VITA

Donald Patrick Osborn

EDUCATION

2013	Indiana State University, Terre Haute, Indiana Ph.D. in Guidance and Psychological Services; Specialization in Counselor Education and Clinical Supervision
1988	Vincennes University, Vincennes, Indiana Professional Academic Certificate in Substance Abuse Counseling
1987	Saint Mary of the Woods College, Saint Mary of the Woods, Indiana M.A. in Pastoral Theology; Specialization in Psychiatry and Religion
1984	Indiana State University, Terre Haute, Indiana M.S. in Agency Counseling
1979	Lincoln Christian University, Lincoln, Illinois (formerly Lincoln Christian College) B.A. in Christian Ministries (major); Psychology and Counseling (minor)

SELECTED CLINICAL EXPERIENCE

2008	Community North Hospital/Gallahue Mental Health Center Indianapolis, Indiana Predoctoral Internship

PROFESSIONAL EXPERIENCE

2006 – present	Indiana Wesleyan University, Marion Indiana Director and Professor of Graduate Addictions Counseling

SELECTED PUBLICATION

Freeman, A., Morgillo-Freeman, S., & Osborn, D. P. (2006) Substance misuse: An issue of degree assessment and empathy. In A. Freeman, & S. Morgillo-Freeman (Eds.) *Cognitive behavior therapy for clinical social work*. New York, NY: Springer.

SELECTED PRESENTATION

Osborn, D. P., Reading, E., Meyers, P., & Bowden, K. (2011). *Issues in legislation and professional licensure.* National Addiction Disorders Conference. San Diego, California.

EVALUATING THE ACADEMIC PREPARATION OF ADDICTION COUNSELORS IN INDIANA FOR PROFESSIONAL PRACTICE

A Dissertation

Presented to

The College of Graduate and Professional Studies

Department of Communication Disorders and Counseling, School, and Educational Psychology

Indiana State University

Terre Haute, Indiana

In Partial Fulfillment

of the Requirements for the Degree

Doctor of Philosophy

---

by

Donald Patrick Osborn

December 2013

Keywords: addictions counseling, addictions curriculum, addictions studies, counselor education counselor ethics

COMMITTEE MEMBERS

Committee Chair: Tonya Balch, Ph.D.

Associate Professor of School Counseling, Department of Communication Disorders and Counseling, School, and Educational Psychology

Indiana State University

Committee Member: Matthew Draper, Ph.D.

Associate Professor of Behavioral Sciences

Utah Valley University

Committee Member: James Fuller, Ph.D.

Dean of the Graduate School

Indiana Wesleyan University

ABSTRACT

Currently, addiction counseling services are provided by individuals who do not possess degrees in addictions counseling or have had courses in addictions-related content in their academic programs of study. There is recognition that addictions counseling is nonexistent or inconsistent in academic curriculum in higher education. Other allied graduate counseling programs of clinical mental health, social work, and marriage and family therapy have established curricula. The current lack of addiction studies education brings questions of competency of the current and future providers of addictions counseling. As a result, inquiry is needed to examine the current addictions counseling workforce, and their academic preparation to determine what if any courses in addictions counseling were offered in their programs of study. Further, what are the current workforce duties and experiences of addictions counselors? With regard to those duties, what could be learned to incorporate into an academic program and curriculum content? The academic preparation of addiction counselors using a qualitative study was investigated. Participants were currently practicing addictions counselors at Indiana treatment programs. Each one possessed a master's degree, and all were grandfathered into an addictions counseling license in Indiana. The participants of this study were interviewed about academic preparation and what correlation the academic preparation had in relevance to current workforce duties and services. Participants also completed a survey related to graduate-level courses and course descriptions in addictions counseling. They endorsed the courses and descriptions with a Likert scale on degree of relevance or nonrelevance related to their workforce duties in addictions

counseling. The participants provided perspectives on their self-awareness as addictions counselors and workforce issues. Their contributions provided data that coalesced into themes to be considered for academic and workforce issues to enhance addictions studies and services.

ACKNOWLEDGMENTS

There have been times when I have stopped to give thanks to God for those people He has placed in the path of my life. They were there at the right time and place in His plan for my life. Each contributed, shaped, and poured into my life in their own way and purpose. This is another one of those times when I can say, if not for them, I would not have made it in completion of this dissertation. I am humbled and blessed by their love, guidance, provision, and encouragement. To the following, I give thanks and gratitude.

Where would I be if not for my parents Robert and Mildred Osborn? They gave me a home of unconditional love and sacrifice on their part due to hard work. Although they did not possess great financial means or higher education, they saw the value that it would bring me in life. They always had faith and the belief that one day they would call me "Doctor." To my Mom and Dad, I love you and miss you, I hope that it is all right that it is a doctorate in counseling and not theology.

To my in-laws and "second parents" Jack and Hazel McIntosh, I am thankful for your love, counsel, and prayers. You were there the day I got my acceptance letter and took joy in providing for my first classes. To my father-in law Jack, I had hoped for you to be here when I crossed the finish line. Yet I know you are cheering from heaven. To Hazel, thank you for loving me as a son, and your prayers have not gone unanswered. You have the power.

For Sara, Shawna, and Tiffany, the three beautiful daughters that my wife Cindy and I share, you are the lights of my life. Stepping back into school was because of your

encouragement, when I thought I was too old. For Shawna, thank you for listening and praying; for Tiffany, thanks for the shared late nights of typing some of my early papers. To my own Sara, thanks for helping dad to discover what the computer actually does. Sara, you took time to calm many of my fears over lunch, and I cherish that we are in graduate school together. I know that all of you and mom are still in wonder that I finally learned how to type, to a point.

When Cindy and I transitioned from Terre Haute to Noblesville, in taking the job at Indiana Wesleyan University (IWU), and were in need of a place to stay after our house sold in two days, the term dear friends took on real meaning again. To Bruce and Jennifer Beck and Ed and Sheri Ring, thanks for being there at the start of my and Cindy's life together. But more so for loving us and opening up your homes to us years later while we transitioned to IWU. Your homes were a place of peace and solitude. Sheri, your gourmet grilled cheese is the best, and Jennifer's garlic chicken is in my top four meals. I know we can never do enough to pay you back and know you ask nothing of us. For Bruce and Jennifer's daughter Lauren Beck, thanks for the late evening study sessions and popcorn. Sadly, Jennifer, you left us too soon and our hearts still have a hole.

To Helen Keller, thank you for your unselfish generous provision and belief in my goal of becoming a professor. To a "dear brother" Joe Hayes, I appreciate your layman's interest in my dissertation. But more so your editorial discoveries that escaped many. To the faithful at Second Christian Church, thank you for your love and allowing me as your minister to have some time away from being with you on Sunday to write on my dissertation.

When I arrived at Indiana State University (ISU), I was appreciative to my first dissertation chair Jim Campbell and department chair Michelle Boyer. You helped count the cost in climbing the "doctoral mountain." To my second dissertation chair Debra Leggett, you

helped me in taking my thoughts to a plan of research. To my current dissertation chair Tonya Balch, thank you for taking on this "dissertation orphan." You are a cherished mentor in leading me through the uncertainty and your patience is calming. I am grateful for you belief and support. For my current department chair Linda Sperry, you are special to me. Your input by email, phone call, in person, and writing has helped me become a better writer. Yet I am sorry for the many edits that I burdened you with. For my dissertation committee members Matt Draper and Jim Fuller, you are true mentors. Matt, thanks for being a champion for me; it was you who lead me to ISU. To Jim, as my Dean at IWU, you are a Godsend in support and encouragement. I hope I make you proud. To my editor, Judy Barnes you are gold! I am blessed to have you. Thank you for your patience and for understanding what I am trying to say. After crossing the finish line with me, I trust that you will have more time in your sewing room.

To my wife Cindy, I am unworthy of you. I still do not know what you saw in me. From the first mention of my going back to school for a Ph.D., there was no hesitation from you. Your belief in me from the beginning as cheerleader, coach, encourager, and sustainer was more than I could ask for. You made sure that I had time to study, checked on my progress, and proofread many a paper. You prayed for me and with me since the first night of class. Several times you got up in the middle of the night to check on me or tell me "it's time to shut it down and go to bed." This has been a sacrifice for you in several ways, but you see the prize ahead and we will celebrate. Because of you, I am reminded everyday that I am living in the answer of my parents' prayers. You are the jewel of my crown.

There is one white-haired furry companion that was faithful in love to me and whom my heart still misses. Ginger, you were more than a little poodle; you were a calming and loving

presence on my lap or on top of my desk. We read many a book together, to the wee hours of the morning. I love you and miss you.

Finally, I would be remiss if I did not thank my Lord. He erased my doubts, calmed my fears, and answered every need to achieve the desire of my heart after 20 years. He has walked ahead of me and at times carried me. I thank, honor, and praise Him for His faithfulness. I have experienced Jeremiah 29:11 in fullness.

TABLE OF CONTENTS

LIST OF TABLES

CHAPTER 1

INTRODUCTION

The field of addictions counseling currently is without a nationally standardized curriculum in higher education. This issue exists for two reasons. The first is due to resistance from some addiction counselors. They conclude that higher education is not needed, nor should be required, to be an addictions counselor. Those who hold this position believe that to be a competent addiction counselor, all one needs is to draw from their own personal experiences of addiction and recovery to help others. Another aspect of the problem is few academic programs in addictions counseling exist at the undergraduate and graduate levels. Connected to this issue, programs vary within the same state related to hours, content, and learning outcomes.

Without academic curriculum standards, addictions counseling is viewed as an unorganized and baseless profession. At best, it is considered as a field of practice, or subspecialty, rather than a profession. Further, ethical problems exist due to the lack of clearly defined theoretical orientations, treatment methodologies, and outcomes for client care. Professions such as social work, marriage and family therapy, and mental health have established nationally accredited standards in higher education. Unlike the field of addictions, these allied program graduates are prepared to practice using ethical protocols and established evidence-based treatment methods.

As an educator in addictions, my personal and professional desire was to initiate from my research the first steps toward a nationally standardized addiction studies curriculum in higher education. Such a study has value to the practice of addictions counseling in the following ways. The study identified specific counselor knowledge and practice skillsets to meet client treatment issues. Academic changes would result in a more relevant workforce, with less counselor burnout, by improving counselor retention and client treatment outcomes due to better academic preparation. The findings also lend direction to interested addictions stakeholders forming a national accrediting body. State legislators who wish to write legislation for the practice of addictions counseling by certification or licensure benefit. Such states would have access to specific criteria to identify competency and ethical practice requirements. The legislation practice components also maximize managed care treatment dollars for patients. Managed care has within the state an identified and trained addiction workforce in which to treat clients. Further benefits for the addictions field is the development of a career ladder, with a defined scope of practice, reflecting academic preparation with levels of competence. Finally, such changes may add to understanding the etiology and process of addiction, in hope of saving and improve quality of life for patients and those who love them.

History of the Field

To begin such a study, it is helpful to review the history of helping those with addiction. Such a study starts with two men with their own personal problems with alcohol who initiated the most widely known approach to helping others with alcohol problems.

Alcoholics Anonymous

Bill Wilson, a margin trader on Wall Street, and Bill Smith, a surgeon, established what became known as Alcoholics Anonymous (AA). AA started in 1935, based on some principles

from an earlier group known as the Oxford Group (OG). The OG was established in England with fewer groups in the United States (Clinebell, 1968). The OG mission was for those with alcohol problems to mutually support and to assist each other in the hope to overcome their drinking. To assist members, Christian precepts were used, such as self inventory, making amends to others for past wrongs, accountability to others, prayer, and carrying the message of the OG to others.

A friend of Bill Wilson's named Edwin introduced Bill to the OG. Edwin had sought treatment for his alcohol problem with the Swiss physician and psychiatrist Carl Jung. Jung believed that Edwin's condition was hopeless. Yet Jung believed that Edwin needed to have a religious experience and saw this as his only hope (Clinebell, 1968; Nace, 1992). Jung directed him to the OG. In time, Bill took the precepts of the OG and with Bill Smith expanded them to become what would be known as AA's 12 steps.

Twelve Step Meetings and Sponsors

The 12 steps established the process by which fellow participants could address their alcohol problems and begin to move toward not drinking, or what would be known as sobriety. In time, AA grew to form local chapters, where those with alcohol problems could come and meet with others. The only requirement to establish a chapter was to have two persons impacted by alcohol. As a result, AA grew to global status with chapters in other countries. A major influence of AA was the creation of other self-help support groups, such as those with cocaine or gambling issues (Capuzzi & Stauffer, 2012). The 12 steps were adopted by these groups and are followed to assist members in overcoming personal problems with these issues.

Another aspect of AA is that individuals with more than a year's abstinence from alcohol serve in the role of mentoring others, in helping them toward recovery. The mentoring role in

time became known as members having a sponsor (AA World Services, 1991; Clinebell, 1968). Members asked others with established recovery time to serve as their sponsors. The sponsors served by helping members overcome urges to drink or discuss how to move through the 12 steps. Sponsors offered support and feedback based in part upon what worked for them or the wisdom gained in their struggle to reach sobriety (Brown, 1995). Sponsors make themselves available 24 hours a day, seven days a week. Contact is by phone or scheduled face-to-face meetings. In some cases, meetings are impromptu depending on the need of the recovering member. Sponsors have been known to go to locations such as bars or parties where the recovering member is and help him or her to leave. Over time those who became abstinent from alcohol transitioned into becoming counselors for others. Opportunities emerged for those individuals to serve in a more formal role, working in hospitals and treatment settings as paid counselors. A transition had begun to take place to establish the early addictions counseling field.

Emergence of Addiction Counseling

Before AA, the medical community and clergy were the main point of help for those with alcohol or drug issues. These individuals when examined by physicians were more likely to be suffering from health problems due to alcohol or other substance use. Treatment efforts were to help alleviate withdrawal by detoxification in order to keep the person alive or in reasonable health. There was little bedside manner, as most physicians could treat the effects on the body, but the mind was not a part of the treatment, except for some encouragement. Another point of support was found among clergy, who offered counsel to the mind and soul. The clergy response was to open rescue missions, where people who had become so destitute by their substance use could find a roof, warm food, shelter, a sermon, and AA. Such refuge and service were found in

the work of the Salvation Army (Clinebell, 1968). Still although both physician and clergy were helpful, there was a stigma upon alcoholics and substance users. For the physician, substance users were difficult to treat. Many, after detoxification, would resume use or be in such poor physical shape that nothing medically could be done. This was also a population that had little to no money for their own care, as it went to purchasing alcohol or drugs. Clergy and church-run rescue missions became revolving doors. Those seeking help also found that not all missions could stay open, because of a lack of dependable donations and funding. Both groups lacked an understanding of how such problems began or how to alleviate the suffering. Substance users were objects of pity and repulsion. In society, substance users were considered hopeless or helpless.

Early Counseling

There were some individuals who were able to regain their lives back from substance abuse and addiction. Individuals, such as those who were AA sponsors, were able to come forward and offer to help others because of personal experience. These individuals became the first substance abuse or addictions counselors. The main value or credential they possessed was understanding the experience of what it was like to be an alcoholic and in recovery. Such individuals were able to offer advice and counsel to others on how to deal with their addictions and maintain sobriety or abstinence. Treatment facilities, such as hospital or mental health psychiatric programs, began to hire such individuals. Their role was to work with patients in groups or individual meetings.

Much of the counsel offered was based upon personal experiences and the guidance of the principles of the 12 steps. Given that there was a lack of understanding of substance abusers, such approaches as personal experience and the 12 steps became the accepted methods of

treatment. Substantiation was given that these methods worked by those who were able to maintain abstinence. However, Emrick, Tonigan, Montgomery, and Little (1993) noted questions began to emerge on the efficacy of the 12-step approach and the qualification of those providing the counseling.

Boundary Issues

Even though social workers and psychologists worked with mental health clients, they were not viewed as the primary point of help for substance-abusing clients. Ingrained in the mind of some clients was the idea that only those who had personal experience with substance abuse could counsel them. If a social worker or psychologist was in recovery and counseling substance-using clients, some clients viewed such as a bonus of a relational aspect, regardless of the degree to which such relationships created boundary issues "Field Grapples With Sobriety," 2006). One such issue was a counselor still active in substance use being effective in helping clients in his or her active addiction. The boundary issue here was one that asked if the counselor should disclose his or her active addiction to the client. Another boundary issue involved sponsorship. In locales with few treatment resources, should a person's former sponsor serve as a counselor? Another concern was the amount of time a counselor in recovery needed before seeing clients. A further issue concerned counselor and client attending the same AA meetings. Such boundary matters also moved toward the issue of competency of providing addictions services.

Competency

The issue of competency came about regarding who would be best to provide treatment. The choice was between academically trained mental health professionals or recovering non-academically trained counselors.

Social workers and psychologists could certainly provide an academic foundation upon which to provide services to people. However, Bina et al. (2008) found among social work academic programs at the undergraduate and graduate level, little if any course work focused on the issues of substance abuse. Social work academic preparations have some courses in counseling theories, techniques, and assessment. A course in psychopathology was the closest addictions counselors got to studying substance use. Yet, not much time would have been spent on substance abuse, assuming it was covered at all. Those academically prepared had skills but limited exposure working with the problem of substance abuse.

When people are struggling with an issue or health problem, it is natural to seek out someone who has experienced the same health concern. Those experiences can be gleaned for information on what to expect or options available on which to make a decision. At best, knowing someone who made it through the problem can be a source of trusted wisdom and comfort. Those in recovery provided this sense of hope for clients and families. There was no concern over a lack of academic preparation or whether the treatment provided was sound or safe.

Counseling competency was an issue for the professional and non-professional Deitch & Carleton, 1997). The professional mental health worker had exposure to methods but was lacking in working with the problem. The non-professional had the experience, but it was only his or her experience and lacked evidence to back up that it worked (Crabb & Linton, 2007). After all, the 12 steps were just self-help principles, which had, by tradition, become labeled substance abuse treatment (Nace, 1992). Second, the first ethical concerns emerged in both professional and non-professional camps related to understanding, assessing, diagnosing, and treating substance abuse (White, 1993). These competency issues, with the related scope of

practice and supervision, initiated the need to examine higher education programs to prepare addictions counselors.

Academic Preparation

Allied professions such as social work and psychology, along with others including mental health and marriage and family therapy, have developed graduate degree programs specific to their field (Council for Accreditation of Counseling and Related Education Programs [CACREP], 2009). Endemic to these academic programs is curriculum that has been standardized specific to course and learning outcomes (Magnuson, Norem, & Wilcoxon, 2002). These courses teach knowledge, theory, research, and skillsets that are pertinent to the presenting needs of the clients. Included in the degree programs are practicum and internship experiences, which evaluate proper integration, connected to efficacious skill of the student, in determining competence.

Each allied program has developed its own respective accreditation organization to ensure periodic review of the program's compliance with established standards (Bureau of Labor Statistics, 2009). Such bodies of academic knowledge take each discipline from a field to a profession. The curriculum competencies have been researched in conjunction with practice standards in order to meet scientific rigor and understanding (Peterson & Nisenholz, 1999). Although most allied professions have established respected programs related to their disciplines, the majority of programs have been absent of addictions-related content. Further, the addictions field is behind in its own academic development and preparation.

Addictions Certification

For several years, the addictions field relied on the experienced, recovering non-professional. Over time, the move was made by those in the field to establish membership

organizations, such as the National Association of Alcoholism and Drug Abuse Counselors (NAADAC) in 1975 (Marisses Communications Group, 2005). The purpose of NAADAC was to network, while sharing current knowledge and methods of working with addicted clients. NAADAC took these and developed a certification in addictions counseling (Manisses Communications Group, 2005).

The certification consisted of passing an exam based upon current knowledge and methods in the field. Those counselors who met an established passing score would then be certified addictions counselors. Several states came to accept this certification and made having a certification a condition to providing services within the state (Kurita & Guydish, 2007). Although this was a step forward, questions arose as to how the certification exam was constructed regarding content. Was the exam easy or hard? How were the content areas decided? Was the content valid and related to addiction counseling issues or treatment concerns? The question still remained of what is accepted treatment in terms of being sound, safe, or effective. The recovering person with some level of certification approach was not perfect, but it was the best that could be offered.

Certification was not built upon nor did it require any academic preparation related to a degree. Later, new requirements were established to help students (or counselors) prepare for the certification exam. NAADAC, along with some state license boards, required taking several hours of training offered in workshops or conferences. The requirements began to focus upon assessment, treatment, and relapse. After a prescribed number of hours was met, a person was eligible to take the certification exam. After the person passed the exam, he or she was required to obtain a specified number of continuing education hours by attending trainings on a yearly basis to renew certification (Fahy, 2007).

Higher Education and Addiction

With regard to education in addictions, some community colleges offered one or two courses in substance abuse or addictions. Four-year colleges and universities did the same with introductory courses. The courses focused on a survey of illicit and licit drugs, including their risks and benefits. A typical assignment given in such courses had students attend one or more AA meetings, then write up their experience in a paper (Sias & Goodwin, 2007). This was the students' introduction to what addicted people are like. Still missing was an understanding of etiology, theory, assessment, and treatment of addiction. Later some junior and community colleges began to offer several courses in substance abuse, resulting in a certificate of completion. However, there was not an established rationale of content, learning outcomes, or hours. Even within states, no two academic programs were consistent (Osborn, 2011).

Changes in Providing Addiction Services

Another concern that emerged was an area called co-occurring disorders, also referred to as co-existing or co-morbid disorders. Mental health research began to show that mental illness and substance abuse had some correlation. Due to these findings, and with the revision of the Diagnostic and Statistical Manual of Mental Disorders (DSM), inclusion of co-occurring disorders brought changes in treatment efforts (Schneider, 2005). Such changes included health insurance or what is now known as managed care. Professionals were reimbursed to provide such services if they possessed graduate degrees and or licensure. Licensure involved each state establishing standards for educational preparation by law to pass exams to practice in the state to treat clients with mental health concerns. What later became an issue were professionals who provided services outside of their scope of practice or academic preparation. Such an example would be marriage and family therapists treating depression or psychologists treating children for

attention deficit disorder, when they did not have course work or supervision to prove they were competent to treat not only the person but also the presenting problem. For many professionals their competency to treat substance use and addictions became a scope-of-practice issue. Although addictions clients can be chronic, managed care soon found an ill-equipped professional workforce to treat addictions (Khantzian, 1985). The need arose to evaluate the addictions field to meet the demands of those with addiction issues. Resistance came from counselors in the field, due to the belief that no one could be educated to be an addictions counselor. The experience of having gone through an addiction was the only credential you needed.

