personal issues and seeking similar resources for recovery. Continued supervision provides the opportunity for support and consultation when ethical dilemmas arise.

Counselor educators can provide opportunities for both pre-service and practicing substance abuse counselors to discuss multiple relationships, thus modeling

the necessity for further debate regarding ethical dilemmas in the workplace. Discussing how to proceed when a multiple relationship is unavoidable and encouraging practitioners to explore personal issues could be beneficial for recovering counselors who may possess issues similar to their clientele.

Discussing different types of supervision in the classroom, including group supervision, peer consultation, and individual supervision, allows students to examine supervision alternatives post-licensure/certification. Recommending and emphasizing the benefits of continued supervision might encourage more counselors to engage in voluntary supervision post-licensure/certification. Counselor educators can play an integral role by emphasizing the contributions of supervision to professional development.

The National Association of Alcoholism and Drug Abuse Counselors (NAADAC) provides substance abuse counselors with ethical standards for the profession. The ethical standards provide a basic template for ethical conduct and briefly address client and interpersonal relationships. However, the standards fail to provide information regarding sponsorship, recovery status, or using similar client community resources, and do not discuss how to proceed when a multiple relationship dilemma is presented. Expanded ethical standards offering recommendations for recovering counselors could be invaluable to practicing professionals. Guidelines and examples for ethical conduct would provide a valuable resource for individuals faced with multiple relationship dilemmas.

Additionally, the NAADAC does not set national standards for all states to follow. While some states adhere to the NAADAC guidelines for education and

number of years of experience, others do not. This discrepancy prevents the field from advancing and becoming a more unified profession. A stronger governing board could assist with the development of national minimum requirements for each state. This could also encourage the development of licensure for each state, as opposed to current variability in certification and licensure among states.

Additional implementation of national requirements to become certified as a substance abuse counselor are warranted. Currently, all states do not adhere to NAADAC guidelines or require substance abuse counselors to obtain membership to the national organization. If the national board were to provide uniformity of requirements to become certified or licensed, this could enhance quality assurance and counselor competency within the substance abuse counseling profession.

Each state board governs the requirements to become licensed/certified as a substance abuse counselor in its state. Consequently, there are no set requirements for licensure/certification across the United States. This lack of uniformity contributes to minimal educational and experience requirements. All states do not require coursework or training in ethics, and supervision varies depending on the state requirements. Lack of consistency prevents practitioners from obtaining standardized coursework and supervision regarding ethical practices. Although results of the current study did not indicate education was a factor in ethical beliefs, basic knowledge regarding multiple relationships is fundamental to practice. Providing mandatory educational requirements in ethics would help to ensure that clients as well as practitioners are protected from unethical practices.

It would be valuable for state boards to recommend supervision post licensure/certification. In this study, substance abuse counselors engaged in current supervision were more ethically concerned than their counterparts. The recommendation of continued supervision would assist with the development of continued discussion and competency related to ethics. Boards could also recommend that members continue individual and peer consultation groups.

Due to the inconsistency of minimum requirements to become certified/licensed and the lack of uniformity among states, future research in this area is warranted. Additional research is needed to examine each state's requirements to become a certified/licensed substance abuse counselor. Examining variations between state requirements related to education, practical experience, and supervision would be beneficial to assist with the development of minimum requirements for each state.

Previous research has emphasized differences among recovering and non-recovering substance abuse counselors (Culbreth, 2000; Shipko & Stout; 1992). The current study supported that there are differences between recovering and non-recovering counselors related to ethical beliefs regarding multiple relationships. Due to these differences, additional research focusing on recovering individuals and ethical dilemmas should be conducted. Research related to recovering individuals' perceptions of ethical dilemmas could provide valuable information to training facilities and supervisors providing training for substance abuse counselors.

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APPENDIX A

Human Subjects Committee Letter

University Committee for the Protection of Human Subjects in Research
University of New Orleans

Campus Correspondence

To: Jennifer Kenney Hollander, graduate student
Barbara Herlihy, faculty supervisor

From: Scott C. Bauer, Ph.D.
Associate Professor and Chair
University Committee for the Protection of Human Subjects in Research

Date: 7/23/03

RE: Substance Abuse Counselors and Multiple Relationships

Because of the anonymous nature of your project it is exempt from committee review as stated in section 46.101 B, paragraph 2 of the OHRP guidelines.

APPENDIX B- Cover Letter to Participants

Dear Participant,

I am a substance abuse counselor and doctoral student at the University of New Orleans conducting a study on substance abuse counselors, ethics, and multiple relationships. As a substance abuse counselor, I believe we face a variety of ethical dilemmas specific to working with the substance abusing population that mental health professionals may not face. To help me gain a better understanding about substance abuse counselor's ethical beliefs, I would like to ask for your participation in this study.

The survey will take approximately 10-15 minutes to complete. You will be asked to circle the answers that best describe your opinion to the statements provided. Each questionnaire will be assigned a number to ensure tracking. No individual identities will be recorded and all responses will be kept confidential. Please do not write your name or sign the survey to protect confidentiality. Participation in this study is voluntary and information will be used to increase knowledge regarding substance abuse counselors. After you complete the demographic questionnaire and survey, please return them in the enclosed self-addressed, stamped envelope.

If you have questions or concerns regarding the purposes, procedures, or results of this study, please contact me at (504) 280-6661 or e-mail jkhollan@uno.edu. Further questions may also be directed to my co-chairs Dr. Barbara Herlihy at bherlihy@uno.edu or Dr. Vivian McCollum at vmccollu@uno.edu, University of New Orleans, (504) 280-6661.

Sincerely, Jennifer Kenney Hollander, MA, LPC, BCSAC, LMFT

APPENDIX C- Demographic Questionnaire

This page will request information related to your substance abuse training, education, experience, and supervision. Subsequent pages will request information regarding your beliefs related to ethical dilemmas experienced by substance abuse counselors. Please be as honest as possible in your responses. Please check the corresponding boxes that apply to the following questions.

1. **Sex:** □ Male □ Female

2. **Racial/ Ethnic Category:**

   □ American Indian or Alaska Native
   □ Asian
   □ Native Hawaiian or Other Pacific Islander
   □ Biracial/Multiracial
   □ Black or African American
   □ Hispanic
   □ White

3. **Alcohol or Drug Recovery Status:**

   □ Non-Recovering
   □ Recovering _____years

4. **Highest Degree Obtained:**

   □ GED
   □ High School Diploma
   □ Associate Degree
   □ Bachelor's Degree
   □ Master's Degree
   □ Doctoral Degree

5. **How many years of post-licensure/certification experience do you have as a counselor?**

   _____ years

6. **Did you gain experience in the substance abuse counseling field prior to licensure/certification?**

   □ No □ Yes _____ number of years

7. **Did you receive clinical supervision of your work as a substance abuse counselor prior to licensure/certification?**

   □ No □ Yes _____number of years

8. **Are you currently receiving clinical supervision of your work as a substance abuse counselor (i.e. staffing cases, discussing clients)?**

   □ No □ Yes

Appendix D- Multiple Relationship Survey for Substance Abuse Counselors

Please give your opinion of the ethics of each of the following statements regarding substance abuse counselor behaviors. Please rate your responses according to the following scale: 1= Never ethical, 2= Ethical under rare conditions, 3= Ethical under some conditions, 4= Ethical under most conditions, and 5= Always ethical. Indicate your answer by circling the corresponding number.