Significance of the Study

This study has several potential benefits. It collected the opinions of addictions counseling professionals related to their academic preparation and adequacy to practice in addictions counseling. Data collected served as a foundation to develop relevant addictions counseling programs of study in higher education. Existing program competencies were validated and areas of weakness were addressed in developing addiction-specific courses. Such interviews also gave insight to the workforce functions of what addictions counselors actually do in their jobs and in treating clients. Understanding was gained into the types of issues or presenting needs of clients relative to specific features and consequences of the addiction.

The study provided information to evaluate further existing theoretical and treatment applications effectiveness. Information collected provided information to develop new theoretical understanding and treatment protocols to improve the lives of those addicted and their aftercare. This assisted in better allocation of time and expense related to managed health care in the treatment of addictions.

Concomitant with the study emerged information to standardize addictions curriculum connected to a defined scope of practice and ethical conduct. In standardizing addictions curriculum, a consistent content for programs of study could be nationalized in colleges and universities. Such a standardized program greatly enhances reciprocity for state credentialing bodies, as graduates become professionals and move from state to state. In turn, employers more clearly defined hiring criteria and job descriptions for addictions counseling positions. Addictions professionals would be enhanced in the components of ethical practice standards and clinical supervision. The findings of the study could advance addictions counseling from a specialty field to a profession by establishing its own academic standing in research and practice.

Student focus could expand beyond the harmful impact of drugs. The new focus seeks to incorporate assessing clients, signs, symptoms, treatment program components, and effective aftercare. Degree programs could expand by adding additional courses or by covering addictions issues in group counseling courses. The area most lacking is in actual degree programs specific to addictions counseling, just as there are those exclusive to marriage and family therapy or rehabilitation counseling.

In time, addictions programs could move to develop and refine competencies. Specific program competencies are related to etiology, assessment, diagnosis, and effective treatment protocols. Besides substance abuse content, process addictions could be studied as well to address the growing treatment needs for problems such as sexual addiction. Students would be immersed in addiction concerns in both practicum and internship experiences. Supervision of students in these experiences provides a level of ethical practice and competence. Even those who are in recovery could enhance the field by enrolling in such programs in bringing some personal perspective to the program of study. Graduates of such programs would move into

positions of research and even return to the higher education programs as professors or eventually department chairs.

Those who benefit the most are clients, their families, and loved ones. Such programs provide more effective treatment protocols with aftercare assistance. There could be relevance for reducing treatment recidivism of clients in treatment programs and those incarcerated. A secondary benefit related to recidivism would be a better use of treatment dollars and allocation. Addictions prevention programs in schools and underserved areas could benefit from such finances.

Purpose of the Study

The purpose of this study was to evaluate the undergraduate and graduate preparation of those currently hired to work as addiction counselors. To those needs, I researched the academic preparation of those currently practicing as addictions counselors in the state of Indiana.

To accomplish this research, I interviewed addictions counselors with bachelor's and master's degrees working in community mental health centers. The focus was to evaluate how well their programs of study, from their perspectives, prepared them for the addictions counseling workforce. Their academic programs were reviewed for strengths or deficiencies of courses and learning experiences in preparation of the goals of meeting needs of clients and practicing in addictions treatment programs.

To evaluate the adequacy of academic programs, counselors were interviewed using a semi-structured interview. Interview questions gathered data to evaluate what addictions counselors found helpful or lacking in their academic programs. In this study, four overarching research questions were (a) Are current degree programs adequate to prepare individuals to be addictions counselors? (b) What do addictions counselors do in practice? (c) How well does

academic preparation match practice? and (d) What current academic preparation is adequate, and if needed, where could improvement be made?

Following the interviews, the same addictions counselors were given a survey consisting of courses related to addictions counseling. Counselors were asked to choose on a Likert-type scale the level of importance and relevance the courses had in providing competence in addictions counseling. The findings of this study could advance the field of addictions to the level of the other allied professions, with its own curriculum and scope of practice.

CHAPTER 2

REVIEW OF LITERATURE

This literature review examined the history, development, and contemporary practice of addictions counseling. Areas reviewed include the education and training requirements of addictions counselors regarding theory, treatment, ethics, and supervision in relation to the practice of addictions counseling. These topics encompassed salient areas to understanding addictions counseling and helped in assessing addictions curriculum in higher education. This review provided an overview of where addictions counseling came from and where it is going with thought toward educating a profession and workforce. Competency in the field of addictions counseling is needed to meet the 23.2 million persons who need treatment, of whom only 2.4 million received services due to a lack of addictions counselors (Harwood, 2003). Subsequently, 5,000 new addictions counselors are needed every year to address the treatment needs of those with addiction (Harwood, 2003).

A Brief Introduction to Addictions Counseling

The field of addictions counseling has been slow in development, due to a lack of agreement on established workforce standards and education. Throughout most of the profession's history, the work of counseling has been provided by lay individuals, who themselves had specific addictions, particularly in the area of alcohol and drugs (Deitch & Carleton, 1997). Physicians were involved to a certain degree, but only in the aspect of medical

care. Many individuals in and out of their own recovery relied upon what worked for them in helping others. Counseling skills, knowledge, and understanding of addictions were non-existent; the main medical goal was to keep an individual alive (Osborn, 2008).

Composition of the Addictions Workforce

The profession of addictions counseling has an interesting composition, unlike other human service counseling professionals. Addictions counseling has recovering and nonrecovering counselors. The field also consists of those with undergraduate and graduate degrees and those without. Some within the field believe that being in recovery is a better qualification for counselors than not being in recovery yet possessing a degree. Other allied counseling professions, such as clinical mental health counseling or marriage and family therapy, do not as strongly equate having a mental illness or marital issue as qualification or competency to counsel. More significant is that to practice in mental health and family therapy, one must have a degree at the graduate level (Bissell & Royce, 1987). In addictions counseling, some states only require individuals to have a high school diploma and pass a certification test to be an addictions counselor. Sias, Lambie, and Foster (2006) found with regard to other allied counseling professions that the master's degree is the minimum standard. Due to allied professional academic standards, the issue of higher education in addictions counseling is in need of a review.

Addictions Training

Several studies of clinical training programs approved by the American Psychological Association (APA) found "a low level of training in the evaluation, treatment, and prevention of substance abuse" (Selin & Svanum, 1981, p. 717). Five years later in a follow-up study, researchers concluded there had been "few changes in the quantity or nature of university

training in substance abuse" (Lubin, Brady, Woodward, & Thomas, 1986, p. 153). Lawson and Lawson (1990) concluded a need of minimum training standards for human service professionals yet found little agreement on prerequisites, curriculum, or instructor qualifications. In these instances, exposure to the complexity of addictions in course work for those going into the helping professions would assist greatly in working with the substance abuser. Addictions coursework would engage students in the need to develop understanding, techniques, skills, and methods to work with such a large population (Osborn, 2008). In this process, counselor educators at the doctoral level could assist the field and profession in establishing a standardized curriculum along with ethical standards for the practice of addictions counseling.

Need for Academic Standards

Due to the lack of educational standards or addictions curriculum in higher education, concerns arise related to an educated workforce. An academic degree program in higher education would assist students and the field in several ways. A curriculum would provide a definition and understanding of the origin of addictions. This understanding would in turn support the development of theories of addiction not just those of etiology but of refining theoretical models of treatment, ethics, and supervision of the field and thus establish a profession. The end result would benefit the addictions counseling profession and clients with established academic programs, practice standards, and research initiatives. In evaluating the addiction profession it is important to examine the definitions and causes of addiction.

Addiction and Etiology

Alcohol use has been the primary substance associated with addictions counseling due to the association of AA (McCrady & Miller, 1993). Over the years, drug use associated with marijuana and cocaine has become a concern as well. In current discussions of addictions

counseling, process addictions such as eating disorders, gambling, and sexual addiction are included for treatment (Hagedorn, 2009). In order to develop an addictions curriculum, it is important that definitions and etiology of chemical and process addictions be reviewed. This is important because a standard working definition enhances clarity to diagnosis and treatment. Further, such definition adds consistency to what is taught for understanding and practice for students in higher education.

Defining Addiction

Addiction has three main components: compulsion, loss of control, and continued use in spite of adverse consequences (Coombs, 1997; Smith & Seymour, 2001). An example of compulsion is an individual who cannot start his or her day without coffee or have a meal without a beer. Loss of control is marked by an individual who states that while at a social gathering, he or she will have no more than two mixed drinks in the evening, only to become intoxicated with five drinks. The individual may bring embarrassment to himself or herself by stating he or she will never do that again, only to do the same behavior the next weekend. This loss of control would then lead to an individual having continued use in spite of adverse consequences. An example is an individual arrested for driving under the influence. The individual has placed himself or herself and others at risk, yet a month later is arrested again for the same offense. He or she now faces fines and jail time resulting in possible loss of his job. The American Medical Association (AMA) was the first group to give attention to a disease model for alcohol addiction.

Disease Model

In 1956 the AMA declared that alcoholism was both chronic and progressive and exhibited a defined course with specific symptoms (Craig, 2004). This also cleared the way for

third-party reimbursement. Leshner (1999), director of the National Institute of Drug Abuse (NIDA), published a report stating that addiction was a brain disease. The report concluded that drug addiction impacts the brain neurochemistry and thus changes brain function. If left untreated, over time other physical and mental health issues develop. As a disease, the drug addiction could progress with the end result being death.

In the addictions field, the issue of drug addiction as a brain disease is controversial. There are several definitions of disease within the medical community. The first definition describes disease as having the normal functioning of the body, impacted by a virus, bacteria, or fungus (Doweiko, 2009). Another definition indicates a disease can cause abnormal growth or functioning in the body due to a genetic disorder. The last definition describes an organ not operating properly due to a trauma (Doweiko, 2009). To date research has not found one single genetic indicator for the etiology of alcoholism or addictions (Blume, 2004; Polich, Pollock, & Bloom, 1994). Craig (2004) and Thombs (2006) pointed out that there are several definitions of disease as related to alcohol. Given the lack of genetic confirmation and the varying definitions of disease, Craig came to believe that alcoholism is a disease in theory but was unwilling to conclude that alcoholism is a disease. Craig acknowledged that in addition to professionals, support groups hold to the disease concept as one would hold to a tenet of religious faith. However, central to Craig's view of alcoholism is that an individual has a loss of control over his or her drinking or drug use. Thombs posited that some people do not have a disease but may be more susceptible to alcohol. In regard to these complex findings, the historical development and practice of addictions counseling needs to be considered.

Early History, Development, and Critical Issues in Addictions Counseling

Craig (2004) stated for those seeking help with alcohol issues, the only avenues of help were AA and the clergy. Although AA was not viewed as treatment, it was a place for support and self-help. Later several other support groups appeared modeled after AA, to work with drug addicts, such as Cocaine Anonymous. Mustaine, West, and Wyrick (2003) noted that even as late as the 1960s, physicians, psychologists, and social workers were reluctant to work with such chronic individuals for two reasons. The first was a lack of understanding in how to treat the person, and the second was difficulty in arranging for payment of services.

Lack of Prepared Addiction Professionals

Along with this professional reluctance, colleges and universities had minimal course preparation in addictions as they related to substance abuse (Howard, Walker, Walker, & Suchinsky, 2004). Howard et al.'s study of nursing graduates found that the nation's one million nurses interact regularly with hospitalized patients, of whom one quarter have substance use disorders. Further, they found nurses less accepting of substance users due to re-hospitalization. The nursing profession is not alone in this perception as other human services workers have exhibited the same reluctance to work with addicted clients. Morgan, Toloczko, and Comly (1997) found that psychologists, social workers, marriage and family therapists, mental health counselors, and physicians exhibit reluctance when they encounter addicted clients.

Co-Occurring Disorders

Mangrum and Spence (2008) noted that there is a significant amount of literature that finds psychiatric diagnosis and substance abuse occurring together. Polcin (2000), in reviewing epidemiological studies, indicated a prevalence rate of 8% to 14% of the population for alcohol dependence, and 29% of clients with mental health issues have a history of a substance abuse

disorder. The same review reported of those diagnosed with schizophrenia, 47% have a history of substance abuse, and 40% of families in counseling have a member who has experienced both mental health and substance abuse concerns.

The significance here is the level of competency needed for counselors to treat issues as related to psychopathology, etiology, prognosis, and psychopharmacology (Meuser & Drake, 2007). Given the coexistence of mental health and substance disorders, academic preparation of future addiction and mental health professionals to treat such clients becomes important. Although substance abuse may not be the presenting problem, substance use may play a negative part in the individual's mental health and need to be addressed in counseling. Treatment professionals must be prepared for and be open to working with such individuals.

When clients present for counseling services to allied mental health practitioners in private practice settings, such as social workers, marriage and family therapists, or psychologists, many clients have substance abuse issues that are not assessed or ignored and thus go untreated (Harwood, 2003). Harwood (2003) found that clients may often present to their therapists with other mental health or social functioning issues including lifestyle concerns. Neither clients nor therapists may recognize the issue of substance abuse, which could be a contributing factor to the clients' issues. In reviewing the coursework and training at the graduate level including postgraduate level among social workers, family therapists, and psychologists, Harwood found that substance abuse as a topic of study was sparse to nonexistent. Because of this, a therapist would not be adequately prepared to assess for substance abuse or contribute to the client's treatment.

Harwood (2003) also reviewed the Practioner's Service Network (PSN). The PSN comprises private practitioners who have membership in the American Association of Marriage

and Family Therapists, the American Counseling Association, the American Psychiatric Association, the American Psychological Association, the Association of Addiction Professionals, and the National Association of Social Workers. He found that substance abuse was not a primary but a secondary diagnosis of co-morbidity. In the review, substance abuse was the diagnosis in 34% of clients who saw professional counselors, and marriage and family therapists, and social workers reported that only 24% of clients had substance abuse issues. Participants of the PSN (not including the substance abuse counselors) reported that fewer than half overall had received training or taken coursework at the graduate level in diagnosis or treatment of co-occurring disorders. Of the psychologists, 30% percent reported some education or training at the graduate level, and 53% of marriage and family therapists reported some graduate training.

Cross Training

Harwood (2003) found only two-thirds of substance abuse counselors had graduate level coursework in substance abuse. Further, many addictions counselors in the workforce did not have graduate degrees in substance abuse or addictions. Most had graduate degrees in other behavioral or social service disciplines, such as mental health counseling or social work. Later they may have transitioned to jobs in substance abuse or addictions counseling. The conclusion indicated the PSN needs to give attention to more contemporary training to the diagnosis and treatment of addiction.

Miller and Brown's (1997) review of private therapists also indicated multiservice mental health agencies had need for counseling skills and treatment practice for substance abuse. As multiservice agencies see a large number of clientele with mental health and substance concerns, substance abuse issues tend to be more prevalent. Von Steen, Vacc, and Strickland (2002)

reported and concurred that substance abuse assessment, family counseling for substance abuse, 12-step principles, relapse prevention, and goal setting/treatment planning would all be important training concerns for multi-service agencies providing substance abuse counseling. In addressing the treatment issue, it would be of benefit to examine the prevention and early detection of substance use issues in school settings. The need for substance abuse course work at the graduate level has also been identified for school counselors.

School Counselors as Frontline Providers

The Substance Abuse and Mental Health Services Administration (SAMHSA, 2003) concluded 11.6% children and adolescents ages 12-17 in the United States were using illicit drugs. A further 8.9% of that age group met diagnoses for substance abuse or dependence. These percentages are vitally important on the issues of prevention and assessment for access to substance abuse counseling services within the school setting. In studies on this subject, Mason (1997), Palmer and Ringwalt (1988), and Sink (2005) concurred that the school counselor is viewed as the person students would talk to regarding personal substance abuse issues. As a result, school counselors need to have requisite knowledge and skills to assist students on substance abuse issues.

Elementary school counselors and students with substance-abusing parents in North Carolina were studied by Vail-Smith and Knight (1995). The results indicated that college courses were not adequate in providing knowledge and practice skills for school counselors to counsel students with substance abuse concerns. School counselors in a study by Goldberg and Governali (1995) reported feeling more adequate to address tobacco, alcohol, and marijuana as health concerns with students. School counselors felt least prepared to address hallucinogens, inhalants, and stimulants with the same students. In a study conducted by Burrow-Sanchez and

Lopez (2009), school counselors wanted training to provide greater services of substance abuse screening, assessment, and group skills. School counselors also indicated that this would be important to include in their graduate education.

Development of Addiction Certification and Licensure

Banken and McGovern (1992) reported that the field of substance abuse counseling began to solidify in the early 1970s when Congress passed the Comprehensive Alcohol Abuse and Alcohol Prevention Treatment and Rehabilitation Act. This legislation provided substantial funding in the form of block grants to states for treatment of alcohol patients and training individuals to work with this population. During this same period, Congress established the National Institute of Drug Abuse (NIDA) and the National Institute for Alcohol Abuse and Alcoholism (NIAAA). NIDA and NIAAA were the first organizations to establish specialized training focusing on counseling skills to meet the needs of addicted persons (Osborn, 2008).

State Requirements

States began to establish substance abuse counselor certification boards that coincided with the birth of two national organizations (Banken & McGovern, 1992). Certification is established by a profession and is granted to an individual who has met the professional requirements of education and training. Competency can be demonstrated by passing an exam or giving an oral case presentation (NIAAA, 1982). The certification can be ascribed to title and practice protection while giving endorsement to the general public. The organizations that developed early addictions certification were the NAADAC, and the International Certification and Reciprocity Consortium (IC&RC). During this time, the Association for Counselor Education and Supervision (ACES) developed the academic minimum standards at the graduate level for professional counseling. Following this effort was the formation of the CACREP in

1981 and the National Board for Certified Counselors (NBCC) in 1982. These organizations began to include within their missions standards for the certification of professional counseling. These would eventually play a role in establishing standards in addictions counseling as well (Osborn, 2008).

Unfortunately during this time, states were given "the authority to determine acceptable professional credentials for individuals performing non-medical treatment services" (Banken & McGovern, 1992, p. 30). Horvatich and Wergin (1998) found in the field of addictions counseling that non-degreed individuals, or at the least high school graduates who were recovering addicts and alcoholics, were recognized as qualified professionals to do substance abuse counseling if they had some level of recognized certification. Some states required a certain number of years in the field before applying for certification by the state. Only a few states required a bachelor's degree, yet other states did not require a certification for work in a state-certified facility. Any substance abuse education or training that individuals received was provided by the state or state-certified institutions by attendance at workshops and conferences rather than academic institutions (Osborn, 2008).

Certification Standards

With the establishment of NAADAC and IC&RC, many counselors began to initiate the process of meeting requirements for certification. The levels of certification range from entry level to advanced certification. In 1995, the addictions counseling field took a major step forward through the joint efforts of the NBCC and NAADAC, when the master addictions counselor (MAC) certification was introduced. The MAC is the highest level of national certification. MAC certification required that candidates "have a graduate degree with emphasis on counseling, including course work in addictions as part of the qualifications along with

postgraduate hours including supervision in addictions" (West, Mustaine, & Wyrick, 1999, p. 38).

One of several criteria for MAC certification, beyond earning a master's degree in counseling, marriage and family therapy, social work, or psychology, is course work related to addictions. The applicant must have a minimum of 12 graduate hours in addictions counseling from a regionally accredited institution. Typical courses and course content cover drug terminology, theories, treatment of addiction, and group counseling (NAADAC, 2008). Yet such a certification lacked a specific master's degree in addictions counseling.

Supervision and oversight hours are included in the certification process. Applicants are to have received 36 months of supervision, with 24 months occurring after graduation. Within the 24-month period, the applicant should have an average of 20 hours per week. The hours are directly associated in face-to-face work with addicted clients. After educational and supervision hours are met, individuals would present an oral case presentation and pass a state or national exam.

The exam covers 91 core tasks identified as the basic competencies needed to work in addictions counseling (Page & Bailey, 1995). The 91 core tasks include skills in screening and intake procedures, orientation of clients, assessment, treatment planning, foundations of counseling, crisis intervention, client education, referral, reporting, record keeping, and consultation with other professionals (NAADAC, 1992; Taleff & Swisher, 2001).

Licensure

Licensure is a professional practice regulation and involves more stringent criteria than certification. Certification can be a requirement for becoming licensed. As some states have established certification, licensure is solely for each individual state to establish. Each state

establishes its requirements for counseling practice by legislation in a licensure bill. Such requirements may be the type of degree needed, number of hours of supervision required, and passing a licensure exam. Magnuson et al. (2002) pointed out that most state licensure laws focus on postgraduate requirements for competency. Examples of postgraduate requirements may be continuing in professional development by attending workshops or conferences in order to stay current with the profession. Newer counselors adhere to ongoing supervision to meet licensure requirements. Further client welfare and standards of care are enforced by ethical codes or law. Although organizations and states developed certification and licensure standards, what was still needed was attention to academic issues such as assessment, psychopathology, theory, and treatment, related to the ethical practice of addictions counseling.

Academics, Managed Care, Theory, and Treatment

For students currently in college, their introduction to the field of addictions comes while taking an introductory psychology or sociology class. A typical assignment is for students to attend one or several AA meetings and write a paper about their experience (Bristow, Provost, & Morton, 2002; Sias & Goodwin, 2007). Some colleges, universities, and graduate schools may have one addictions course, yet the course may not address how to work with the treatment needs of the substance user or addicted (Osborn, 2008).

Lack of Academic Requirements

Page, Bailey, Barker, and Clawson (1995) found that although NAADAC and IC&RC saw the importance of academic preparation for the professional counselor, they did not require the completion of any academic program for the certification process. In 1993, the Center for Substance Abuse Treatment (CSAT) created and developed the Addiction Technology Transfer Center (ATTC); there are currently nine regional ATTCs. Part of the task of the ATTCs was to

"foster improvements in the preparation of addiction treatment professionals" (Horvatich & Wergin, 1998, p. 2). The ATTC established a committee to review current addictions courses and programs. The committee found that the field of addictions counseling did not have a defined knowledge or skill set.

From this, the committee went on to establish four transdisciplinary foundations and eight practice dimensions, which incorporated 121 competencies published in a technical assistance publication known as TAP 21 (CSAT, 2006). Horvatich and Wergin (1998) presented categories forming transdisciplinary foundations for addictions counseling. These included understanding addiction, treatment knowledge, application to practice, and professional readiness. The practice categories are (a) clinical evaluation, (b) treatment planning, (c) referral, (d) case management, (e) counseling of client and family, (f) community education, (g) documentation, and (h) professional and ethical responsibilities (Osborn, 2008). Tap 21 became the reference point for addictions training for workshops and conferences on continuing education.

Managed Care and Addictions Treatment

The 1980s managed care brought scrutiny to substance abuse counseling and began to evaluate the impact of treatment methods and techniques used. The main inquiry wanted some evidence that the methods and techniques used in substance abuse counseling were of benefit to the client. The inquiry was due to the growth and predominance of managed care and reimbursement to treatment programs that were effective (Eaves, Emens, & Shepris, 2008). What worked previously for counselors, a 12-step approach to helping clients, was given blind acceptance. Thombs and Osborn (2001) noted that counselors preferred to use experiential models encountered in their own recovery from addiction. Furthermore, treatment programs

adhered to practices that were based on personal recovery experience rather than any kind of empirical study. Managed care changed reimbursement practices, and it generally based reimbursement on evidence-based treatment methods that were effective (Shaffer, 1986). Due to either unproven methods or lack of competency by therapists or programs, managed care concluded that treatment of addictions was a costly revolving door (Brown, 1985; Khantzian, 1985; Vaillant, 1995).

Reimbursement of licensed counselors holding graduate degrees was becoming the choice of managed care in several states (Mustaine et al., 2003). These counselors met academic criteria to provide managed care services, although many lacked training in addictions counseling (Fisher & Harrison, 2005). Reimbursement for substance abuse services was less than mental health. What contributed to this difference was mental health had empirical evidence to show the effectiveness of counseling methods with clients. Besides managed care, accreditation agencies such as the Joint Commission on Accreditation of Healthcare Organizations emphasized the implementation of evidence-based practice as effective treatment modalities and practices (Cesare-Murphy, McMahill & Schyve, 1997). In time, substance abuse counseling embraced cognitive behavior therapy (CBT) and motivational interviewing (MI) as empirically based theoretical treatment approaches to answer the concerns of managed care (McCambridge & Strang, 2004; Miller, Wilbourne, & Hettema, 2003).

Evidence Based Theory and Treatment

CBT was found to be the most conducive therapy in the treatment of addictions (Beck, Wright, Newman, & Liese, 1993; Miller, Zweben, DiClemente, & Rychtarik, 1992; Morgillo-Freeman & Osborn, 2006). Other studies conducted by Miller and Brown (1997) and Ouimette, Finney, and Moos (1997) found CBT and MI to be effective as well in treating substance abuse.

Cognitive Behavioral Therapy

The CBT approach is to instruct patients in cognitive behavioral skills in coping with addiction relapse. CBT views substance use and addiction as dependent upon the factors of environment, family, and social use. The factors are then based on physiological response to initial use, as either reinforcing or negative in consequences (Beck et.al., 1993).

Motivational Interviewing

In MI, the motivation to change is elicited from the individual rather than prescribed from a treatment entity. The task of the client is to articulate what changes he or she need to make, based upon current life circumstances. MI was first developed to work with resistant substance-abusing clients in a variety of settings, mainly in criminal justice (Miller, 1983). Clients work through a *stages of change* process. The stages of that process are pre-contemplation, contemplation, decision-making, action plan, maintenance, and lapse or relapse. These theoretical approaches give clients a constructive approach to understand their thoughts, feelings, and behavior, while assessing the stage of their addiction or recovery in order to take control. With these theoretical treatment approaches in place, other addictions besides substance abuse have also been identified. No longer is addiction just viewed as alcohol and drugs.

New behavior syndromes such as gambling, eating, and sexual disorders have been placed under the addictions umbrella. These syndromes further the need for competent ethical professionals who use proven theoretical approaches. It was soon discovered some clients were receiving treatment from individual therapists who did not have training, education, or certification in addictions (Osborn, 2008). Such practices without a defined scope of practice or standards of care give opportunity for unethical professional conduct and client abuse.

Ethics, Counselor Differences, Supervision and Recommendations

With all the efforts made in addictions counseling regarding certification, licensure, competencies, and knowledge and skill development, there exists a lack of consensus on a national academic standard or course of study. This can translate to ethical concerns in the field and the practice of addictions counseling.

Ethical Requirements

The concerns are related to the same ethical issues that counselors in mental health are aware of (e.g., confidentiality, abuse, dual relationships). Only 14 states currently require addictions counselors to have training or education in ethics. This is compounded by different entry or certification levels, which are based upon passing an exam, years in the field, and scope of job duties (Bissel & Royce, 1987). For example, in addressing confidentiality, as it pertains to the Federal statute known as the Confidentiality of Alcohol and Drug Abuse Patient Records Code 42 (CFR 42; U.S. Department of Health and Human Services, 1987), there are more stringent rules of confidentiality with substance abuse treatment records than with any other profession (Osborn, 2008). CFR 42 set federal standards specific to addiction treatment, patient care, subpoenas, criminal justice guidelines, and client records (CSAT, 2004).

Under these guidelines, a specific release of information to the person who is making the request is warranted as set forth in CFR 42, which speaks to more specific detail. Included in CFR 42, if records are being requested under subpoena, a hearing must be held first to determine the standing of the person making the request, what information is being asked for, and how the information will be used. The substance abuse record must also be sealed and brought to the hearing by a therapist. Recent changes in the law pertain to individuals in treatment while in the criminal justice system. Counselors may now disclose information as it relates to institutional or

supervisory infractions, possession of minor contraband, general threats to the safety of the institution, or positive urinalysis (Osborn, 2008). These apply to those classified as probationers, parolees, or incarcerated offenders (Fitch, 1991).

There are some circumstances in which an individual may function above his or her level of certification, such as a counselor without a degree formulating a treatment plan, or giving an interpretation of an assessment to a client. Even though NAADAC has a code of ethics, and the national certification exam has an ethics domain, these do not ensure that code of ethics will be practiced, applied properly, monitored, read, or remembered (Osborn, 2008). It is important to frame a means by which ethical compliance may be enforced.

The Value of Addictions Counseling Standards

Perhaps the most exhaustive and most troubling review of addictions counseling related to education, practice, and ethics was conducted by the Justin Foundation (2007). The Justin Foundation was founded in 2006 by Cathie Smith, as a nonprofit organization. Her son, Justin, entered a drug treatment facility in the state of California and died in an accident while in the facility. Due to his death, the Justin Foundation was established in his name and conducted a review of the California Department of Alcohol and Drug Programs (CDADP). CDADP oversees the state's treatment programs and, by policy, reviews treatment facilities every two years. Part of the CDADP purpose is to investigate complaints and deaths of individuals in treatment.

The Justin Foundation (2007) reviewed 67 death investigations in California's addictions treatment facilities and found that the CDADP does not name counselors or staff involved in investigations which were connected to client deaths and, subsequently, does not keep track of counselors. California has nine different certifying bodies with their own codes of ethics, which

contribute to variation not only of codes but also of application and enforcement. Thus, counselors could move from treatment facility to treatment facility without any checks and balances by the state.

Examples of violations included lack of recognition of suicidal warnings, improper sexual relations with clients resulting in relapse, violation of client rights, and medication mismanagement. The Justin Foundation (2007) also found that California had the largest number of people in treatment and the lowest addictions counseling practice standards in the nation, contributing to a large number of untrained and thereby potentially unskilled and unethical counselors. California requires only 155 hours of formal education, 160 hours of a supervised practicum, and one year of experience. With regard to formal education, these low minima do not necessarily mean college-level coursework that is from an accredited institution; the hours could be from a workshop or training institute (Kurita & Guydish, 2007).

Given these dynamics, including the issue of recovering and non-recovering counselors, the issue of ethics becomes important to include in academic study. The inclusion of ethics as a course has merit in educating future counselors for professional ethical behavior and treatment of clients. For example, students must become aware of professional expectations, standards of client care, conducting ethical research, and client counselor boundaries. Ethical issues related to recovering and non-recovering counselors were reported by White (1993) and Zinnbauer and Pargament (2000) in addictions counseling. Their conclusions were that ethical decisions can be influenced by the counselors' own values, especially those of recovering counselors. In a study that looked at the relationship of substance-abuse counselors' level of education, relationship to recovery, and cognitive level of moral reasoning, Sias et al. (2006) found that as the level of education increased, so did moral and ethical reasoning.

Knowledge of professional ethics is important, yet due to the composition of the addictions profession, practitioners' ethical conduct and application can be lacking. Because of this disparity, an ethics course related to addictions counseling would be important and would expose students to more than just an ethics code. Students can be introduced to problems faced in addictions counseling and become aware of ethical thinking, with thoughtful and rational professional conduct.

Traditional Recovering vs. Nontraditional Nonrecovering Counselors

There is the belief that counselors who are in recovery (Culbreth, 2000) are more qualified to do addictions counseling because of personal experience with addiction. This belief was also confirmed by Thombs and Osborn (2001). Their study of counselors' clinical orientations showed that a counselor's recovery is a primary qualification for providing treatment, even in cases where clinicians lack specific counseling skills or techniques. White (2008) reported a different perspective. He found to be an effective addictions counselor one does not need to have a past history of addiction. What is important are the counselor's educational preparation, professional credibility, and acceptance of the addicted client population.

Another difference of recovering and non-recovering counselors is in their understanding of the etiology of addiction. The differences are described as *traditional* for the recovering counselor and *nontraditional* for the nonrecovering counselor (Crabb & Linton, 2007). The traditional approaches to treatment advocate that persons have the disease of alcoholism and the 12 steps of AA are the only way to recovery. The nontraditional approach advocates a different understanding of the disease concept of alcoholism and rejects the disease etiology for lack of

scientific proof. The nontraditional approach may use some of the tenets of the 12 steps but will use other treatment methods of counseling theory and techniques.

For recovering counselors hired to work in addictions, several ethical implications come into question (Bissel & Royce, 1987). Such questions are related to what steps should be taken if a counselor relapses. The implication here is the effectiveness and impact may be compromised of the counselor's work with those trying to make it to recovery or those in recovery. Given that AA is connected to some treatment components, should those who are counselors sponsor individuals in AA? Of concern is the issue of dual roles with the client. Subsequent to this, what would happen if a counselor who has relapsed should attend AA and come into contact with past, present, or possible future clients?

Crabb and Linton (2007) noted that the traditional counselor having personal experiences and without formal academic training is at a disadvantage that can impact treatment. The traditional counselor is less exposed to and some may be less accepting of current research findings that may be effective for addictions treatment. Such counselors believe that clients can overcome addiction in the same way they did. To ignore research is detrimental to the counselor in knowledge, treatment, and skills in fostering recovery in clients. This underscores the value of a place for research an in addictions curriculum. Research becomes vital to the academic makeup of curriculum for addictions counselors, not just in the aspect of learning about research but also in knowing how to do research and, most importantly, applying research to practice.

Another issue is the amount of research being conducted specific to substance abuse. Campbell, Daood, Caitlin, and Alberson (2005) noted that such information overload can be overwhelming to the counselor. Given the number of stakeholders, such as administrators, clinical supervisors, and policy makers from whom the information about research is coming and

the perspective they bring to treatment, the counselor can struggle to find relevant application. From an educational standpoint, most addiction counselors indicate what research they have become acquainted with has come from workshops and conferences, with little relevance to understanding why the research is important for application to practice (Campbell et al., 2005).

Role of Supervision

Clinical supervision has been viewed as the most logical place for integration and application of research in addictions counseling (Campbell et al., 2005). Clinical supervision evaluates the student's graduate experience. Supervision serves in evaluating the student's understanding of course content and learning objectives. Clinical supervisors further evaluate counseling skill and competencies applied in observed practice, including ethical and professional conduct. Among administrators, clinicians, educators, and policy makers, the assumption has been made that the clinical supervisor is usually a more advanced and senior clinician. The advanced status is based upon years of experience, specialized training in clinical supervision, or both, thus possessing more knowledge to integrate research to practice (Garland, Kruse, & Aarons, 2003). Further, this suggests that academic programs place research courses at the front end of the student's program. Front-placement would assist students to display application of research in practicum and internship course work. The result of front-placement would be to help the students develop an appreciation of understanding and application, while clinical supervisors would provide the resources for illustrating the ethical application of research to treatment. Garland et al. (2003) advocated for a re-examination of current academic and training programs regarding research. The conclusion brings an appreciation of research connected to practice relevance; not doing so can create a "What's the use and value?" mentality among students.

Supervision of Addictions Counseling

In the counseling profession, the role and function of supervision has had an important place in counselor development. Unfortunately, the idea exists in some facilities that the longer one counsels, the more experience he or she garners and that elevates the counselor to the status of supervisor. Yet years alone should not be the major qualifying criterion for being a clinical supervisor. The role of supervisor is to evaluate the knowledge, skills, and application of sound and ethical counseling practices (Bernard & Goodyear, 2004; Schultz, Ososkie, Fried, Nelson, & Bardos, 2002). The literature indicates that most articles on supervision have supervisee development as the main focus, but little on the development of the supervisor (Baker, Exum, & Tyler, 2002). The same lack of research on supervisor development has been indicated in the area of addictions (Culbreth, 1999, 2000). Reeves, Culbreth, and Greene (1997) conducted a study of addictions supervisors' perceptions and factors influencing their supervisory style. Culbreth (2003) conducted a later study that focused on the factors and topics of recovering supervisees including their supervisors. Both studies determined that counselors saw the recovery status of their supervisor as important and that recovery from the supervisor's perspective contributed to the supervisee's resistance. The supervisor found that nonrecovery counselors were more open to direction and the authority of the supervisor's position.

Culbreth and Cooper (2008) indicated that in their review no empirical studies on the factors or stages of development of addictions supervisors could be located. They also underscored that the recovering counselor arriving at a supervisory role will have less experience. Such deficits will likely impact the effectiveness of the supervisor related to ethical and legal issues of his or her supervisee. This underscores the need for supervision in an

addictions curriculum not only for students receiving supervision but also for competency in developing supervisors.

Academic Changes

Currently psychologists, mental health counselors, and marriage and family therapists view the profession of addictions counseling as a valued allied profession (Osborn, 2008). Yet there is the recognition by many students, and those in other counseling professions, that the field of addictions counseling must academically evolve. Given this level of recognition to the field of addictions counseling, a review by CACREP determined to introduce addictions course criteria in all CACREP-accredited programs by 2010 (Salyers, Ritchie, Cochrane, & Roseman, 2006). All students in graduate-level programs accredited by CACREP will take one addictions course as part of the core curriculum. Primarily this is due to the rise of addictive substances and the impact on society. Prior to this, the majority of students in CACREP programs received little to no coursework in addictions; however, they worked with such clientele after graduation. This is a major ethical concern in that counselors may be practicing outside of their academic training or, worse yet, ignoring or allowing the issues to go unnoticed.

Klutschowski and Troth (1995) suggested that a lack of direction in the field produces a lack of expectations of the addictions counselor regarding competency, skill, and knowledge. West et al. (1999) concluded that despite the codes, laws, certification, and state standards, there is still a need for a national educational standard for the profession. Because of this, West et al. concluded that society will see addictions counseling as lacking professionalism and addicts as second-class citizens who should receive second-class treatment. Competency and skill are needed in the treatment of a variety of client populations. Today's addictions counselor must also be aware of other cultural and gender issues in the treatment of addiction.

Multicultural and Gender Issues

As the United States experiences growth in multicultural populations, the need to understand how these populations are at risk for substance abuse issues is important. Such risk factors for substance abuse may in part be connected to socioeconomic status (Lassiter & Chang, 2006). Lassiter and Chang also found the highest rate of treatment needs for illicit drug use was among persons of mixed racial and ethnic heritage. This issue would support the need for risk factors of minority groups to be included in academic course work in addictions counseling related to multicultural counseling. Another important component in treatment of individuals from various cultures is to understand the role of alcohol and drugs within each culture.

In a review of the literature, Lassiter and Chang (2006) found there is a lack of focused study on multicultural issues in the addictions literature. Klutschowski and Troth (1995), in a study of addictions counselors related to academic preparation, found addictions counselors ranked the need to take a course on multicultural issues as low. Nugent (2000) reported substance abuse is connected to other issues such as child abuse, neglect, and domestic violence. Due to the frequent association of substance abuse in connection with abuse, neglect, and violence, these special problems need to be a part of higher education and training in addictions work. In this way higher education provides attention to the understanding of not only treatment for the abuser but also responsible ethical intervention in and protection of those in the substance abuser's life.

Multicultural Issues

In reviewing multicultural competency among certified substance abuse counselors, it was concluded by Lassiter and Chang (2006) that substance abuse counselors will work with clients of different cultures. They emphasized that substance abuse counselors will need training

not only to be competent in understanding treatment for clients of diverse cultural and racial backgrounds but for the counselors to recognize how their culture plays a role in treating and understanding clients. The value of inclusion of multicultural awareness speaks to decreasing stereotypes and counselor bias. Substance abuse counselors would also benefit in detail and application of culturally relevant assessment, diagnosis, counseling, intervention, and relapse prevention (Kiselica, Maben, & Locke, 1999). The following descriptions provide some specifics related to multicultural issues for addictions counseling with some affected groups.

African Americans

Substance abuse in African American communities contributes to a high rate of violence and health problems (Luchansky et al., 2006). One such health concern is fetal alcohol syndrome (FAS). FAS is seven times higher among African Americans (NIAAA, 1990). Lex (1985) reported that African Americans begin drinking at an earlier age, drink more often on weekends, and have more severe psychiatric problems associated with substance abuse. For counselors working with African Americans, the U.S. Department of Health and Human Services (2001) noted that they are resistant to treatment provided by providers from the dominant culture. Other issues to consider in the African American community are external stressors related to family, economic status, and shortened life span. hooks (1984) indicated that African American women are impacted by negative images of who they are compared to other cultural groups; as a result, there is a tendency to internalize the images. Some of the images include providing for children as a single parent due to dissolution of marriages, abandonment, or incarceration of the children's fathers. As a single parent, African American women face higher rates of poverty and unemployment. The latter two issues present concerns about illness and shortened life span. Finally, self esteem can be impacted because of limited opportunities

for education and career development. As a result, some African American women succumb to measures to provide for their families such as selling drugs or prostitution. The risk of such activity could result in their incarceration and feel they have failed as parents and women.

Counselors should be mindful when working with this population, that life skills training is important, and the integration of spiritual issues helps and heals. Further, Collins (2000) found it is important for the counselor to share his or her own personal experiences. Personal experiences related to successful outcomes are of great benefit especially to African American women.

Latino

The term *Latino* refers to many distinctive groups. There are Mexican American, Cuban American, Puerto Rican American, and Latin Americans within the group of Latinos. Mexican American and Puerto Rican men are the most at-risk groups. They are susceptible to joining a gang, dropping out of school, and criminal activity (Craig, 2004). Mexican American men have a high rate of heroin, cocaine, and marijuana use. Puerto Rican men also have a high rate of illegal drug use. Factors leading to such behavior are poverty, limited job opportunities, stress, discrimination, and acculturation issues (De La Rosa, Khalsa, & Rouse, 1990).

Among Latino women, drug use is infrequent and abstinence from substance abuse is largely practiced (Chavez & Mora, 1994). The reason for this behavior is found in the strong disapproval in the culture for women to use drugs. In Latino culture, women are viewed as needing protection. Latinos respond well to individual and group counseling but are found to be less successful in therapeutic community treatment settings. Characteristics and skills needed in the treatment of Latinos involve understanding the power, and influence of the family, the gender hierarchy, and potential language barriers including distrust of White culture. Addiction issues

are complex, so it is best to help Latinos focus on their own beliefs, attitudes, and values, rather than make assumptions about them based on members of the dominant culture (Torres-Rivera, Wilber, Phan, Maddux, & Roberts-Wilber, 2004). It is helpful to understand that identity, self-esteem, and self-definition come from the family (Arrendondo, 1995).

Native American

Substance Abuse and Mental Health Services Administration (SAMHSA, 2002) determined that Native Americans have a high rate of alcohol use and subsequent problems. Of all ethnic populations, Native Americans have the highest rate of alcohol-related deaths (Ehlers, 2007). In most cases the leading cause of death is cirrhosis of the liver related to alcohol. Consumption of alcohol is often done in a group in public with the goal of intoxication. Subsequently, Native Americans have greater rates of arrests for drunk driving as well as fetal alcohol syndrome (Westermeyer & Baker, 1986).

Counselors should be aware of their own cultural stereotypes and sensitive to spiritual differences. An example of spirituality would be respect for the wisdom of elders and a tangible connection to nature. The counselor will also need to be skilled in incorporating the place of family and kin in treatment, communalism, and healing customs (Cliff, 2005).

Gender

Research in substance abuse, related to understanding and treatment, has largely focused on men. The literature reveals little research involving women. Reasons cited are that drug trials are sometimes sensitive to hormone changes characteristic of women (Gomberg, 1986). Such hormone variation can skew the findings. Another problem is the teratological impact of drug trials, especially if a woman is unaware that she is pregnant. Gomberg (1986) also stated that there is debate on whether to use the same diagnostic criteria for men and women, as the effect

and symptoms of alcohol are not the same for both genders. From a biological point of view, women metabolize alcohol in a different manner leading to liver problems with the potential of cirrhosis (Angove & Fothergill, 2003). Susceptibility to heart problems is mentioned by Haseltine (2000), including osteoporosis, and the risk of breast cancer increases. Of further note in doing research, the environment may have something to do with the epidemiological information collected on surveys. Such an example would be clinical reports versus community surveys. Women use health care facilities more frequently than men. Further, there is reluctance in these health care facilities to diagnose women as alcoholics (Craig, 2004).

Of studies on women, NIAAA (1990) found that women drink less than men; of women who drink as much as men, such women would be considered heavy drinkers. Further, those women have more health concerns due to drinking. Other findings pointed out that women's emotional traumas in childhood, such as abuse, divorce, or abandonment, precipitated drinking. Research also found that women, more often than not, are inclined to drink alone and at home, which is related to experiencing a depressive episode. Such findings related to trauma suggest that women may need more ongoing treatment to alleviate depression and other co-occurring disorders (McKechnie & Hill, 2009).

Conclusion

The profession of addictions counseling must now move forward and consolidate the field's body of knowledge, competencies, and skills into a cohesive, nationally standardized academic course of study. Additional areas must now be added to bachelor's and master's level courses of study. These would include, but not be limited to, family dynamics, relapse prevention, co-occurring disorders, cultural issues, ethics, and supervision. With the advent of managed care, institutions of higher learning would do well to offer degrees of a crossover or

hybrid nature, with an emphasis on quality control, utilization review, grants, policy and procedure, and clinical supervision.

From the findings of this study, the field of addictions counseling could become a profession. The study would provide the profession with data to move forward with a review of current degree programs, courses, and course content relevant to scope of practice, including workforce development. The mission and goal of this study is to create a national standardization of addictions studies and standards in higher education from the associate's to doctoral-level degrees and lay the foundation for establishing an ongoing national accreditation agency for the addictions profession.

CHAPTER 3

METHOD

In seeking to understand the real world experiences of addictions counselors, this study was a qualitative study using a mixed methods approach, with phenomenological, descriptive, and action research components. In using mixed methods, researchers recognize the weakness of both quantitative and qualitative approaches, yet the strengths of each are used to the completion of the study (Castro & Coe, 2007). As an example, by combining such methods a researcher may quantify the results, by counting responses or themes of responses, of a survey or interview in a qualitative study. Further, a researcher conducting a quantitative study can use some elements of a qualitative approach, such as noting the emotions and reactions of participants to treatment experiences.