	Never Ethical				Always Ethical
1. Accept a gift worth less than $10	1	2	3	4	5
2. Go out to eat with a client after outpatient counseling group	1	2	3	4	5
3. Attend the same 12-step meeting as a current client	1	2	3	4	5
4. Refuse to give a client a ride in your car	1	2	3	4	5
5. Lend a client cigarettes or a small amount of money (under $10)	1	2	3	4	5
6. Serve as a client's 12-step program sponsor	1	2	3	4	5
7. Keep quiet about a client's relapse to other treatment team members	1	2	3	4	5
8. Disclose one client's progress to another client	1	2	3	4	5
9. Decline to write a job recommendation letter for a client	1	2	3	4	5
10. Provide non-substance abuse related counseling to a client's family member	1	2	3	4	5
11. Avoid attending the same religious or social activity as a client	1	2	3	4	5
12. Hire a client to babysit your children	1	2	3	4	5

Multiple Relationship Survey for Substance Abuse Counselors

Please rate your responses according to the following scale: 1= Never ethical, 2= Ethical under rare conditions, 3= Ethical under some conditions, 4= Ethical under most conditions, and 5= Always ethical. Indicate your answer by circling the corresponding number.

	Never Ethical				Always Ethical
13. Talk about a client's therapy issues to colleagues outside the treatment facility	1	2	3	4	5
14. Offer privileges or preferential treatment to a favorite client such as shortening the length of treatment	1	2	3	4	5
15. Avoid a friendship with a client's family member	1	2	3	4	5
16. Disclose a client's HIV status in a group counseling setting	1	2	3	4	5
17. Barter with a client for services	1	2	3	4	5
18. Avoid self-disclosing personal information to a client	1	2	3	4	5
19. Disclose treatment information to a client's sponsor	1	2	3	4	5
20. Go into a business partnership with a former client	1	2	3	4	5
21. Touch a client when the client has not requested it	1	2	3	4	5
22. Tell a client that you will not write a letter for the client to receive child custody	1	2	3	4	5
23. Borrow money from a client	1	2	3	4	5

Multiple Relationship Survey for Substance Abuse Counselors

Please give your opinion of the ethics of each of the following statements regarding substance abuse counselor behaviors. Please rate your responses according to the following scale: 1= Never ethical, 2= Ethical under rare conditions, 3= Ethical under some conditions, 4= Ethical under most conditions, and 5= Always ethical. Indicate your answer by circling the corresponding number.

	Never Ethical				Always Ethical
24. Become involved in a romantic or sexual relationship with a client	1	2	3	4	5
25. Decline to provide treatment to a friend's family member	1	2	3	4	5

APPENDIX E- Questionnaire for Expert Reviewers

The intent of the survey is to examine the beliefs of substance abuse counselors' and multiple relationships. Items have been designed to specifically address multiple relationships that may be faced by substance abuse counselors in outpatient and inpatient treatment settings.

1. Do the items accurately represent the multiple relationship issues faced by substance abuse counselors?

2. Is the survey format clear and easy to read?

3. Are the items clearly worded and easy to understand?

4. Were any items confusing or ambiguous?

5. If any items were unclear, how would you suggest re-wording?

6. Are there any items you would suggest adding or deleting?

7. Are the sub-scales appropriately titled?

VITA

Jennifer Kenney Hollander was raised in Fort Ashby, West Virginia. She earned an Associate of Arts Degree in Mental Health Counseling from Allegany College of Maryland in May 1993. Jennifer transferred to Frostburg State University in Frostburg, Maryland where she received a Bachelor of Science Degree in Psychology in December 1994. She subsequently graduated from West Virginia University with a Master of Art Degree in Counseling in December 1996. She is a National Certified Counselor, Licensed Professional Counselor, Board Certified Substance Abuse Counselor, and Licensed Marriage and Family Therapist in Louisiana.

During Jennifer's master's program, she completed her practicum at Johns Hopkins Hospital in Baltimore, Maryland where she worked with substance abusing clientele. Jennifer completed her internship with the West Virginia University Student Assistance Program where she counseled college students. Upon graduation, Jennifer worked at various inpatient and outpatient agencies as a case manager, program director, substance abuse counselor, and college mental health counselor.

In January 2000, Jennifer was accepted into the Counselor Education Doctoral Program at the University of New Orleans. She continued to work full-time at Southeastern Louisiana University Counseling Center as a mental health counselor until August 2003 when she accepted a graduate assistant position at the University of New Orleans. During her assistantship, she taught and assisted with research.

Upon completion of her dissertation, Jennifer opened Hollander Counseling and Consulting, a private practice located in Hammond, Louisiana.