The phenomenological and action research approach seeks to look at the lived experiences related to the phenomenon under study, in this case, how addictions counselors practice treatment based upon education and training. Data were collected through an interview and survey in a sample of addictions counselors currently in practice.

Mixed Methods Approach

In starting the study, a qualitative approach was the primary structure in completing the research. Qualitative studies seek to study a phenomenon, in the phenomenon's natural or real world setting. The goal of qualitative research is "to gain an in-depth holistic perspective of

groups of people, environments, programs, events or any phenomenon one wishes to study by interacting closely with the people one is studying" (Farber, 2006, p. 368). Peshkin (1993) pointed out that qualitative research can serve several purposes.

A qualitative approach provides opportunity for a rich description. Here, the researcher may find the character of people, systems, relationships, settings, or environment revealed in a way not previously expected. Next the researcher uses interpretation to arrive at new ways of understanding a specific phenomenon. Connected to this new understanding, alternate theoretical concepts may develop about the phenomenon, or unexpected problems in the phenomenon may be discovered. Another purpose of qualitative research is verification. Verification tests the validity of the researcher's real world assumptions, claims, generalizations, or theories about the phenomenon. A final purpose of qualitative research is evaluation. In evaluation the researcher can ascertain the degree of how effective certain innovations, policies, or practices may be. Thus, the phenomenon under study may not be a simple subject but have several areas of understanding (Leedy & Ormrod, 2010).

The researcher can look at multiple perspectives of the phenomenon and draw some general conclusions from an insider's perspective about what something is like. The qualitative method of this study sought to interview and survey practicing addictions counselors in their place of work. The primary area of the qualitative study was the academic preparation of addictions counselors for the workforce, including service needs in providing treatment to clients (Denzin & Lincoln, 2005).

Phenomenological Approach

To conduct this study, a phenomenological approach was be used. The core of a phenomenological approach is an individual arriving at the meaning of an event. Developed

further, it is a study attempting to arrive at knowing the meaning of a person or group's perception of or perspective on a particular phenomenon. McLeod (2001) stated that the purpose of a phenomenological study is to "produce an exhaustive description of the phenomenon of everyday experience, thus arriving at an understanding of the essential structures of the 'thing itself,' the phenomenon" (p. 38). In a phenomenological study, it is not uncommon for the researcher to have experienced the phenomenon being studied. The researcher may desire to gain a better understanding, perspective of another person, or a group's lived experience. Further, a phenomenological approach seeks to fill in the void between "knowledge and reality that requires qualitative knowledge, that is an understanding of what occurs" (Wertz, 2005, p. 7). Such an approach is appropriate for this study, as the data collection methods to be used include structured interviews and surveys with practicing addiction counselors.

Action-Based Research

Action-based research (ABR) is conducted with or by insiders who possess knowledge of a community, facility, profession, or organization. Participants have taken, are currently taking, or wish to take action on an identified problem or issue. The action taken is one of correction or improvement to the existing methods of structure. ABR seeks to work in collaboration with those who have a stake in the issue being studied. ABR was the most conducive for this study, as addictions counselors will participate in identifying needed workforce skills, competencies, and knowledge (Herr & Anderson, 2005). Those in the practice of addictions counseling have vital input and share in the ownership of analysis. In ABR, addictions counselors can take action to provide academic and practice information in resolving the lack of addictions standards, with an action goal to produce standards (Kemmis & McTaggart, 2005). This method is powerful and truly invites addictions counselors interested in this issue to participate. Addictions counselors,

clients, higher education addictions studies personnel, and other addiction providers such as hospitals or criminal justice entities can bring their knowledge to look at themselves collectively in the process of a collaborative solution (Kemmis & McTaggart, 2005). In this study, ABR can add to the knowledge base of addictions counseling by publishing the findings of the study and working with national organizations to improve the relevance of academic course work to workforce functions (Charmaz, 2005). Further, the findings can be used to assist in the development of an effective nationally standardized academic curriculum for the addictions profession.

Research Design

This project was a mixed methods project with a qualitative interview followed by a standardized survey regarding curriculum preferences.

Researcher as Instrument

In conducting this study, it was important to recognize the types of possible bias that could occur with me as the researcher. Some factors that could contribute to my bias included my years of experience, positions held, working environment, credentials, and professional affiliations.

I have over 30 years' experience as a certified and licensed professional counselor. My positions in the addictions workforce include clinician, supervisor, and administrator all in private and government facilities. My experience with qualitative research has come from doctoral course work in research and conducting two mini research designs for course competency. In conducting this research, I anticipated that both age and experience could be a factor in acceptance, perception, and attitude of participants. In these interviews, I may be older and hold higher credentials compared to the addictions counselors I interviewed. The majority

of my professional time was involved in addictions counseling, and I am now working in higher education as a graduate school director and professor of addictions counseling. I needed to monitor my experience for influencing questions and survey content. Further, I have held elected office in addictions membership and certification organizations. Currently, I hold the office of National President of NAADAC. Another reality is that I am not in recovery from any addiction.

To account for these sources of bias, I asked members of my dissertation committee to review my semi-structured interview and survey to examine them for such biasing influence. In this way my beliefs and perceptions of curriculum would not remain hidden.

As the focus of my research concerns addictions counseling preparation in higher education, the following measures were in place. Although some counselors involved in the study may be familiar with my name or professional history, steps to correct this were taken. Except for my name, no mention detailing my professional titles, experience, or recovery status was on any document. Further, should recognition of me occur, I maintained the working role of a doctoral student conducting research. To soften the perceptions and maintain a low profile, I maintained a respectful attitude of a student in my inquiry. Further, genuine warmth and appreciation were shown of the participants' experiences. In this way rapport and trust may evolve (Fontana & Frey, 2005).

Participants

My participants were six volunteer addictions counselors who worked in community mental health (CMHC) and treatment facilities (TF). A sample size between 5 and 25 participants is recommended for phenomenological research (Creswell, 1998). They must be at least 21 years of age. No further information for ethnicity or social class was collected.

However, gender and educational level were ascertained. Specifically, only counselors with a bachelor's or master's level license from the Indiana Professional Licensing Board (IPLB) were included. Those individuals who graduated from Indiana Wesleyan University and pursued their addictions license were excluded from this study. The reason for this exclusion was to limit the bias that could be part of the interview since I was employed by Indiana Wesleyan University.

The confidentiality of my participants was protected through data collection procedures, including the use of informed consent. The counselors were informed that their identity was known to relevant CMHC or TF research staff or supervisors. The designated staff, or supervisor in some circumstances, needed to approve the counselor's time away from their duties to participate in the interview. The participants' comments were kept confidential and not shared with any supervisor.

Upon the initiation of the interview, the participant's identity and answers were maintained by assigning a participant code. Each CMHC and TF was assigned a letter of the alphabet, which preceded a two-digit number assigned to each counselor. The code was placed on the upper right hand of each interview protocol document. The same code without their name was placed on each corresponding audio tape. The interview protocol document was the only identifying document. The documents were maintained in a file in a locked briefcase which was maintained in a locked metal file cabinet behind a locked office door.

Procedures

Type of Sampling

A sample of addictions counselors was interviewed and surveyed to assist in constructing a reality of addictions counseling in the workforce setting (Holstein & Gubrium, 2005). Data collection focused on current workforce activity of addictions counselors in the state of Indiana

and how the counselors described their academic preparation to be addictions counselors.

As the study sought to contribute to establish a standardized academic curriculum in addictions counseling, convenient and purposeful sampling was used. The rationale for the sampling methods is articulated in the convenience sampling section.

Convenience Sampling

Convenience sampling provides for a population that is accessible and reduces cost for the researcher (Houser, 2009). This research was not funded; therefore, all costs such as travel, materials, and transcription were at my expense, thus convenience sampling was the most suitable. Given that the focus of research was on the Indiana addictions counseling workforce, convenience sampling became of benefit in using CMHCs and TFs in Indiana. CMHCs and TFs had as part of their treatment services addictions counseling programs, which employed addictions counselors. In this way, addictions treatment facilities provided a workforce population in a convenient geographical area within a day's travel time, which limited the financial costs of data collection.

The rationale for using CMHCs and TFs was based upon CMHCs and TFs holding certification by the state of Indiana and holding accreditation by the Joint Commission on Accreditation of Health Organizations in order to operate and provide services. Each organization has established operational criteria for CMHCs and TFs to operate in providing clients' care. Such guidelines provide a consistent application of quality of care criteria for clients. CMHCs also have established criteria for hiring addictions counselors. Certification involves counseling practice standards that have been established by the field. The IPLB licensure standards are beyond certification in that they require a bachelor's or master's degree in behavioral sciences from a regionally accredited institution of higher learning.

Purposeful Sampling

Purposeful sampling involves collecting information from a specific sample that has or can provide a specific knowledge based upon a common or unique experience (Berg, 2004). In my study, addictions counselors in Indiana were a purposeful sample, rather than such counselors as marriage and family therapists or psychologists. These two groups do not work exclusively with addictions clientele, whereas addictions counselors work predominantly with such clients.

Sources of Data

I used two sources of data: an extensive qualitative interview regarding counselors' perception of preparedness for addictions therapy and a fixed-choice survey about curriculum preferences.

Qualitative interview. The interview shown in Appendix A consists of eight open-ended questions regarding academic preparation and current job expectations regarding addictions therapy. Silverman (2001) indicated the researcher should ask questions that relate to facts as well as people's beliefs and perspectives regarding the facts, feelings, and motives for present and past behavior including standards of competency. My questions originated from my review of the literature, previous conversations with the population about the phenomenon under study, and my clinical experience as an educator (Hill et al., 2005). In particular, the literature documented a paucity of standardized addictions study courses or programs in higher education that are available to prepare a competent addictions workforce. The context of the questions focused on exploring how adequately the counselor's degree program prepared him or her to work in addictions counseling and determined from the participant's feedback what academic improvement could be made, if any. The semi-structured interview format allowed for follow-up

questions to clarify dialogue between the researcher and participant (Morrow, 2005). Competencies were characterized as the perceived requisites of knowledge, skills, and aptitudes to function in the role of an addictions counselor.

Survey. The survey shown in Appendix B contains the program curriculum from the existing addictions counseling graduate program where I teach. The survey did not contain any identification as to my academic institution; in this way, bias was addressed that could have influenced participant responses. The specific content of each survey question was the title of each course with a brief course description so that addictions counselors could rate each course related to its perceived relevance to their work as addictions counselors.

The survey responses used a Likert-type scale, with which counselors rated each course using a 5-point scale with designated response choices of *highly relevant* = 5, *somewhat relevant* = 4, *neutral* = 3, *somewhat irrelevant* = 2, and *highly irrelevant* = 1 in relation to how beneficial the counselors think the course would be.

Data Collection Procedures

The first step in data collection was a review of the state of Indiana's Department of Family and Social Services website for location and contact information of the state's CMHCs and TFs. Next, I made telephone contact with selected CMHCs and TFs to identify the appropriate staff overseeing research at the facility to discuss and seek approval for the study. Once identified, a telephone call was placed to the staff person, and I introduced myself, the reason for the call, and a brief introduction about the study (Appendix C). I inquired about their interest in participation, and if interest was confirmed, a letter on Indiana State University letterhead was sent by mail or emailed as a pdf file (Appendix D). The letter was an introduction and description of the research with next steps. It emphasized the importance of identifying

volunteers from the addictions counseling staff to participate in the study. In the letter a request was made to conduct the interviews in a private location, such as in a vacant office or meeting room. The length of each volunteer interview and survey of approximately 75 to 120 minutes was indicated as well. Included in the letter was my contact information on smaller fliers.

The fliers were handed out or posted in public areas for interested volunteer counselors. The fliers contained my home and cell phone numbers, including my Indiana State University (ISU) email address, for volunteers to contact me (Appendix E). The flier included a date by which I needed to have contact to start the study and information about the next step in the interview process. After the fliers were sent, I checked my ISU email for interested volunteers on a daily basis. I also utilized email and daily phone calls to the CMHC and TF contact staff to check on the process.

As volunteers came forward giving notification of their interest, I contacted them by email or phone call to schedule an interview appointment at their respective CMHC or TF. I also informed the respective CMHC or TF contact staff to verify the time and location to conduct the interview.

During the interview, I reviewed with the volunteer the informed consent document detailing the study with risks and benefits before proceeding. Most important to any study were the issues of confidentiality and volunteer questions. Volunteers were informed in the consent form about measures of maintaining participant confidentiality (Appendix F). As in any study, questions may arise in the course of the volunteer's participation. The consent form stated that if volunteers had questions they were free to ask questions. In this way, as concerns arose they were answered and clarified to alleviate those concerns. The counselors who opted to participate in the study were informed that their identities were known only to the relevant CMHC research

staff or supervisors. The participants' comments were kept confidential and were not shared with respective supervisors.

Upon the initiation of the interview, each participant's identity and answers were maintained by assigning a location code and participant code. Each CMHC was assigned a letter of the alphabet, which preceded a two-digit number assigned to each counselor. The code was placed on the upper righthand corner of each interview protocol document. The same code without his or her name was placed on each corresponding audio tape. The interview protocol document was the only identifying document. The documents were maintained in a file in a locked briefcase, which was maintained in a locked metal file cabinet behind a locked office door.

Counselor responses to the interview of workforce experience and the curriculum survey were evaluated for aspects that could enrich or add to academic curriculum and instruction. When the interview and survey protocol revealed that academic improvements or enhancements were needed, they were identified for inclusion in a standardized addictions counseling curriculum. Interviews were recorded on audiotape for later analysis. Audiotapes were used as the best method to capture the exact content and affective tone of the counselors. In this way accuracy was maintained regarding the counselor's answers in connection with context and was more amenable to the coding process in data analysis. A transcriptionist was employed to transcribe the audiotapes for analysis and coding. To protect the identity of the participants, the transcriptionist signed a confidentiality agreement (Appendix G).

Maintaining the addictions counselors' confidentiality in the final write-up of the study was detailed in the documents describing the study sent to the CMHC or TF designee. Counselors were informed in consent documents prior to the interviews that they could decline to

participate any time while the interview was being conducted without negative consequence. Upon the volunteer's satisfaction with the content, he or she was asked to sign the consent document and the interview commenced.

Data Analysis Procedures

Once the data were collected I looked for and inductively described common themes in the described experiences of the participants. When performing analyses, Creswell (1998) pointed to the following general steps that are typical in data analysis.

The first step was to locate statements that related to the research question. I found statements that were relevant from the interview. From the relevant statements, I identified specific words, phrases, or sentences that reflected connection to the topic. Next, I grouped those statements into meaning units. Such a method was used to develop categories from the statements. The third step looked at divergent perspectives. In this step, I read for how various statements from individuals shared a commonality in describing the phenomenon. From this point, the task was to develop a composite. This involved combining all of the various meanings to describe an overall understanding of how people experience the phenomenon.

Such data collection in the phenomenological approach allows for "empirical observation of events" (Guba & Lincoln, 2005, p. 203). Further, Kemmis and McTaggart (2005) indicated the relationship of the participants as well as stakeholders' collective experiences can validate their shared knowledge and application of that knowledge as in this study of the addictions counselors' experiences. In this study the addictions counselors were not only participants but invested stakeholders. As stakeholders they benefit from research information that improves addiction workforce training and education. As the stakeholders they also helped in developing ideas and new concepts of meaning. These came from the reality and experiences of addictions

counselors in client work, while at the same time allowed me to have an interpretive frame of reference (Charmaz, 2005). In this way the experiences of the addictions counselor related to workforce demands could be referenced against the same workforce experiences of my existing frame of reference and possibly come to a new interpretation of workforce demands.

Interview. For coding purposes I structured the interview questions in the following manner. Questions 1 and 2 focused on career choice, Questions 3 and 4 focused on training and current professional duties. Questions 5 through 8 focused on academic preparation, and finally Questions 9 and 10 focused on future workforce needs and preparation. As the responses were recorded, a final transcript was prepared by a transcriptionist. I used the transcription to evaluate the responses by color coding them (Charmaz, 2005). Open coding was used and the transcription was analyzed line by line. In this process I looked for emergent themes of commonality and the frequency of the themes were noted. Here, words, phrases, and sentences that centered on a topic could in turn possibly develop into categories. I used this in order to compare data from one participant with data from another participant by category based upon the analysis of interview questions. Such methods are useful in determining common areas of weakness or strength in career choice and clinical practice. Results were used to endorse current practices and provide information for future addictions professionals, while seeking to improve academic workforce preparation.

Survey. Curriculum survey responses were tallied across the six participants to determine most valued to least valued courses. Because all the participants were practicing counselors, the survey data were presented as a hypothetical addictions counseling curriculum. After the curriculum surveys were completed by the volunteers, I recorded, using a check mark on a separate chart, what each volunteer had selected under each course for the choices of highly

relevant, somewhat relevant, neutral, somewhat irrelevant, and highly irrelevant. Upon completion of recording the volunteer responses, I then tallied which course or courses received the most check marks under each choice. From this tally, I ranked courses based upon the number of highly relevant to highly irrelevant responses received. This ranking was used to determine which course or courses were found to be of most to least value in terms of relevance to work force activity and academic preparation for the practice of addictions counseling.

Trustworthiness of Qualitative Data Analysis

Qualitative research has been criticized related to the trustworthiness of qualitative methodology (Shenton, 2004). The criticism is based upon vague confirmation of validity and reliability that are criteria found in quantitative research methodology. To address the criticism Guba (1981) presented four criteria for qualitative researchers for inclusion. The four criteria were reviewed and adopted by researchers of qualitative studies (Lincoln, 1995; Silverman, 2001). The four criteria for trustworthiness in qualitative research are credibility as compared to internal validity, transferability as compared to external validity/generalizability, dependability as compared to reliability, and confirmability as compared to objectivity.

Credibility

A primary area to be addressed in research is internal validity. Internal validity ensures the research has indeed measured or tested what was to be studied. In qualitative research Merriam (1998) pointed out that credibility is the comparison to internal validity by asking the question, "How congruent are the findings with reality?" Lincoln and Guba (1985) posited that establishing credibility and its underlying provisions are one of the most important factors for confirming trustworthiness. Under the criteria of credibility are provisions to undergird confidence in the issue under study in qualitative research. For the purpose of my study, I

included here the salient provisions and the related procedure that I implemented to ensure credibility. The aspects of methodology were briefly highlighted, as they were described in more detail and function in other sections of my study.

The first provision was adopting research methods that are well established. An example of such would be using methods of questioning or data gathering and analysis that have been used in comparable studies. In my study I gathered data by interview and survey and used open coding in reviewing data.

Another provision was developing familiarity with the culture, group, or organization before data collection began. Because I had both professional expertise in addictions counseling, having served in various administrative capacities in the profession, I was familiar with the professional culture and treatment practices before I began data collection.

Sampling methods are part of the provisions with random sampling as the preferred method. The rationale for random sampling was that possible suspicion of researcher influence and bias is removed. My study used purposive sampling given that I sought input from professionals within the state. However, I had some elements of the benefits of random sampling, as the participants were volunteers and came from separate locations. My sampling method used a collective case study (Stake, 1994). Stake pointed out each case represents similar or dissimilar voices, with some redundancy and some variety across the collective. He also pointed out that such an approach presents various voices and characteristics of being similar, dissimilar, or redundant across the totality of the collective.

Triangulation is another method for establishing credibility. Triangulation involves the use of different angles on collecting data. These would include but not be limited to observations from different points of view. For my study, I used a semi-structured interview,

which was audiotaped and transcribed, and a structured survey. Another feature of triangulation is the value of verifying viewpoints and experiences of participants. This is of benefit as those participating in my study were informants and added to the knowledge base as providers. A final aspect of triangulation is that the information is provided from more than one location.

A further provision is implementing tactics that ensure the honesty of informants. Examples here were collecting data from participants who wanted to be a part of the study and who also had the opportunity to refuse to participate in the study. Another example is a researcher with independent status from superiors. The benefit here is that participants were at greater liberty to share information without concern of negative consequences. In my study documents and face-to-face encounters, I brought these to the attention of participants. They could drop out at any time and also be uninhibited in conversation.

Frequent debriefing sessions should be utilized by the researcher. This provision is addressed in my study by virtue of having a dissertation chair, committee, and department chair. As is indicated by this provision I could use my superiors as debriefers to test ideas and interpretations or point out researcher bias and preferences.

Similar to debriefing sessions is the provision to utilize review by peers and colleagues. Examples include faculty and professional colleagues who are familiar with the researcher and subject of study. When conducting my study, I had several faculty and professional colleagues whom I could call upon. The benefit of peer and colleagues was that they bring fresh perspectives and, if needed, challenge my assumptions or bias.

The researcher is also considered a provision of the process, as the researcher can have his or her own reflective commentary (Guba & Lincoln, 1989). Besides having the feedback of debriefers and peers, the researcher should be in a mode of continual evaluation of the research.

Such an example would be for me to write or record observations at the conclusion of interviews, or times of data collection or analysis. Guba and Lincoln (1989) referred to this as *progression subjectivity* in that the researcher can monitor his or her own perceptions and constructs of the process. As I conducted my study, I was doing such reflection in copious notes of written observations after interviews and writing up my findings.

In conjunction with the person as the researcher is a slight provision on the background, qualification, and experience of the researcher. Patton (1990) found that credibility of the researcher is relevant of the qualitative researchers as they are main gatherers and interpreters. Individuals who scrutinize research will often value the background of the researcher as much as the methods of conducting the study (Alkin, Dailak, & White, 1979). For this provision, my decades of professional clinical experience as an addictions counselor and professor provide such an experienced background. Two examples are my serving as the Regional Vice President and National President of NAADAC, and writing and consulting on addictions counseling legislation and licensure.

Another provision that adds to credibility is member checks. Member checks relate to the accuracy of the data collected (Guba & Lincoln, 1981). I addressed this in my study because I used an audio recorder and verbatim transcription. The recording and transcript was shared with participants in a member checking process.

A final provision under credibility is an examination of previous research findings. In this provision, evaluators can assess the results of the study with past studies to see how congruent the studies were. Examples of this provision are published reports of studies that followed the same topic of inquiry and similar methodology. In my study, previous research was documented in the review of the literature, and I have established that this study reflects the topic

and similar methods. Future researchers could easily follow the methods that I have provided to replicate or expand upon this research question with a larger sample.

Transferability

In qualitative research, transferability is compared to external validity/generalizability found in quantitative research. Merriam (1998) gave clarification of external validity/generalizability as the degree to which the results of one study can be applied to other field sites or situations. For qualitative research, Lincoln and Guba (1985) suggested that it is the responsibility of the researcher to provide adequate contextual information about the fieldwork site. In this way readers can transfer the details of the field site to other studies for replication or comparison. The contextual information that should be set forth is the number of organizations taking part and where they are located, restriction on participants in providing data, number of participants involved, data collection methods, number and length of sessions, and the time period over which the information was gathered. On these items I indicated in my study that the sites were certified treatment facilities in Indiana and the number of participants I had selected for interview.

Dependability

In qualitative research, dependability is a provision as compared to reliability in quantitative research. Reliability is understood as a researcher being able to replicate a study in the use of context, techniques, and participants to determine if the same results be produced (Guba & Lincoln, 1981). For this to be accomplished as dependability in qualitative research, the reader should be provided with the research design and factors for implementation, the operation of how data were gathered in the field, and a reflection of the study to appraise the results of the final project. My study incorporated this provision as I had described the

construction and rationale of the methods related to sampling, location of interview, and coding used.

Confirmability

Confirmability is the qualitative researcher's comparison to objectivity in quantitative research. Objectivity is understood as the results of the findings being the experiences of the participants versus the preferences or wishes of the researcher. To address this in my study, I indicated how data were collected and coded. Secondly, acknowledgement of researcher bias was articulated for readers.

Risks, Benefits, and Limitations

Risks. The risks of this study impacted the participants to no greater degree than a professional conversation or discussion in a professional setting. The volunteer participants needed to place my interview in their work schedule. Doing so might have impacted their normal duties. The participants may have had uncomfortable feelings in recognition of their lack of professional preparation.

Benefits. The benefits of this study are that the strengths of current academic content related to the profession of addictions counseling were evaluated. Further, deficiencies were noted among the current addictions counseling workforce, and these deficiencies may contribute to an evaluation for inclusion of curriculum in academic program content for learning outcomes. In this way, further research could be conducted to evaluate theories, treatment protocols, program components, and program design. The addictions profession and clients may benefit in terms of possible cost saving and establishment of more effective treatments for individuals and families impacted by addiction.

Limitations. This sample was small and limited to the state of Indiana. The sample may not have been representative of addictions counselors within the state of Indiana or other states related to education, credentials, or competencies. In such a sample, not all addictions counselors were selected randomly; in fact, the sample was composed of the first six persons to volunteer for the study. Other volunteers may have come forward as well and might have had an impact on the study. The sample size also prevented broader generalization to the field of addictions counseling among the larger population of addictions counselors. Such a geographical reality may find a number of counselors from a particular program, single academic institution, or limited number of academic institutions. It was not the purpose of this study to inquire about the participants' academic institutions, only the degree and coursework taken. This could translate in a narrow assessment of academic programs related to degree studies.

There may also have been reluctance for some counselors to participate because they felt uncomfortable discussing their preparation and exposing professional weakness. Some participants may have had a specific motivation to participate in the study, which was unknown and undetected. Participants' answers may have been influenced by their having a good or bad day prior to the interview or by life circumstances between giving consent and participating in the interview. It must also be recognized that participants may not have reported all they did accurately. Another limitation is the remembrance of experiences. For some, their recall was spread out over a longer professional experience. Length of time may change purpose, recollection of experiences, and their feelings. The variance of participants' ages and years of professional experience may have influenced the degree of content in answers. Although steps were taken to control researcher bias due to my identity, my experiences may have influenced the data analysis and interpretation. To conclude, self-reporting can also be unreliable should

participants want to appear more knowledgeable or competent, and some participants may be modest in reporting their workforce skills and performance.

CHAPTER 4

RESULTS

To provide context of participants and data collection, the following details give clarity and understanding in the results. In the process of data collection, the original methodology noted six participants. However, one treatment facility scheduled an additional interested person. This individual was a clinical supervisor of addiction counselors. The clinical supervisor was added to be respectful to the individual and avoid their feeling slighted or unimportant. Further, I wanted to show appreciation and honor their interest in the study. The contribution of a clinical supervisor brought a different perspective and increased the richness of information in the interviews and survey collection. There were a total of seven participants instead of the intended six.

Demographics of Participants

The participants came from three locations that provide addictions services with the following demographics. Of the seven, five were women and two were men. Six were licensed as a licensed clinical addictions counselors (LCAC) and one was a licensed addictions counselor (LAC). The LCAC is a graduate-level license, and the LAC is an undergraduate license. All the participants were "grandfathered" into their licenses in the state of Indiana. Participant ages ranged from 37 to 63 years. All participants had masters' degrees in the following concentrations. Four participants had masters' degrees in social work (MSW); the remaining

four had graduate degrees in clinical mental health, agency counseling, counseling psychology, and general counseling. Their years of professional counseling ranged from 10 to 16 years. This information can be found in Table 1.

Table 1

Participants' Personal Characteristics

Participant	Age	Sex	Licensure	Degree	Years Counseling
Violet	50	F	LAC	MS Mental Health	12
Sally	54	F	LCAC	MSW Social Work	14
Snoopy	37	F	LCAC	MSW Social Work	11
Charlie	63	M	LCAC	MSW Social Work	16
Linus	46	M	LCAC	MS Agency Counseling MSW Social Work	14
Patty	55	F	LCAC	MS Counseling Psychology	10
Lucy	45	F	LCAC	MS General Counseling	12

Note. LAC – Licensed Addictions Counselor (undergraduate licensure); LCAC – Licensed Clinical Addictions Counselor (graduate licensure); none of the participants had taken the LAC or LCAC exam; all participants were grandfathered into their Indiana state licenses when first offered from 2011 – 2012; none had coursework in addictions; Violet was a master's degree clinician with an LAC due to not meeting all LCAC addictions training criteria at close of grandfathering period.

Participant identities were protected in the research and in the results section they were given fictitious names. In an effort to assign names, characters were selected from a well known comic strip. The names in no way reflect an identity characterization or association to the participants. The names are Violet, Sally, Snoopy, Charlie, Linus, Patty, and Lucy.

Data Analysis

Participants were interviewed and completed a survey. The following describes the process of data collection and analysis for the study.

Interview

A recording was made of each interview and a transcriptionist was employed to transcribe and prepare a final transcription of each participant's interview. I read the transcripts several times in order to be immersed in the data and become familiar with the participant and content. The transcripts were then compared to the tapes. This was accomplished by listening to the tapes twice while reading the transcript for accuracy. To assure trustworthiness, each participant read his or her transcript for accuracy. Upon completion of external validation, I read each transcript line-by-line to extract statements connected to the purpose of the study. I evaluated statements for overt and covert meanings. The statements in each transcript were also compared to other participants' transcript statements to identify similar content or meaning and then coded. From the coded content, emergent themes were identified and organized into clusters of themes. The clustered themes were then placed into larger descriptive categories.

Survey

Each participant survey was examined. Each course had 5 choices on a Likert scale, of which participants made one selection. The choice selected was based upon the perceived relevance of the course. The score values ranged from five points for *Highly Relevant*, to one

point for *Highly Irrelevant*. A master course score list was made, and each participant's selection was marked under the choice he or she had selected for each course. After all participants' choices were recorded on the master course list, a tally was made resulting in a final score for each course. The number of participant marks was multiplied by the number of the points designated for the choice selected. For example, if five participants selected the choice of *Highly Relevant*, having a designated score of 5 points and two other participants selected the next choice of *Somewhat Relevant* with a score of 4 points, the *Highly Relevant* total would be 25 points and *Somewhat Relevant* would be 8 points. The points would then be added together and equal 33 points for the course. After total scores were determined, the courses were ranked by score from highest in importance to lowest in importance. In some instances, some courses received the same score.

Themes

From the interviews, four invariant categories emerged from themes identified in the analysis of the coded clusters. The invariant categories were academic preparation, current practices, curriculum, and addiction counseling curriculum. Each category was reviewed in the context of its themes and the supporting endorsements of the participants. These can be found in Table 2.

Table 2

Invariant Theme Clusters of the Sample

	Participants						
Themes	Violet	Sally	Snoopy	Charlie	Linus	Patty	Lucy
Academic Preparation							
Theme 1: No course work	X	X	X	X	X	X	X
Theme 2: On the job training	X		X		X	X	
Current Practices							
Theme 3: Intake and assessment	X			X	X	X	
Theme 4: Individual, family, and group	X	X		X	X		
Curriculum							
Theme 5: Transferable content	X		X		X	X	X
Addictions Counseling Curriculum							
Theme 6: Abstinence and recovery		X	X	X			X
Theme 7: Dual diagnosis (medication)	X	X	X	X			

Academic Preparation

By far the largest shared consensus came from all participants, noting they did not feel prepared to do addictions counseling. All participants, when reflecting upon their academic

programs, expressed not having adequate courses or courses with significant addictions content in their undergraduate or graduate studies. Much of their addictions counseling preparation came after they were hired by gaining certification and on-the-job training.

No Coursework

Violet reported that in her master's program there was a lack of focus in addictions as an issue. She stated, "The education piece was, specifically for addictions, was non-existent." She went on to relate that she found herself working with a family and that the parents had addiction issues. It was then she realized she "was lost" and "did not know where to begin."

Linus had completed two separate master's degree programs. Both programs were devoid of any addictions courses or content. Linus elaborated,

> Whereas the social work degree was more holistic, more the collaborative approach, looking at it from a more macro perspective, in terms of working with families, working with individuals, and the same thing with collateral sort of interaction with the courts. So, the social work was more comprehensive, in terms of preparation. And the agency counseling degree was more dealing with the family therapy, individual therapy, the client, per se. So, and neither one of those had an emphasis on addiction.

Of the participants, Charlie indicated his program had one three-hour course in addictions, but he elaborated,

> It was completely irrelevant for what, what's—well, I am, I am being harsh, maybe. There, there was stuff that was helpful, as far as understanding things like, you know—actually, I have a minor in psychology. So, that helped prepare me more than, than any social work courses. But, basically, when I got into the field of addictions, I discovered I was woefully unprepared. And even as a recovering person, I real-, I knew that I, I was

> going to need to do a lot of self-study if I was going to be effective, which was my goal. I wanted to be an effective clinician. So, I, I was woefully unprepared. All I had was the ability to do what I thought was supposed to be done. And I realized very quickly, hey, you know, there's, there's, to be a clinician is not just my personal thoughts and feelings about this. There needs to be some structure behind that that supports the, the presentation of ideas.

Like Charlie, Lucy stated that she had a course but to a lesser extent; the course only consisted of some addictions content. She indicated that "the only course that specifically discussed addictions was abnormal psychology."

Patty indicated that her graduate training had application to her functioning as a counselor. However, her coursework in addiction counseling was lacking. She stated, "Well, in general, it was applicable, but I feel that it was certainly not, as far as addiction counseling goes. In assessment, it, it was completely inadequate." Of her academic experience, she further stated, "I had nothing, undergraduate or graduate level that was relevant regarding addiction."

On-the-Job Training

All participants indicated that after they had graduated with master's degrees and were hired as addictions counselors, they did engage in the process of training or education in addictions counseling. There were several approaches taken by the participants.

After a job change, Violet came to understand addictions and addictions counseling through another clinician. She stated,

> The program I was in was closing. And so, I had to find another program to move into. And I came down here and interviewed with the supervisor at that time. And the person

> who was the lead clinician was absolutely phenomenal in teaching me the nature of addictions and what is going on.

Patty shared a similar experience, as her training came after she was employed. With regard to addictions counseling, she stated,

> A lot of it, I learned hands-on. I've been here for 16 years and doing all of the trainings. And I got grandfathered into the LCAC Program. So, it's just going through, you know, the different training and getting the certification in different areas.

Snoopy gained knowledge and experience due to a practicum placement that happened to be in addictions. Snoopy stated, "And then, I did a practicum here, where I was working with the addictions area. And then, I have been working here for 13 years. So, through that, I earned my LCAC, through my experience here working."

Like the other participants, Linus gained addictions training on the job and outside education opportunities in workshops:

> The addiction piece didn't come in until I was in the field, in terms of supervision with the staff, supervision with the supervisor, and going to outside workshops and training. As far as getting the addiction training, very little. I don't think I even had a course in two master's programs that focused on addiction. So, all of the training, I would say, was either on the job or at workshops, trainings, while in the position.

Current Practices

An important theme emerged in identifying the current practices and treatment activities of addiction counselors. Five of the seven participants indicated their first activity with clients was conducting an intake assessment. Four participants indicated offering services to clients in individual, family, and group counseling.

Intake Assessments

Violet gave descriptive detail of the varied components of her intake assessments activity:

> The intake is, I, I do the initial assessment. The Biopsychosocial Assessment is the tool that we use. We also use the Eureka, the MME, Mini Mental Status Exam. And we also use the Simple Screening Inventory for Alcohol and Drugs, I think is the formal title of it, as part of the assessment piece of it. We also have to do the ANSA, the Adult Needs and Strengths Assessment, and we also have them, because we are a training mental health center. We do the ACE, which is the Adult Child—not the Adult Child, the Adult—wait, the ACE is Adverse Child Experiences, that's what it is, as part of the assessment piece. And trying to get as much symptomology as possible, initially, as far as what brought them in, and then, trying to obtain the history.

Charlie completed a variety of intake assessment protocols. He commented,

> We have to, we have to, you know, complete, of course, the Biopsychosocial Assessment. We have to do a diagnosis entry. We have to do the ANSA. We have to complete a HAP. We have to complete an ACE, ACE. We have to complete TB testing results. All in all, at least for me, I am able to complete an assessment in a little over an hour, and then I got to add another little over an hour to do all of the paperwork. And then we also, or I also obtain, you know, the family history, the treatment history, their current living situation, the economic situation, their legal situation, the whole gamut.

Linus provided a plethora of information related to who performs the intake assessment, the components, and the purpose behind the process:

> Well, first and foremost, the way the clinic is set up, as an addictions counselors, we do what we call individual admission evaluation and assessment or an intake appointment. So, that's the initial assessment, the client's point of entry into the addiction program. We, the agencies do hire an intake specialist that does all of the intakes. But all of the licensed clinicians, they do provide, on a supportive level, some form of intake, as well. So, that's—the initial assessment, the process is about a two to, about a, for me, it's about a two hour interview with clients. It's called the Biopsychosocial Assessment, information gathering background, looking at specific addiction issues, also dual diagnosis issues. There are several assessments that we use that's a part of that initial intake that assess the client's stage of change, that that's going to tie into where exactly in the program they go. There is another assessment we use, which is called the Adult Needs and Strength Assessment. And that's really pushed by the state, and that assesses the client's level of functioning, in terms of the, or in combination with their mental health addiction, mental health diagnosis under the addiction diagnosis.

Patty provided the following information on her duties: "Primarily in the Access Department, I assess for current level of care that's indicated." She then concluded by saying, "And then from that point, if, if they are agreeable to admission here, either inpatient or outpatient, then I assist with the admission process, which can, particularly if it's inpatient, include talking with the insurance companies for prior authorization."

In her duties Lucy stated, "Currently, I am working in the Access Department. My job is just to enter assessments and admissions."

Individual, Family, and Group Counseling

As previously indicated, Violet provided intake assessments but also indicated she provided group services. Violet stated, "Currently, I am the primary intake clinician for this clinic. And then, I also facilitate one group, or two groups a week."

In Sally's work, she indicated providing services to individuals, families and groups. She stated,

> I do group counseling, individual counseling. I do some, do some family, but not a lot of that. I probably do more like conjoined, or couples, and case management. Probably the bulk of what I do, though, is the group and individual.

Charlie spoke about his main efforts in groups by saying, "I do group counseling. It's an intensive program that we have here. So, I meet three times a week with folks for three hours each time. I do, that's an outpatient program, essentially."

Linus spoke about working with individuals, families, and groups in his duties as an addictions counselor. He also indicated providing services of case management in the following:

> And then, we have a caseload of clients that, while they're in the program, that we provide individual counseling. We also do some family counseling, but not as much, because, given the nature of our clients, usually the, the family is not a place where they can be supportive, you know, in their recovery. So, we do the intake assessment, groups, individual, and there is some case management along with it. A lot of our clients are what we call involuntary clients, they are referred by probation and parole. So, there is some level of case management and reporting back to the referring agency. So, there is some level of case management. We also do what we call urine drug screens on the client. And that would fall under, you know, the case management aspects of, you know,

> collecting the actual urine sample with the client. So, that's in a nutshell a summation of the position of addiction counseling.

Curriculum

Participants provided information relative to curriculum and two themes emerged. As previously indicated, the participants shared that their master's degree programs lacked relevant addictions content. However, comments emerged from five participants that courses taken in their graduate programs had transferable content, which was applicable to working with the addiction client. The participants related that counseling techniques, group counseling, multicultural issues, abnormal psychology, symptomology, and coping skills were relevant in addictions work. Based upon their experience as addictions counselors, the participants gave input to courses and course content that should be part of an addictions counseling curriculum.

Transferable Content

Violet reflected upon her training in mental health and found that her understanding of dual diagnosis was relatable:

> But I do believe my training in mental health, even though I didn't know it at the time, did prepare me to help people with addictions, because they are so tied together. The dual diagnosis ablation is so high, very rarely do we have anybody who is just addictions. There is depression, there is anxiety, there is, there is other symptomology involved. So, I believe that helps me understand and, and helped me help other people develop those coping skills that could be used both towards mental health or addictions issues.

She also spoke of the relevance of learning how to ask questions to extract client information. She indicated this by saying, "Learning how to ask questions, learning how to delve into the history. You know, learning to, to keep an open mind. Those skills were present in my training

in my master's degree. Specifically towards addictions, was not." In working and looking at transferable content and skills, Snoopy indicated the following:

> In the different individual-, group-, family-dynamics of social work were relevant to both mental health and addictions. It wasn't specific on the addictions diagnostic criteria, or domains, or different pieces of that. But it applied to just working with people and the overall wellness of people, but not specifically to the addictions.

The same transferable course content was shared by Linus:

> I think it prepared me very well, again, for the actual having an agent, a client in the counseling session, different clinical orientations to use, because, usually, what we are finding out with addiction, there is also mental health symptoms, or even diagnosis, that go along with it. So, again, it helped prepared you, prepared me in that aspect. And the social work, then, it prepares you with how you interact outside.

Patty mentioned three courses of relevant graduate work. Patty stated, "Counseling techniques. I had a, a course on group counseling, assessment, though not specific to addiction, multi-cultural counseling. That applies. That's about it."

Lucy included the following statement: "Moderately. And that is, you know, teaching interview rapport, those types of things. Nothing specific, as far as addictions goes."

Addictions Counseling Curriculum

The participants provided some specific courses and focused content for inclusion in addictions counseling curriculum. This information was based upon workforce competencies in providing addictions counseling and services. Four participants endorsed abstinence and recovery, four participants endorsed dual diagnosis, and four endorsed evidence-based practices.

Abstinence and Recovery

Relative to abstinence and recovery, Sally stressed the importance of students' awareness of support group activities in their studies:

> I would say, I would say get out there and learn as much as you can. If you can get into some open meetings, AA, NA, because you're going to learn the most hands-on that way, from the actual clients themselves. You're going to learn a lot that way. So, if you can get out there and hear their stories, where they're coming from.

Snoopy also endorsed the value of support groups exposure in the academic experience. Snoopy said,

> Also, just practicum experience. I think that was huge for me. If they are doing practicums, or have that opportunity to observe treatment, or even be involved in the community with different support groups that increase their awareness of AA, NA, Smart Recovery, different areas there.

Charlie continues to believe that recovery and abstinence still need to be emphasized. He stated the following:

> I would have like to have had a study program on, hell, the AA Book and the NA Book. Those are the best books ever written on recovery. And it would have been great if someone's preparing to be in this field that they study those books, because those, that's, that's about the best information on recovery you can get, I, in my opinion.

He elaborated further on the value of support groups when he said,

> But the, the, there still is nothing wrong with some of the stuff. You know, you read the AA, NA Book, and, boy, they had a pretty damn good idea on how to help people get well. And when I give it here, and I reference, and it's not just here.

Upon graduation, Lucy spoke of her work experience and the value of recovery support groups:

> But if I were brand new, coming out of school—yeah, I, I was not prepared for what I was going to see when you actually see someone in withdrawal, and you actually see someone's entire life, their family, their, you know, everything has just fallen apart. I had no training whatsoever when it came to recovery. I was just, what is, it's a disease. There was never, let's, okay, and then, these are the—And, and I'm very biased to 12 steps. I mean, there are others who would like to, you know, who do try other methods, and that's probably not part of my training either.

She also added the following for future counselors. "Spend as much time as you can in AA meetings, conferences, anywhere where there are actual addicts, alcoholics, real people that are struggling, to see what, what it's like when they are coming in those doors."

Dual Diagnosis

The subject of dual diagnosis was endorsed for the preparation of addictions counseling curriculum. Sally spoke of consistency and dual diagnosis:

> I think, I think we need more consistency. I think everybody's everywhere. We need more dual diagnosis because we are a dual diagnosis center here, but a lot of places, they address only the addiction, and not the mental health. So, I think they have to be, everybody has to be a dual diagnosis clinic.

Charlie spoke about the changing needs in treatment and the need to be mindful of dual diagnosis. "But I, I think that, that the field is, is, is rapidly evolving and, and to just have it as an addiction. It's really a dual diagnosis now." He went on to add,

> And just even today, there is still so much confusion about substance use disorders that stand, we have stand-alone situations that do have significant influence and impact on other mental health disorders, and even mimic other mental health disorders, to include personality disorders.

Charlie had some distinct observations of dual diagnosis and young addictions professionals:

> The dual diagnosis component of, of the recognition of how these things play into each other. And, again, it's, it's so much easier I see for the younger clinicians. And, and, and maybe I am dating myself, but, you know, again, and so, I don't give a shit any more. But the younger clinicians, it's so easy for them to buy into the, the substance use, use disorders being created because of the mental health disorder. And, and they simply don't understand the distinction between these things, and that it, it's that, it's really kind of the other way around. Until the substance use disorder is, is, is managed, you really don't know what all of the other stuff is. You have, there is no clarity involved [in] understanding what's going on. But, but folks, the younger folks seem to have a tendency to want to back off from the confrontation, the respectful confrontation, that needs to be involved with someone that's abusing substances. I think they're afraid of it. That's, that's been the case for a very long time period.

The lack of co-occurring dual diagnosis as a focus in degree programs was a concern of Linus. He offered the following:

> I would say it definitely would be helpful if the actual degrees focus on co-occurring disorder dual diagnosis or the real addiction at the core. So, everything right now what I had was, was the mental health and the counseling was the core of the program, and

> addiction was non-existing. So, I would think addiction should be at the core, and the other should be, you know, more supportive.

Linus also added, "Just, again, just more training, particularly on co-occurring disorders that go along with the addiction that we've seen, various type of substances, various type of addiction that, you know, that's coming out."

Medications

The participants underscored the need for programs to have a course in medication. Violet offered the medications and replacement therapy as important to addictions preparation, "The, the, the advancement in medication, replacement therapies, you know, the interventions, as, as effective interventions for family work. I think that's something more I'm going to see here, big time."

Linus suggested that programs need to look at the various types of medication:

> I could see a course work on the various, different types of substances—stimulants, sedatives, anti-anxiety, different types of addiction, I mean, more specific to the addiction. Another course, I think, would have been really helpful is the medication, a course that addressed, specifically, the medication.

Lucy validated the need to study medications further with an awareness of designer drugs:

> I would like to personally have more just in all of the new designer drugs (laughs), all of that stuff that's coming out week after week that we just don't, can't hardly keep up with. I mean, a lot of times, it's my, my patient or client who is educating me about what's out there and what's, you know, what's the new trend.

Related Research and Content

Patty indicated the need for addictions counselors to be aware of current research to remain up-to-date in practice:

> Well, certainly anything new that comes up regarding research. For example, years ago I, the way that I learned about soboxone was actually through one of my clients who had a serious and persistent mental illness. I had no idea that that kind of thing was going on. So, things that are, that, that will keep us updated, let us know what's going on with current research, evidence-based practice, things of that nature. I mean, people need to, to be trained on what's, what's known, just as I said in a previous response, evidence-based practice, what works, what doesn't, what we learn as we go along, to stay on top of it.

Patty also indicated content that is applicable to techniques and understanding the addictions process:

> Certainly, techniques, theory, education on the, the addiction process, what can happen. I, I feel as if I went through the majority of my career until, I came to Fairbanks, and, and learned through my job here, how important it is that withdrawal from particular substances, to have treated on an inpatient basis.

Sally offered that research trials related to new medications or therapies are important to the workforce:

> I think anything new coming out right now. I always want to be offered any, you know, anything new, any new interventions, therapies that are coming out or anything like that. There is a lot of new medications that are in research trials. I'd love to be a part of the research studies.

Charlie suggested the addictions curriculum also focus on specific talk therapies, post traumatic stress' connection to substance abuse, and finally mental health concerns:

> Unfortunately, those of us in the addiction field created a monster with some of the techniques that were, were used, I believe, in, in the past that were disrespectful, and harmful, and caused more harm than good. But there needed to be a lot more stuff regarding cognitive behavioral interventions that could be applicable. I came into the field completely naive about CBT. I knew what it was, but as far as how to apply it, I, I had no idea how to do that. So, I could have used addiction-focused CBT training. Motivational interviewing would have been, would have been a good thing to have had.

Charlie also spoke about inclusion of post traumatic stress disorder in curriculum content:

> There are so many—post-traumatic stress disorders, which I, I think is tragic, the, the lack of intervention that's done with PTSD, both—I work with combat vets. So, of course, you have your combat PTSD. But you also have complex PTSD with folks that have, you know, child abuse and different things like that. And, and if, if I were in a, in the position to be designing a training program, I would certainly make sure that not only was there some substance use disorder specific training that went on, but I would also ensure that there was post-traumatic stress disorder training—what it is, what kind of interventions might be helpful. Other mental health disorders, such as depression and anxiety. Clarification so that folks can, I mean, I, I have learned that even here is, is all everybody has made you depression and anxiety, and we still use them.

Content with regard to brain development, functioning, and the progression of addictions on the brain was noted by Violet:

> I would have loved to have had more course work on, on the function of the brain, the development of the brain, of, of, of the progression of addiction, the chronic nature of addiction, understanding, you know, the different types of addiction that are out there, and what each drug can do to the brain, and how, how it changes the normal function of the brain.

In the work of addictions, Violet endorsed the value of family health and participation in the treatment of addictions and course work: "How to get families involved, and help the families get healthy also, because, unfortunately, they come from, you know, generations of addictions. That would be very beneficial. Family systems work is the biggest one."

Survey Results

The following are the results of the survey that all seven participants completed. In listing the results, courses with the highest scores are first and then move down in score. Courses with the same score are grouped together. Participants are listed with their endorsement choices and designated point value of the response choices as shown in Table 3.

Table 3

Survey of Addictions Counseling Graduate Program Ranking by Score Results

Score	Course	# on Survey	HR	SR	N	SI	HI
35	Issues in Addictions and Recovery	7	All participants				
35	Theories and Treatment of Addiction	10	All participants				
35	Counseling Addicted Families	11	All participants				
35	Supervised Practicum	17	All participants				
35	Supervised Internship	18	All participants				
34	Legal, Ethical and Professional Issues	6	Violet, Sally, Snoopy, Charlie, Patty, Lucy	Linus			
34	Psychopharmacology	8	Violet, Sally, Snoopy, Charlie, Linus	Lucy			
34	Psychopathology	9	Violet, Sally, Snoopy, Charlie, Linus, Lucy	Patty			
34	Clinical Mental Health Assessment and Intervention	15	Violet, Sally, Snoopy, Charlie, Linus, Lucy	Patty			
33	Multicultural Counseling	1	Violet, Sally, Snoopy, Charlie, Patty	Linus, Lucy			

Table 3 (continued)

Score	Course	# on Survey	HR	SR	N	SI	HI
33	Theory and Techniques in Group Counseling	3	Violet, Sally, Snoopy, Charlie, Lucy	Linus, Patty			
33	Appraisal of Individuals and Groups	4	Violet, Sally, Snoopy, Charlie, Linus, Lucy	Patty			
33	Human Growth and Development	12	Violet, Sally, Snoopy, Charlie, Linus	Patty, Lucy			
33	Foundations in Clinical Mental Health Counseling	14	Violet, Sally, Snoopy, Charlie, Lucy	Linus, Patty			
32	Theory and Techniques in the Helping Relationship	2	Violet, Sally, Snoopy, Charlie	Linus, Patty, Lucy			
31	Ecological Counseling and Prevention	16	Violet, Sally, Snoopy, Charlie	Linus, Lucy	Patty		
29	Research and Evaluation of Methods and Practice	5	Sally, Snoopy	Violet, Charlie, Linus, Lucy	Patty		
25	Theory and Techniques in Career Counseling	13	Charlie	Sally, Snoopy, Lucy	Violet, Patty	Linus	

Note. Highly Relevant (HR) = 5 points; Somewhat Relevant (SR) = 4 points; Neutral (N) = 3 points; Somewhat Irrelevant (SI) = 2 points; Highly Irrelevant (HI) = 1 point

Courses With Scores of 35 Points

Five courses out of 18 received scores of 35 and were endorsed as highly relevant by all participants. Those courses were Issues in Addiction and Recovery, Theories and Treatment of Addiction, Counseling Addicted Families, Supervised Practicum, and Supervised Internship.

Courses With Scores of 34 Points

Courses with scores of 34 points were as follows with varying endorsement by participants: Legal, Ethical and Professional Issues was chosen as highly relevant (5 points). One person endorsed the course as somewhat relevant (4 points).

Psychopharmacology was endorsed as highly relevant by Violet, Sally, Snoopy, Charlie, Linus, and Lucy. Patty endorsed the course with her choice of somewhat relevant.

Psychopathology was endorsed as Highly Relevant by Violet, Sally, Snoopy, Charlie, Linus, and Lucy. Patty found the course to be somewhat relevant.

Clinical Mental Health Assessment and Intervention was endorsed as highly relevant by Violet, Sally, Snoopy, Charlie, Linus, and Lucy. Patty found the course to be somewhat relevant.

Courses with Scores of 33 Points

Multicultural Counseling was endorsed as highly relevant by Violet, Sally, Snoopy, Charlie, and Patty. Linus and Lucy gave the course and endorsement of somewhat relevant.

Theory and Techniques of Groups Counseling was endorsed as highly relevant by Violet, Sally, Snoopy, Charlie, and Lucy. Linus and Patty gave the course and endorsement of somewhat relevant.

Appraisal of Individuals and Groups was endorsed as highly relevant by Violet, Sally, Snoopy, Charlie, and Lucy. Patty gave the course and endorsement of neutral (3 points).

Human Growth and Development was endorsed as highly relevant by Violet, Sally, Snoopy, Charlie, and Linus. Patty and Lucy gave the course an endorsement of somewhat relevant.

Foundations in Clinical Mental Health Counseling was endorsed as highly relevant by Violet, Sally, Snoopy, Charlie, and Lucy. Linus and Patty endorsed the course as somewhat relevant.

Single Score Courses of 32 or Less

Receiving a score of 32 points was Theory and Technique of the Helping Relationship. Violet, Sally, Snoopy, and Charlie endorsed the course as highly relevant. Linus, Patty, and Lucy endorsed the course as somewhat relevant.

Receiving a score of 31 points was Ecological Counseling and Prevention. Violet, Sally, Snoopy, and Charlie endorsed the course as highly relevant. Linus and Lucy endorsed the course as somewhat relevant. Patty endorsed the course as neutral.

Receiving a score of 29 points was Research Evaluation and Methods of Practice. Here the endorsements among the participants began to spread out. Only Sally and Snoopy endorsed the course as highly relevant. Violet, Charlie, Linus, and Lucy endorsed the course as somewhat relevant (4 points). Patty endorsed the course as neutral.

Receiving a score of 25 was Theory and Technique of Career Counseling. Only Charlie endorsed the course as highly relevant. Sally, Snoopy, and Lucy endorsed the course as somewhat relevant. Violet and Patty endorsed the course as neutral. Linus endorsed the course as somewhat irrelevant (2 points).

CHAPTER 5

DISCUSSION

The purpose of this study was to evaluate the academic preparation of addictions counselors practicing in the state of Indiana. The most important finding of the study was the discovery that the practice of addictions counseling does not have a professionally established curriculum in higher education as do other allied practices in psychology, social work, or clinical mental health. The lack of such academic standards brings into question the relevance of addictions counseling. Questions that come to mind include issues of ethics, competency, knowledge, and skills of the current and future workforce to treat clients effectively. As an addictions professional and educator, I had the following areas of inquiry. First, what is the academic preparation of the current practicing addictions counseling workforce? What are the duties of an addictions counselor? Is the academic preparation adequate and relevant to do addictions counseling? After employment as an addictions counselor, are issues present necessitating further training and education? If academic preparation is lacking and further training and education are needed, are there components that can be added in higher education degree curriculum development, specific to addictions counseling? My belief was that this study would add to the lack of literature on addictions curriculum in higher education that might be used to call for a re-evaluation of existing degree programs and at the same time contribute to the creation of new programs in addiction counseling in higher education.

Overview of the Results

The results from the four social workers and three mental health counselors' interviews documented in Chapter 4 found that all participants stated they were not adequately prepared from their academic study to function as an addictions counselor. Charlie, as a master's level social worker, stated his academic preparation was "completely irrelevant" and Patty stated that she "had nothing undergraduate or graduate level that was relevant regarding addictions." Together these comments underscore a common academic problem that may create a professional and client treatment problem. Such statements and others gave evidence of the first emergent theme of a Lack of Preparation. Each concluded the need for a more specific addictions curriculum in higher education. Further, in their interviews the participants endorsed content to be included in current academic courses they found necessary for their addictions practice and future addictions counselors. The content was based on their own experiences in their current workforce duties and resulted in four invariant theme clusters. Lack of Preparation clustered around the themes of no coursework and on-the-job training. The second invariant cluster was Current Practices with the themes of intake assessment of the individual, family, and group. The next invariant cluster was Curriculum and the theme of transferable content, followed by the invariant cluster of Addictions Counseling and the themes of abstinence, recovery, and dual diagnosis.

In the surveys, the participants endorsed specialized addictions courses that would be highly relevant to their current client population and treatment needs. Those main courses were Issues in Addiction and Recovery, Theories and Treatment of Addictions, and Counseling Addicted Families. This evidence possibly points to the need for new programs of study in higher education at the undergraduate and graduate levels in addictions counseling. The

evidence also indicates that without a specific new academic curriculum in addictions counseling, let alone the standardized curriculum in counseling skills, as the past and current addictions counseling workforce will not be prepared to counsel or treat persons and families impacted by addictions and is in concurrence with Lawson and Lawson (1990) in the literature.

Curriculum Concerns

Six of the seven participants indicated in interviews that as a part of their degree programs they did not have a single course in addictions or addictions-related content. Information shared also revealed that addiction courses were not even available should a student want to take one as an elective course. This lack of courses runs counter to Howard et al. (2004), who asserted that colleges and universities typically had at least minimal preparation in addictions and substance abuse. The one participant who attended an addictions course in graduate school indicated that the course was inadequate and irrelevant in preparation or application to the addictions workforce.

This experience underscores my previous research that programs in higher education do not focus on treatment needs (Osborn, 2008). In the interview, Lucy indicated that her closest study of addictions came at the undergraduate level in an abnormal psychology course. The lack of addictions content in academic preparation in degree programs is also in agreement with Khantzian (1985). Also in the literature and evidenced in this study, Fisher and Harrison (2005) reported that managed care found an ill-prepared workforce to do addictions counseling.

Information from the participants indicated that higher education does not view addictions prevention or treatment as a health issue worthy of specialized treatment, resulting in a low level of content need in the curriculum of academic programs. Selin and Svanum (1981) found addictions training not to be important among APA degree programs. Five years later in a

follow-up study, Lubin et al. (1986) found no changes were made in APA programs specific to the inclusion of addictions courses or content. In the present study, four of the seven participants had degrees in social work and shared they did not have any academic preparation in addictions. Although there is general counseling content in counseling degree programs such as counseling techniques or group work that has application to addictions work, Bina et al. (2008) did not find any social work programs with addictions content. Salyers et al. (2006) suggested that in CACREP programs students should be given the opportunity to develop clinical skills under supervision in practicum and internship sites with addicted populations. They also recommended that CACREP should move forward with developing a common core substance abuse curriculum and incorporating substance abuse issues into current courses.

Competence

In the interview process, I also found evidence indicating a lack of competency of the current addictions workforce, which confirmed one of the questions of the study. The evidence is related to the various degree specialties or concentrations of the addictions counseling workforce. Many current and past addictions counselors do not have, as Harwood (2003) found, degrees in addictions counseling. He found the majority earned degrees in something other than addictions counseling. Of those working in addictions counseling, he found their degrees to be in another area of behavioral or social sciences, such as social work or mental health. This was true of all the participants in this study. Four held degrees in social work and one of the four had a second degree in agency counseling. The remaining three earned degrees in mental health, general counseling, and counseling psychology.

This study also found that counselors who were hired into addictions counseling positions needed to meet only minimal standards established by the state's certification or licensure board.

All of the participants in this study candidly stated they did not come to their positions in addictions counseling prepared. Participants indicated they came to work as addictions counselors due to the necessity of finding employment or to provide for their families. In seeking employment, some applied for the position of addictions counselor because it was available and open. One participant said her current counseling program was being cut and this was an available position. Another participant, while completing her graduate practicum in social work, had been placed in the addictions counseling area and later gravitated toward working in addictions. The requirements for employment given by their employers for an addictions counseling position were interesting. Participants indicated employers required a master's degree and licensure, neither of which specified knowledge of addictions counseling. The addictions content could be acquired after hire. This is also indicative that meeting criteria of addictions knowledge and skills is an afterthought and confirms Harwood's (2003) assertion that counselors transition to addictions counseling from other positions. Once addictions counselors acquire their positions, then they seek the necessary knowledge and skills for the job. Participants in this study reported the same.

Post Hire Qualifications

In review of licensure, six of the seven possessed the LCAC which is a graduate-level license, and one participant was a LAC, which is an undergraduate-level license. The one participant explained that although she had a master's degree, she had not worked long enough to gather postgraduate hours to meet the requirements for the master's-level licensure. Instead, she met the qualifications for the undergraduate licensure. All of the participants stated that they were able to become licensed as addictions counselors in Indiana per the 2010 addictions licensure law. A grandfathering period was open for a total of 18 months. During this time

period, grandfathering into licensure had less rigorous criteria to be met, such as not having addictions-specific course work or passing a state licensure exam. Additionally, the certification process in Indiana did not require a return to the classroom as indicated in the literature (Osborn, 2008; Page et al., 1995).

Four of the participants made reference to specific activities they engaged in to meet the licensure requirements during the open grandfathering period. Those activities involved ongoing supervision during hours of their work with addicted clients and attendance at addictions-related workshops and conferences for continuing education to be applied toward certification. The experiences of the participants give credence to claims by Magnuson et al. (2002) and Kurita and Guydish (2007) that state licensure laws typically allow for postgraduate requirements to be satisfied by participating in professional development conferences and workshops. Banken and McGovern (1992) found the same credentialing process for addictions in other states. Individual states set up certification and training guidelines and emphasize that newer counselors were meeting requirements through ongoing supervision (Magnuson et al., 2002).

An issue that warrants mention is the primacy of being a recovering versus a non-recovering person as a qualification to work as an addictions counselor. This issue has been a matter of internal debate in the area of addictions counseling for many years. Horvatich and Wergin (1998) argued that nondegreed persons who were in recovery from addiction were qualified to do addictions counseling. Their premise was that if you had the experience of addiction and were now living in recovery, this experience provided unique sensitivity and insight to help others compared to those who did not have addictions issues. Only one of the seven counselors in my study was in recovery from addiction specific to alcohol. The others indicated they were not in recovery and had never had addiction dependency issues of any type.

They also believed that having such an issue would give them no more insight and was not a condition of their employment. The lone participant in recovery mentioned that even with his unique status of being a person in recovery, he still lacked understanding and was sorely underprepared to be an addictions counselor.

These results provide evidence that is counter to the literature and at odds with Culbreth (2000), Thombs and Osborn (2001), and Crabb and Linton (2007). These researchers cited that being a counselor in recovery is believed to offer an empathetic qualification in understanding the needs of addicted clients. In effect, the advent of licensure standards requiring a master's degree in one of the behavioral or social sciences, without addictions content, has now minimized the advantage of having experience as a recovering addict. White (2008) also found that recovery was not important. By contrast, White found that academic preparation, professional acumen, and acceptance of addicted clients were important.

Workforce Duties and Needs

Regarding workforce duties of addictions counselors, five participants stated they conducted intake interviews and assessment appraisal with clients seeking addictions services. This job duty was a feature not given large mention in the literature reviewed. Such an activity is deemed important to academic consideration in content for the following reasons.

Intake and Assessment

Intake is significant in the aspect of competency related to skills and knowledge needed to collect the client's past and current history of addiction severity, including chronicity. In assessment, a variety of instruments are available requiring appraisal and interpretation skills. Both intake and assessment skills are needed to gauge the overall physical and mental health functioning of the client. This is in connection with a diagnostic impression for treatment needs,

level of care, and program placement to maximize potential treatment success. Evidence of this was found in the survey results, as participants endorsed courses in Clinical Mental Health Assessment as well as Intervention and Appraisal of Individuals and Groups. They deemed these courses as important in an academic program of study, based upon their experience as addictions counselors.

Diagnostic Integration and Care

An issue that was strongly confirmed by the participants was the matter of working with clients who had both mental health and addiction issues. The literature noted that identifying co-occurring disorders, also known by the term *dual diagnosis*, is a significant treatment concern. A plethora of literature indicates that mental illness and addiction in the form of substance abuse occur together (Mangrum & Spence, 2008). Polcin's (2000) review of epidemiological studies found high correlations of dual diagnosis; for example, of persons diagnosed with schizophrenia, 47% have histories of substance abuse. Polcin also indicated that 40% of families in counseling have family members dually diagnosed with a mental health and addiction diagnosis. Miller and Brown (1997) found that treatment facilities reported growth in combined mental health and substance abuse needs. Von Steen et al. (2002) discussed dual diagnosis as it is related to relapse prevention and intervention. Family counseling and treatment planning are required for multiservice treatment facilities. Meuser and Drake (2007) also found that today a counselor must have a high level of competency in such areas as etiology, prognosis, psychopathology, and psychopharmacology.

Another issue related to the problem of dual diagnosis is that counselors, social workers, marriage and family therapists, and psychologists who lack course work or training specific to substance abuse addiction can intentionally or unintentionally either not diagnose or misdiagnose

clients (Harwood, 2003). Such a practice may place the client at risk or endanger the client's life in regard to physical condition, mental health, or medication need. As a result, cross-addiction or even overdose may occur. Several of the courses endorsed by the participants in the survey align with the needs of addictions competency in addressing client treatment in issues of dual diagnosis. The courses from the survey were Psychopathology, Psychopharmacology, Issues in Addiction and Recovery, Theories and Treatment of Addiction, Counseling Addicted Families, and Legal, Ethical, and Professional Issues. These courses met the challenges noted to address etiology, diagnosis, prognosis, relapse, and the medication and treatment needs of clients and family counseling with guidance for competent practice, ethics, and law.

Content Contrary to the Literature

This study also found the participants made minimal or no mention of several issues given attention by other studies in the literature. Only two participants spoke of the importance of using or the need for a theoretical treatment approach for working with addictive clients. These two participants spoke of the value of cognitive behavioral therapy (CBT) and motivational interviewing (MI) as primary to working with addicted populations. Such a lack of endorsement is contrary to the significant amount of attention given in the literature to CBT (Beck et al., 1993; Miller et al., 1992; Morgillo-Freeman & Osborn, 2006). Other studies by Miller and Brown (1997) and Ouimette et al. (1997) found MI and the stages of change process as primary methods for working on resistance with addicted clients. No indication was given by the participants of working with other addictions known as process addictions. Examples of such process addictions are eating disorders, gambling, or sexual addiction, as noted by Osborn (2008). Instead, all of the participants spoke of working exclusively with substance abuse clients or substance abuse in conjunction with co-morbidity.

Other areas of study in the literature that were not mentioned were as follows. Participants did not raise concerns about being supervised in clinical supervision by someone who was not an addictions counselor, especially supervision of addictions content. Clinical supervision specific to substance abuse was deemed important in order to ensure competency by Campbell et el. (2005), Culbreth (1999, 2000), Culbreth and Cooper (2008), Garland et al. (2003), and Reeves et al. (1997). Further, participants did not come forward with concerns regarding multicultural or gender issues as important in addictions counseling. Several studies in the literature focused on the need for addictions counselors to become prepared to work with multicultural clients (Lassiter & Chang, 2006; Kiselica et al., 1999). At the same time, a study of addictions counselors done by Klutschowski and Troth (1995) remarked that addictions counselors ranked the need of a course in multicultural counseling as low. Although participants in this study did not comment specifically on multicultural issues, they ranked the multicultural counseling course third among scores in the survey.

Trustworthiness of the Study

Shenton (2004) pointed out that qualitative research has met with criticism due to questions of trustworthiness in qualitative methodology. The issue concerns the appropriateness of validity and reliability that are commonplace in quantitative research methodology. Guba (1981) presented four criteria to be used by qualitative researchers. Trustworthiness in qualitative research consists of credibility as compared to internal validity, transferability as compared to external validity/generalizability, dependability as compared to reliability, and confirmability as compared to objectivity (Lincoln, 1995; Silverman, 2001).

Internal Validity as Credibility

Credibility with regard to internal validity gives confirmation that what was studied was measured and tested. For qualitative research, Merriam (1998) found that credibility in comparison to internal validity seeks to ask "How congruent are the findings with reality?" Confirming trustworthiness as related to credibility is the most important undertaking of a study (Lincoln & Guba, 1985). For my study, I implemented methods to ensure credibility with the following provisions.

To begin, I used established qualitative research methods. For this study, I collected data by interviews and surveys, which I then subjected to analysis by using open coding. Before collecting data, having familiarity with the culture, group, or organization was another provision. I have served in several clinical and administrative positions in the addictions counseling profession for several decades. Over the years, I have come to possess professional expertise, which gives me familiarity with the professional culture and treatment practices of addictions counseling.

Another provision for qualitative research was the sampling methods used. Random sampling is considered a strong method for such a study. In this study, the benefit of random sampling ensured participants would be volunteers from multiple locations and that as the researcher I had no control over who participated. Elements of purposive sampling were also used, as the participants were located in Indiana. Further, the sampling methods used a collective case study approach. Stake (1994) found in the collective case study approach that each participant presents as a case where there can be a collective commonality and yet each case can be similar, dissimilar, or redundant in perspective.

Triangulation as a provision was used as it incorporates various angles on data collection. Primary examples are not limited to but include various points of view and observations. This study used two different techniques for collecting data: a semi-structured interview, which was audiotaped and transcribed, followed by a structured survey instrument. In addition, in this study participants came from several treatment facilities.

Honesty is an important provision of trustworthiness. Essential to honesty are participants who have reason to be truthful in providing information while having the opportunity to decline to participate should they so choose. Connected to the provision of honesty is the independent status of the researcher from superiors. This ensured the participants had liberty to contribute without fear of negative experiences from their superiors. I had provisions in my documents informing participants I had no connection to their superiors. I also emphasized this in my face-to-face interview with each participant. They were also informed they could withdraw at any time and also be unguarded in conversation.

A researcher should also utilize frequent debriefing sessions. I addressed this provision in the study by virtue of a dissertation chair, committee, and department chair. This provision was used on a few occasions to debrief, clarify understanding, test assumptions, interpretations, or check against potential bias.

A similar aspect of debriefing sessions is the provision to include peers and colleagues. Examples are those familiar with the researcher and subject or content of study such as professional colleagues or faculty. In conducting my study, I consulted with faculty and professional colleagues working in addictions at an academic and clinical level. They contributed some fresh perspectives and gave feedback on my assumptions while being mindful of potential bias.

In addition to feedback of debriefers and peers, the researcher must be recognized as a provider of the process with his or her ongoing reflective commentary (Guba & Lincoln, 1989). Examples of ongoing reflective commentary would be the researcher's written or recorded observations. These occurred at the conclusion of interviews. Guba and Lincoln (1989) also referenced *progression subjectivity*, where the researcher monitors his or her perceptions and constructs of the study process. For this study, I frequently reflected on copious notes of written observations after interviews in writing my findings.

Another aspect of credibility concerns the background, qualification, and experience of the researcher. Patton (1990) found that credibility of the researcher is more relevant to qualitative researchers as they are main gatherers and interpreters of data. Alkin et al. (1979) remarked on the importance of the person as researcher based on the practice of scrutinizing the background of the researcher as much as the methods of conducting the study. My decades of professional clinical experience as an addictions counselor and professor provided such an experienced background. Such examples also include my time of service to NAADAC as a Regional Vice President, President, and now Immediate Past President plus an invitation from the state to work with addictions licensure legislation.

Member checks also add to the credibility of the study by contributing to the accuracy of the data collected. This aspect of credibility was met in the study by the use of audio recordings and verbatim transcription. The transcripts were shared with participants in a member checking process.

Examination of previous research findings is a final research provision. Here, evaluators assess the results of the study in conjunction with past studies, to determine how congruent the studies are. Previous research has been documented in the review of the literature of this study.

Further, I established that this study reflects the topic and similar methods. If needed, future researchers could follow my methods with ease to replicate or expand upon this research study, using a larger sample.

Transferability

Transferability in qualitative research is compared to external validity or generalizability in quantitative research. Merriam (1998) clarified external validity and generalizability as related to the degree results of a study can be applied to other field sites, or in kind sites. Lincoln and Guba (1985) suggested that in qualitative research the researcher is responsible for giving adequate contextual information of the fieldwork site. Readers can transfer such field site details to replicate or bring comparison to other studies. Examples of contextual information include the number of organizations represented including location, possible restrictions of participants in provision of data, total number of participants, methods of data, length of sessions, and the period over which data were collected. This provision has been indicated in the methods section of the study, as the sites were certified treatment facilities in Indiana, including the number of participants I interviewed.

Dependability

Dependability in qualitative research is a provision that has comparison to reliability in quantitative research. Here reliability refers to a researcher replicating a study in the context, techniques, and participants to ascertain if similar results are produced. In qualitative research for dependability to be accomplished, the reader should be provided with the design of research, along with factors for implementation, the method of data collection gathered from the field, with a reflection on the research, to appraise the final results of the research. This study

incorporated such a provision in my description of the construction and rationale of the methods which included sampling, interview location, and coding.

Confirmability

The qualitative researcher uses confirmability as a comparison to objectivity in quantitative research. Objectivity concerns whether the results reflect the findings and experiences of the participants versus the preferences or desires of the researcher. To address this in my study, I indicated how data were collected and coded. Secondly, acknowledgement of researcher bias has been articulated for readers.

Benefits of the Study

This study confirmed through the real-life experiences of addiction counselors several contributions to benefit the practice of addictions counseling and added to the literature for future study. The first contribution is the affirmation of the participants that the practice of addictions counseling is a bona fide area of counseling, needing its own degree programs in higher education. Addictions counseling is not a subspecialty of another area of clinical mental health counseling or social work. The study also provided information that allied practitioners from non-addictions counseling degree programs are, by their own admission, not prepared to do addictions counseling. As a consequence, allied degree programs in higher education would also benefit from specific courses in addictions. This study is of benefit as it exposed the need for a consistent or at best a standardized curriculum. In conjunction, there is a need to establish addictions counseling degree programs in higher education at the undergraduate and graduate levels.

This study also helped to define further what specific duties addiction counselors do, as presented by the participants currently in the addictions counseling workforce. The participants'

work specific to addiction clients provided a beginning foundation of what to incorporate into course content in higher education. Such content will help to train and educate a future generation of addictions counselors. Participants confirmed the need for courses specific to dual diagnosis of addiction and mental illness in psychopathology and an understanding of medications used in psychopharmacology as related to neurochemistry, biophysiology, and addictions recovery. Courses are needed emphasizing how intake and assessment results should be linked to client placement and treatment planning. These courses also translate to inclusion of content for courses in individual, group, and family counseling and theories. Academic programs by virtue of a curriculum should define a profession-specific scope of practice and cover the legalities for ethical practice and conduct for the addictions profession.

This study also added to the literature related to addictions education, counselor education, supervision, and client treatment for practicum and internship experiences. Further, this study helped define addictions counseling as a diagnosis-specific profession, while providing a study for replication with salient issues and topics. In these ways, addictions counseling would benefit from research conducted to evaluate theories, treatment protocols, program components, and the effectiveness of program design in higher education.

Limitations

The following limitations are noted. For this study the sample size was small consisting of seven participants from three treatment facilities, all of which were in the state of Indiana. Second, some interviews could have gone longer. Most interviews were limited to 60 minutes' as interviews took place at the participant's place of work, I did not want to impinge upon their productivity or schedule or create a negative experience. Third, all the participants were several years removed from their graduate school experiences. The least amount of time was 10 years

from degree completion. Such duration could impact details of their experience in recall. This could also impact the survey results, as the participants may not have understood the content of a course based on its title and rank a course lower. Also an opposite effect can happen. Participants may overendorse a course based upon what they think a title addresses, without fully understanding the course description and content application. A fourth limitation was the representation of gender balance, as only two participants were men and five were women. Fifth, with regard to academic discipline, most graduate degrees were in social work. The course orientation of social work is standardized at the undergraduate and graduate level, yet all participants stated that addictions content was not represented. Sixth, some participants may have had self-interest and wanted to please self or others, or express grievances. Another limitation is that participants may have had awareness of more contemporary academic requirements. This could have been due to coworkers recently hired, having completed graduation from a more contemporary and more recently standardized graduate curriculum. There is also my awareness of subtle or covert undetected researcher bias, coupled with unintentional neglect of some areas for inquiry. Finally, participants may have had a stressful experience prior to, or anticipated after the interview, that impacted their participation levels.

Examiner Lived Experience

In conducting the study, I was mindful of dynamics where I could bias the participants. I attempted to conduct the interview without vocal tone or facial affect that would convey positive or negative affirmations of the participant and responses. Participants may have, without mention to me, been aware of or knew my current positions in academia and national office in addictions. Such awareness could have influenced their motives for participation. Their participation could have had a subtle or covert motive undetected that was not made known to

me. There were three occasions where I was not pleased with the interview situation. The areas where the interviews took place had some irritation due to outside noise and phone interruption. Such irritations, I felt at the time, may have impacted the quality of the audio recording, broken concentration in the interview, or extended the time required to complete the interview.

Strengths

The strengths of this study are in the following. Accuracy was increased because audio recordings were made to capture participants' words. Transcripts were made from the audio recordings and compared with each other on two separate occasions for accuracy. A transcriptionist was employed to ensure accuracy of audio content. All audio equipment was in working order and operated during the interviews without interruption. The participant's content was captured in full and in context on the audio in one session.

Implications for Future Research

I recognize that this study is not exhaustive; nevertheless, the study has provided a foundation for further study, inquiry, and research. First, as the participants of this study are several years removed from graduate study, this study could be extended by examining recent graduates of counseling programs from within the last 2 to 7 years. An added component could examine recent graduates of the last 2 to 7 years against the experiences of the participants in this study. Second, this study could be replicated in states outside of Indiana. This would also identify similarities and differences of addictions counselors in education and job functions across states for comparison. Third, a closer examination of the themes of this study could be done by placing themes into a Likert-type scale in order to test for robustness. Fourth, based upon the participants' responses of academic need and practice readiness, a researcher could conduct a similar study with current graduate faculty. This type of study could focus on graduate

faculty members' perceptions of addictions counseling, related to the addictions as a profession, client treatment needs, and academic concentration. Fifth, an important study could be done by interviewing addictions clients regarding their perceptions of counselor education and training to ascertain effectiveness. Sixth, I could conduct the same study and make a change to interview addictions counselors in a group, across a more extended period of time. Finally, I might do a comparative study of current academic catalogues of several colleges and universities at the undergraduate and graduate level, in different states, with the purpose of reviewing addictions-relevant content of courses, or addictions courses in various disciplines.

Conclusions

In completing this study, I offer my comments and observation on the findings of the study related to higher education and the addictions counseling profession. These observations come from what I learned and what I believe should be done. As the study had four overarching questions, I will address those first from the interview and second from the survey.

Overarching Research Questions, Themes, and Comment

The first question asked if current degree programs are adequate to prepare individuals to be addictions counselors. The overall answer is that current degree programs are not adequate to prepare individuals to be addictions counselors. This perception was confirmed unanimously by the participants' own words and their experiences regarding their academic preparation. Other support came from the literature. However, the degree programs were not without relevance to core counseling skills.

The first descriptive category concerning a lack of preparation developed with two cluster themes. The two cluster themes were lack of course work and dependence on training on the job. I would posit that from the cluster themes a person would ask me, "So are you saying that

the current workforce is not competent?" My response is "No, they are not competent *in* addictions counseling; however, I need to explain my rationale as to why. The passage of the two-tiered addictions counseling licensure of 2010 provided a one-time-only opportunity through grandfathering for many general counselors to become addictions counselors. As I have written part of the addictions licensure law and collaborated on other sections, I can speak with some authority here. Grandfathering is the political cost of passing legislation. It was a way to satisfy opposition to the legislation.

The opposition could come from other allied counseling professionals who are licensed and who believe addictions licensure would present an encroachment upon their territory. The allied professions may have licensure in another area such as social work by having passed the profession's licensure exam but without addictions content in the exam and no course work in addictions. Another opposition group consists of non-degreed addictions counselors because they believe they would lose their jobs. They also believe their years of experience have value and would be thrown out. For the nondegreed counselors, they would have passed a certification exam over addictions content but would have neither addictions course nor counseling coursework.

The grandfathering process is open after passage for one year for those who meet minimal standards of the licensure bill. In grandfathering, two standards are absent in the Indiana addictions counseling licensure bill. The first standard relates to academic course work specific to addictions and the second concerns passing a licensure exam. In essence, the grandfathering aspect is saying that for some counselors you do not meet full standards, only minimal standards. So for those counselors who grandfathered in, if not for grandfathering they

would not be licensed addictions counselors, because they neither have the addictions course work nor do they have evidence of having passed the addictions licensure exam.

The second theme of on-the-job training was the method that counselors desiring to be licensed would need to satisfy. Once again, I return to the issue of grandfathering in the addictions licensure passage. As the grandfathering was for a period of one year and the standards were minimal, some counselors, but not all, were able to meet the minimal standards. Examples of the minimal standards are having licensure in another allied counseling profession or attending continuing education workshops or conferences in addictions counseling endorsed and certified by NAADAC. Further, standards involved working in or with an addictions treatment program or seeing addicted clients. For some counselors, this condition was met at their current work locations. In this way, counselors were under clinical supervision and kept documented records of their work. Finally, some counselors may have met most of the requirements and had time to complete certification testing by NAADAC. The certification test did meet all minimal standards for the addictions licensure.

Although the grandfathering process was not ideal in that it possibly allowed marginally prepared counselors to be licensed, it lasted only for one year. Now that the licensure is fully implemented, marginal counselors must meet the rigors of the two-tiered addictions licensure specific to addictions course work, successfully complete a supervised practicum and internship, and pass the licensure exam. At some point within a few years, those grandfathered in will transition out of the addictions profession due to job changes or retirement. On this point, I will add two more comments. It has been my experience that some of those counselors who were grandfathered in have been conscientious about continuing to meet and maintain addictions licensure standards after passage by attending addictions workshops and conferences for

continuing education units, and some have returned to higher education to take relevant courses to meet competencies. This has been a silver lining of the grandfathering provision as the addictions counseling workforce has increased to meet the demand. The final observation is that during the passage of the addictions licensure bill there were those counselors who met the full standards of the bill. These counselors had the requisite undergraduate and graduate courses of the time, had practicum and internship experience, and already had passed the NAADAC national addictions certification exam.

The next overarching question asked what addictions counselors do in practice. What emerged was current practice as a second descriptive category, with one theme of intake and assessments and the second theme of working with individuals, families, and groups. This was not new information, yet the content area related to addictions was missing. For example, some counselors stated they did not have in their academic programs courses or content instruction on addictions assessment instruments. Their addictions experience came while on the job. In serving clients without such academic instruction, I would wonder if addicted client needs and diagnoses were reliable as this would translate to program placement and treatment goals. In short, were some addictions issues missed?

In working with individuals, families, and groups, participants commented that their academic coursework did not prepare them in addictions. The concern is that treatment issues could be overlooked or ignored. To treat such clients presents issues of scope and practice and ethical concerns. Learning on the job with treating addictions is more serious than learning on the job with completing progress notes or treatment plans properly. For addictions, such learning on the job can slow the progress of clients as it is attached to the learning curve and supervision of the counselor in training. Further, the severity of the client's addiction and impact on relapse

could grow. As a result, harm could be done to the clients in their personal lives, mental health, and physical well-being. This is especially true in working with addicted families as co-dependency issues and triangulation can impede homeostasis. I would also posit that in group counseling some counselors may learn by gaining knowledge about addictions from just the experiences and dynamics of the group members. Several of the participants spoke about the benefit they received by going to AA meetings.

The third overarching question in the study asked how well academic preparation matches practice. The emergent category of curriculum came about, with a theme of transferable content. Here several participants stated that they did learn some general counseling skills in learning to ask questions, counseling techniques, or assessing coping skills. These would have transferable merit and value to engaging with clients on a first level of gaining trust and empathy. Yet, on the secondary level of problem content, addictions etiology, neurochemical impact of cognitive functioning, and relapse behavior, such transferability is sorely lacking in effectiveness of understanding or treatment.

The final overarching question asked, "If academic preparation is inadequate, where could improvement be made?" The emergent category of addictions counseling was developed with two themes. The first was abstinence and recovery and the second concerned dual diagnosis. It is also here that I will include my comments on the results specific to addictions counseling curriculum from the survey. As evidenced by the participants, the coexistence of addiction and mental health issues often present together as treatment concerns. The participants spoke about the challenges of serving such clients, complicated by the need to understand relapse in the context of having the main goal of addictions treatment be sobriety. On the issue of dual

diagnosis, I would offer that the participants felt at a loss of what to treat first or even of knowing what they were seeing. Is it cocaine withdrawal that is presenting or schizophrenia or both?

The curriculum in the survey results gives the addictions profession and more importantly the clients they serve a beginning blueprint as to what an addictions counseling degree would look like. A starting point is the five courses that were endorsed by all the participants. Issues in Addiction and Recovery could serve as an introductory course in higher education especially at the graduate level. For those students in a variety of counseling specialties, the course could be a smorgasbord approach to addictions as overview. Students could be introduced and exposed to the issues in addiction such as drug classifications, withdrawal signs and symptoms, and treatment approaches and modalities.

In the course of Theories and Treatment of Addiction, students would garner a working understanding of the etiology of chemical and process addictions such as eating or sexual addiction. Students would understand the manifestations of cognitive and physiological impairments and devise treatment approaches specific to the bio-psycho-social-spiritual needs of clients and families.

Adding to the curriculum, a course in Treating Addicted Families would add greatly to a curriculum. This course would expose student to the control addiction has over not just one person, but also how addiction impacts and changes the entire family. Students would be able to examine families to determine how addiction changes relationships and communications and, more importantly, educate the family about addiction, especially what to do when relapse occurs.

Courses in the second group endorsed by the participants that, in my opinion, have relevance are Psychopharmacology and Psychopathology. These courses are important to a core addictions program. Psychopharmacology provides understanding of the types of drugs

available for licit and illicit use and the cognitive and physiological impact. A course in Psychopathology would address the issue of dual diagnosis in manifestation and treatment needs. These courses would culminate in evaluating a student's competency with a specific practicum and internship in addictions which were both deemed important in the first group of courses.

Final Thoughts

For me, this was a study that challenged my stamina and endurance as in climbing a mountain. I can now stand on top of the mountain to pause to take it all in and give some reflection on the climb. Many of the initial questions of inquiry were substantiated by the participants. This study helped define the current needs in addictions counseling related to academic preparation, current workforce functions, and services. The participants were helpful in the survey and at times insightful in the interviews. Their years of experience gave a richer content to the study. I found them to be honest, if not bold, in their admission that they and the current addictions counseling workforce were not prepared for the positions in which they now work. All came into addictions counseling positions by a back door, if not through different paths. Most of the participants were social workers and the rest possessed master's degrees in other counseling disciplines. This required them to retrofit themselves into their positions further, with ongoing training and education. There were some who were a bit apologetic having gotten in through a grandfathering process, which allowed them to wind up with a state license in addictions counseling. Some were privately candid and still did not see themselves as legitimate addictions counselors "by earning the licenses the old fashioned way." I was appreciative of their honesty and candor. Several hoped their answers and contributions would be relevant to bring needed changes in addictions counseling as a profession. With that, I still found all of the participants were not connected to the addictions counseling profession in national or state

professional organizations. As a result, all will struggle with knowing or having awareness of current discussions and information on a state or national level, including research regarding treatment or policy initiatives relative to their needs as addictions counselors.

I found all the participants interested in the outcome of this study, as all indicated that such a study needed to be done for addictions counseling. Several felt that in the United States health care system, addictions counseling was swallowed up by mental health counseling and, as a result, had become a less than important treatment concern. All agreed that it was time for addictions counseling to emerge as a serious, front and center healthcare and societal issue. With this study, I am confident that addictions counseling will emerge as a profession by giving it a direction and defining expectations culminating in a new academic degree with specialized courses in addictions counseling at the undergraduate and graduate levels. Most important, addictions counseling will no longer be viewed as lacking in professionalism.

REFERENCES

AA World Services. (1991). *Alcoholics anonymous* (3rd ed.). New York, NY: Author.

Alkin, M., Dailak, R., & White, P. (1979). *Using evaluations: Does evaluation make a difference?* Beverly Hills, CA: Sage.

Angove, R., & Fothergill, A. (2003). Women and alcohol: Misrepresented and misunderstood. *Journal of Psychiatric and Mental Health Nursing, 10,* 213-219.

Arrendondo, P. (1995). MTC theory and Latina (o)-American population. In D. W. Sue, A. E. Ivy, & P. B. Pedersen (Eds.), *A theory of multicultural counseling and therapy* (pp. 217-235). Pacific Grove, CA: Brooks/Cole.

Baker, S. B., Exum, H. A., & Tyler, R. E. (2002). The developmental process of clinical supervisors in training: An investigation of the Supervisor Complexity Model. *Counselor Education and Supervision, 42*(1), 15-42. Retrieved from http://www.eric.ed.gov

Banken, J. A., & McGovern, T. F. (1992). Alcoholism and drug abuse counseling: State of the art consideration. *Alcoholism Treatment Quarterly, 9*(2), 29-51.

Beck, A. T., Wright, F. T., Newman, C. F., & Liese, B. S. (1993). *Cognitive therapy of substance abuse.* New York, NY: Guilford Press.

Berg, B. (2004). *Qualitative research methods for the social sciences* (5th ed.). Boston, MA: Pearson.

Bernard, J. M., & Goodyear, R. K. (2004). *Fundamentals of clinical supervision* (3rd. ed.). Needham Heights, MA: Allyn & Bacon.

Bina, R., Hall, D. M. H., Mollete, A., Smith-Osborne, A., Yum, J., Sowbel, L., & Jani, J. (2008). Substance abuse training and perceived knowledge: Predictors of perceived preparedness to work in substance abuse. *Journal of Social Work Education, 44*(3), 7-20.

Bissell, L., & Royce, J. E. (1987). *Ethics for addiction professionals* (2nd ed.). Center City, MN: Hazelden.

Blume, A. W. (2004). Understanding and diagnosing substance use disorders. In R. H. Coombs (Ed). *Handbook of addictive disorders: A practical guide to diagnosis and treatment.* (pp. 63-93). Hoboken, NJ: Wiley & Sons.

Bristow, A. R., Provost, J., & Morton, K.. (2002). Attending step meetings as a course requirement: A preliminary investigation. *Teaching Psychology 29*(2), 125-128. Retrieved from ERIC database. (EJ673834)

Brown, S. (1985). *Treating the alcoholic: A developmental model of recovery.* New York, NY, Wiley.

Brown, S. (1995) *Treating alcoholism.* San Francisco, CA; Jossey-Bass.

Bureau of Labor Statistics, U.S. Department of Labor. (2009*). Counselors occupational handbook,* 2010-2011. Retrieved from http://stats.bls.gov/oco/ocos067.htm

Burrow-Sanchez, J. J., & Lopez, A. (2009). Identifying substance abuse issues in high schools: A national survey of high school counselors. *Journal of Counseling & Development, 87*(1), 72-79. Retrieved from http://www.eric.ed.gov

Campbell, T. C., Daood, C., Caitlin, L., & Alberson, A. (2005). Integration of research and practice in substance use disorder treatment: Findings from focus groups of clinicians, researchers, educators, administrators and policy makers. *The Journal of Addictions & Offender Counseling, 26*(1), 4-11. Retrieved from http://www.eric.ed.gov

Capuzzi, D., & Stauffer, M. D. (2012). *Foundations of addictions counseling* (2nd ed). Boston, MA: Pearson.

Castro, F., & Coe. K. (2007). Traditions and alcohol use: A mixed methods analysis. *Cultural Diversity and Ethnic Minority Psychology, 13,* 269-284. doi: 10.1037/1099-9809.13.4.269

Center for Substance Abuse Treatment. (2004). *The confidentiality of alcohol and drug abuse patient records regulation and the HIPAA privacy rule: Implications for alcohol and substance abuse programs.* (DHHS Publication No. SMA 05-4037, NCADI Publication No. PHD1083). Rockville, MD: Author.

Center for Substance Abuse Treatment. (2006). *Addiction counselor competencies: The knowledge, skills, and attitudes of professional practice*. (CSAT Technical Assistance Publication Series 21). Rockville, MD: Author.

Cesare-Murphy, M., McMahill, C., & Schyve, P. (1997). Joint commission evaluation of behavioral healthcare organizations. *Evaluation Review: Measuring Quality in Mental Health Services, 21,* 322-329.

Charmaz, K. (2005). Grounded theory in the 21st century: Application for advancing social justice studies. In N. K. Denzin, & Y. S. Lincoln (Eds.), *The Sage handbook of q**ualitative research* (3rd ed., pp. 675-694). Thousand Oaks, CA: Sage.

Chavez, E. L., & Mora, J. (Eds.). (1994). Special issue on substance use patterns of Latinas. *International Journal of Addictions, 29,* 1079-1204.

Cliff, S. (2005). *Culturally sensitive substance abuse treatment for Native Americans.* Retrieved from http://www.wellbriety-nci.org/Publications/CulturallySensitiveSubAbuseTX.doc

Clinebell, H. J., Jr. (1968). *Understanding and counseling the alcoholic.* New York, NY: Abingdon.

Collins, P. H. (2000). *Black feminist thought: Knowledge, consciousness, and the politics of empowerment* (2nd ed.) New York, NY: Rutledge.

Coombs, R. H. (1997). *Drug impaired professionals.* Cambridge, MA: Harvard University Press.

Corbin, J., & Strauss, A. C. (2008). *Basics of qualitative research: Techniques and procedures for developing grounded theory* (3rd ed.) Thousand Oaks, CA: Sage.

Council for Accreditation of Counseling and Education Related Programs. (2009). *2009 standards.* Retrieved May 14, 2012, from http://cacrep.org/doc/2009%20standards%with%cover.pdf

Crabb, A. C., & Linton. J. M. (2007). A qualitative study of recovering and nonrecovering substance abuse counselors' belief systems. *Journal of Addiction & Offender Counseling, October, 28*(1), 4-20. Retrieved from http://www.eric.ed.gov

Craig, R. J. (2004). *Counseling the alcohol and drug dependent client: A practical approach,* Boston, MA: Pearson.

Creswell, J. W. (1998). *Qualitative inquiry and research design: Choosing among five traditions.* Thousand Oaks, CA: Sage.

Culbreth, J. R. (1999). Clinical supervision experiences and preferences of substance abuse counselors. *Journal of Addiction & Offender Counseling, 20,* 15-25.

Culbreth, J. R. (2000). Substance abuse counselors with and without a personal history of recovery: A review of the literature. *Alcoholism Treatment Quarterly, 18*(2), 67-82.

Culbreth, J. R. (2003). Chemical dependency counselor supervisors' of supervisee resistance and anxiety in supervision. *Journal of Teaching in the Addictions, 2*(1), 39- 49. Retrieved from http://www.eric.ed.gov

Culbreth, J. R., & Cooper, J. B. (2008). Factors impacting the development of substance abuse counseling supervisors. *Journal of Addictions & Offender Counseling, 29*(1), 22-35. Retrieved from http://www.eric.ed.gov

Deitch, D. A., & Carleton, S. A. (1997). Education and training of clinical personnel. In J. H. Lowinson, P. Ruiz, R. B. Millman, & J. G. Langrod (Eds.), *Substance abuse: A comprehensive textbook* (3rd ed., pp. 970-982). Baltimore, MD: Williams &Wilkins.

De La Rosa, M. R., Khalsa, J. H., & Rouse, B. (1990). Hispanics and illicit drug use: A review of recent findings. *International Journal of Addictions, 25,* 665-691.

Denzin, N. K., & Lincoln, Y. S. (Eds.). (2005). *The Sage handbook of qualitative research* (3rd ed.). Thousand Oaks, CA: Sage.

Doweiko, H. E. (2009). *Concepts of chemical dependency* (7th ed.) Belmont, CA: Brooks/Cole Cenage Learning.

Eaves, S., Emens, R., & Shepris, C. (2008). Counselors in the managed care era: The efficacy of the data based problem solver. *Journal of Professional Counseling: Practice Theory and Research, 36*(2), 1-12.

Ehlers, C. L. (2007). Variations in ADH and ALDH in southwest California Indians. *Alcohol Research and Health, 30*(1), 14-17. Retrieved from http://pubs.niaaa.nih.gov/publications/arh301/14-17.htm

Emrick, C. D., Tonigan, J. S., Montgomery, H., & Little, L. (1993). Alcoholics Anonymous: What is currently known? In B. S. McCrady & W. R. Miller, (Eds.), *Research on Alcoholics Anonymous: Opportunities and alternatives* (pp. 41-78). New Brunswick, NJ: Rutgers Center of Alcohol Studies.

Fahy, A. (2007). The unbearable fatigue of compassion: Notes from a substance abuse counselor who dreams of working at Starbucks. *Clinical Social Work Journal, 35,* 199-205. doi: 10.1007/s10615-007-0094-4

Farber, N. (2006). Conducting qualitative research: A practical guide for school counselors. *Professional School Counseling, 9,* 367-365. Retrieved from http://www.eric.ed.gov

Field grapples with sobriety time for counselors in recovery. (2006). *Alcoholism and Drug Abuse Weekly, 18*(47), 1-8.

Fisher, G. L., & Harrison, T. C. (2005). *Substance abuse: Information for school counselors, social workers, therapists, and counselors* (3rd ed.). Needham Heights, MA: Allyn & Bacon.

Fitch, W. L. (1991). In the Virginia general assembly: Recent amendments and additions to the code of Virginia. *Developments in Mental Health Law, 11*(1), 16-19.

Fontana, A., & Frey, J. H., (2005). The interview: From neutral stance to political involvement. In N. K. Denzin, & Y. S. Lincoln (Eds.), *The Sage handbook of qualitative research* (3rd ed., pp. 695-727). Thousand Oaks, CA: Sage.

Garland, A. F., Kruse, M., & Aarons, G. A. (2003). Clinicians and outcome measurement: What's the use? *Journal of Behavioral Health & Services Research, 30,* 393-405. Retrieved from http://www.seattleimplementation.org/wp-content/uploads/2011/12/Garland-et-al-2003-Clinicians-and-outcome-measurement.pdf

Goldberg, R., & Governali, J. (1995). Substance abuse counseling and the school counselor: A needs assessment. *Wellness Perspectives, 11*(4), 19-28.

Gomberg, E. S. (1986). Women with alcohol problems. In N. Estes & M. Heinemann (Eds.), *Alcoholism development, consequences, and interventions* (pp. 241-256). St. Louis, MO: Mosby.

Guba, E. G. (1981). Criteria for assessing the trustworthiness of naturalistic inquiries. *Educational Resources Information Center Annual Review Paper, 29,* 75-91.

Guba, E. G., & Lincoln, Y. S. (1989). *Fourth generation evaluation.* Newbury Park, CA: Sage.

Guba, E. G., & Lincoln, Y. S. (2005). Paradigmatic controversies, contradictions, and emerging confluence. In N. K. Denzin & Y. S. Lincoln (Eds.), *The Sage handbook of qualitative research* (3rd ed., pp. 191-215). Thousand Oaks, CA: Sage.

Hagedorn, W. B. (2009). The call for a new "diagnostic and statistical manual of mental disorders" diagnosis: Addictive disorders. *Journal of Addiction and Offinder Counseling, 29*(2), 110-127. Retrieved from http://www.iaaoc.org

Harwood, H. (2003, November/December). Training of behavioral health practitioners to address substance abuse disorders. *Family Therapy Magazine,* 40-42.

Haseltine, F. P. (2000). Gender differences in addiction and recovery. *Journal of Women's Health & Gender Based Medicine, 9,* 579-583. doi: 10.1089/15246090050118080

Herr, K., & Anderson, G. L. (2005). *The action research dissertation: A guide for students and faculty.* Thousand Oaks, CA: Sage.

Hill, C. E., Knox, S., Thompson, B. G., Williams, E. N., Hess, S. A., & Ladany, N. (2005). Consensual qualitative research: An update. *Journal of Counseling Psychology, 52,* 196-205. Retrieved from http://www.eric.ed.gov

Holstein, J. A., & Gubrium, J. F. (2005). Interpretive practice and social action. In N. K. Denzin & Y. S. Lincoln (Eds.), *The Sage handbook of qualitative research* (3rd ed., pp. 483-506). Thousand Oaks, CA: Sage.

hooks, b. (1984). *Feminist theory: From margin to center.* Boston, MA: South End Press.

Horvatich, P. K., & Wergin, J. F. (1998, April). *Building a new profession: Defining and measuring the competence of addiction counselors.* Paper presented at the American Educational Research Association Annual Meeting, San Diego, CA.

Houser, R. (2009). *Counseling and educational research: Evaluation and application* (2nd ed.). Thousand Oaks, CA: Sage.

Howard, M. O., Walker, D. R., Walker, P. S., & Suchinsky, R. T. (2004*). Alcohol and drug education in schools of nursing.* St. Louis, MO: Washington University, George Warren Brown School of Social Work.

Justin Foundation. (2007). *The war on addiction: Inadequate regulation, standards and oversight allow untrained, unskilled and unethical counselors to jeopardize lives, health and recovery. A review of public records regarding California substance abuse treatment facilities. 2000-2006.* Danville, CA: Author. Retrieved from http://www.thejustinfoundation.org/documents/TJFReportWithCovers_000.pdf

Kemmis, S., & McTaggart, R. (2005). Participatory action research: Communicative action and the public sphere. In N. K. Denzin, & Y. S. Lincoln (Eds.), *The Sage handbook of qualitative research* (3rd ed., pp. 559-603). Thousand Oaks, CA: Sage.

Kiselica, M. S., Maben, P., & Locke, D. C. (1999). Do multicultural education and diversity appreciation training reduce prejudice among counseling trainees? *Journal of Mental Health Counseling. 21,* 240-254. Retrieved from http://www.eric.ed.gov

Khantzian, E. J. (1985). Psychotherapeutic interventions with substance abusers: The clinical context. *Journal of Substance Abuse Treatment, 2*(2), 83-88. doi: 10.1016/0740-5472(85)90031-5

Klutschowski, F., & Troth, W. A. (1995). Components for a substance abuse counselor education curriculum: A Delphi study. *Journal of Addictions & Offender Counseling, 15*(2), 34-41. Retrieved from http://www.eric.ed.gov

Kurita, K., & Guydish, J. (2007). Substance abuse counselor certification in California: How is nicotine addiction addressed? *Journal of Psychoactive Drugs, 39,* 437-477.

Lassiter, P. S., & Chang, C. Y. (2006). Perceived multicultural competency of certified substance abuse counselors. *Journal of Addictions and Offender Counseling, 26*(2), 73-83. Retrieved from http://www.eric.ed.gov

Lawson, G., & Lawson, A. (1990). Quality substance abuse education: To be or not to be? *Psychology of Addictive Behaviors, 4*(1), *37*-39. doi: 10.1037/h0080599

Leedy, P. D., & Ormrod, J. E. (2010). *Practical research; Planning and design* (9th ed.) New York, NY: Pearson.

Leshner, A. (1999). *Principles of drug addiction treatment: A research-based guide.* Bethesda, MD. National Institute on Drug Abuse.

Lex, B. W. (1985). Alcohol problems in special populations. In J. Mendelson & N. Mello (Eds.), *The diagnosis and treatment of alcoholism* (pp. 89-187, 2nd ed.). New York, NY: McGraw-Hill.

Lincoln, Y. S. (1995). Emerging criteria for quality in qualitative and interpretive research. *Qualitative Inquiry, 1,* 275-289.

Lincoln, Y. S., & Guba, E. G. (1985). *Naturalistic inquiry.* Beverly Hills, CA: Sage.

Lubin, R., Brady, K., Woodward, L., & Thomas, E. A. (1986). Graduate professional psychology training in alcoholism and substance abuse: 1984. *Professional Psychology Research and Practice, 17*(2), 151-154. doi: 10.1037/0735-7028.17.2.151

Luchansky, B., Nordlund, D., Estee, S., Lund, P., Krupski, A., & Stark, K. (2006). Substance abuse treatment and criminal justice involvement for SSI recipients: Results from Washington state. *American Journal on Addictions, 15,* 370-379. doi: 10.1080/10550490600860171

Magnuson, S., Norem, K., & Wilcoxon, S. A. (2002). Clinical supervision for licensure: A consumer's guide. *Journal of Humanistic Counseling, Education and Development, 41*(1), 52-60.

Mangrum, L. F., & Spence, R. T. (2008). Counselor and client characteristics in mental health versus substance abuse treatment settings providing services for co-occurring disorders. *Community Mental Health, 44*(3), 155-169.

Manisses Communications Group. (2005). NAADAC directory of education and training. *Behavioral Healthcare Tomorrow, 14*(2), S72-83.

Mason, M. J. (1997). Patterns of service utilization for Mexican American majority of students who use alcohol or other drugs. *Journal of Health & Social Policy, 9*(2), 21-28. doi: 10.1300/J045v09n02_02

McCambridge, J., & Strang, J. (2004). The efficacy of single-session motivational interviewing in reducing drug consumption and perceptions of drug-related risk and harm among young people: Results from a multisite cluster randomized trial. *Addiction, 99*(1), 39-52.

McCrady, B. S., & Miller, W. R. (Eds.). (1993). *The research on Alcoholics Anonymous: Opportunities and alternatives.* Piscataway, NJ: Rutgers Center of Alcohol Studies.

McKechnie, J., & Hill, E. M. (2009), Alcoholism in older women religious. *Substance Abuse, 30*(2), 107-117. doi: 10.1080/08897070902802026

McLeod, J. (2001). *Qualitative research in counseling and psychotherapy.* Thousand Oaks, CA: Sage.

Merriam, S. B. (1998). *Qualitative research and case study applications in education.* San Francisco, CA: Jossey-Bass.

Meuser, K., & Drake, R. E. (2007). Comorbidity: What have we learned and where are we going? *Clinical Psychology: Science and Practice, 14*(1), 64-69. doi: 10.1111/j.1468-2850.2007.00063.x

Miller, W. R. (1983). Motivational interviewing with problem drinkers. *Behavioural Psychotherapy, 11*(2), 147-172. doi: 10.1017/S0141347300006583

Miller, W. R., & Brown, S. A. (1997). Why psychologists should treat alcohol and drug problems. *American Psychologist, 52,* 1269-1279.

Miller, W. R., Wilbourne, P. L., & Hettema, J. E. (2003). What works? A summary of alcohol treatment outcome research. In R. K. Hester & W. R. Miller (Eds.), *Handbook of alcoholism treatment approaches: Effective alternatives* (3rd ed., pp. 13-63). Boston, MA: Allyn & Bacon.

Miller, W. R., Zweben, A., DiClemente, C. C., & Rychtarik, R. G. (1992). *Motivational enhancement therapy manual: A clinical research guide for therapists treating individuals with alcohol abuse and dependence.* Retrieved from http://casaa.unm.edu/manuals/met.pdf

Morgan, O. J., Toloczko, A. M., & Comly, E. (1997). Graduate training of counselors in the addictions: A study of CACREP approved programs. *Journal of Addictions & Offender Counseling, 17*(2), 66-77. Retrieved from http://www.eric.ed.gov

Morgillo-Freeman, S., & Osborn, D. P. (2006). Substance misuse: An issue of degree, assessment and empathy. In A. Freeman & T. Ronen (Eds.), *Cognitive behavior therapy in clinical social work practice* (pp. 491-517) New York, NY: Springer.

Morrow, S. L. (2005). Quality and trustworthiness in qualitative research in counseling psychology. *The Journal of Counseling Psychology, 52,* 250-260. Retrieved from http://www.eric.ed.gov

Mustaine, B. L., West, P. L., & Wyrick, B. K. (2003). Substance abuse counselor certification: Is it time for a change? *Journal of Addictions & Offender Counseling, 23*(2), 99-107.

Nace, E. P. (1992). Alcoholics Anonymous. In J. H. Lowinson, P. Ruiz, R. B. Millman, & J. G. Langrod (Eds.), *Substance abuse: A comprehensive textbook* (2nd ed., pp. 488-489). Baltimore, MD: Williams & Wilkins.

National Association of Alcoholism and Drug Abuse Counselors. (1992). *NAADAC ethical standards of alcoholism and drug abuse counselors.* Arlington, VA: Author.

National Association of Alcoholism and Drug Abuse Counselors. (2008). *National Association of Addictions Professionals code of ethics: Guide to certification.* Alexandria, VA: Author.

National Institute on Alcohol Abuse and Alcoholism. (1982*). Development of model professional standards for counselor credentialing: A contract report.* Rockville, MD: U.S. Department of Health and Human Services, Public Health Service, Drug Abuse, and Mental Health Administration.

National Institute on Alcohol Abuse and Alcoholism. (1990). *Alcohol alert* (No. 10 PH 290). Washington, DC: U.S. Department of Health and Human Services.

National Institute on Alcohol Abuse and Alcoholism. (1994). *Alcohol alert.* (No. 23 PH 347). Washington, DC: U.S. Department of Health and Human Services. Retrieved from http://pubs.niaaa.nih.gov/publications/aa23.htm

Nugent, F. A. (2000). *Introduction to the profession of counseling* (3rd ed.). Columbus, OH: Prentice Hall.

Osborn, D. P. (2008). Building a curriculum: Efforts to more clearly define the skills counselors need could produce national education standards. *Addiction Professional 6*(3), 8-19.

Osborn, D. P. (2011). Journey to a profession: Counselors already have taken important steps to position for the future. *Addiction Professional, 9*(4), 32-38.

Ouimette, D. C., Finney, J. W., & Moos, R. H. (1997). Twelve step cognitive-behavioral treatment for substance abusers: A comparison of treatment effectiveness. *Journal of Consulting and Clinical Psychology, 65,* 230-240. Retrieved from http://homepage.psy.utexas.edu/homepage/class/Psy394Q/Behavior%20Therapy%20Class/Assigned%20Readings/Substance%20Abuse/Ouimette97.pdf

Page, R. C., & Bailey, J. B. (1995). Addictions counseling certification: An emerging counseling specialty. *Journal of Counseling and Development, 74*(2), 167-172. Retrieved from http://www.eric.ed.gov

Page, R. C., Bailey, J. B., Barker, S., & Clawson, T. W. (1995). The development of a knowledge-based content area for the examination of master's-level addictions counselors. *Journal of Addictions and Offender Counseling, 16,* 2-13. doi: 10.1002/j.2161-1874.1995.tb00100.x

Palmer, J. H., & Ringwalt, C. L. (1988). Prevalence of alcohol and drug use among North Carolina public school students. *Journal of School Health, 58,* 288-291. Retrieved from http://www.eric.ed.gov

Patton, M. Q. (1990). *Qualitative evaluation and research methods* (2nd ed.). Newbury Park, CA: Sage.

Peshkin, A. (1993). The goodness of qualitative research. *Educational Researcher, 22*(2), 23-19. Retrieved from http://www.eric.ed.gov

Peterson, J. V., & Nisenholz, B. (1999). *Orientation to counseling* (4th ed.). Boston, MA: Allyn & Bacon.

Polcin, D. L. (2000). Professional counseling versus specialized programs for alcohol and drug abuse treatment. *Journal of Addictions & Offender Counseling, 21*(2), 2-11. Retrieved from http://www.iaaoc.org

Polich, J., Pollock, V. E., & Bloom, F. F. (1994). Meta-analysis of P300 amplitude from males at risk for alcoholism. *Psychological Bulletin 115*(1), 55-73.

Reeves, D., Culbreth, J. R., & Greene, A. (1997). Effect of sex, age, and education level on the supervisory styles of substance abuse counselor supervisors. *Journal of Alcohol and Drug Education, 43*(1), 76-86. Retrieved from http://www.eric.ed.gov

Salyers, K. M., Ritchie, M. H., Cochrane, W. H., & Roseman, C. P. (2006). Inclusion of substance abuse training in CACREP-accredited programs. *Journal of Addictions & Offender Counseling. 27*(1), 47-58. Retrieved from http://www.eric.ed.gov

Schneider, J. P. (2005). Coexisting disorders. In R. H. Coombs (Ed.), *Addiction counseling review: Preparing for comprehensive and certification and licensure examinations* (pp. 293-316). Mahway, NJ: Lawrence Erlbaum.

Schultz, J. C., Ososkie, J. N., Fried, J. H., Nelson, R. E., & Bardos, A. N. (2002). Clinical supervision in public rehabilitation counseling settings. *Rehabilitation Counseling Bulletin, 45,* 213-222. Retrieved from http://www.eric.ed.gov

Selin, J. A., & Svanum, S. (1981). Alcoholism and substance abuse training: A survey of graduate programs in clinical psychology. *Professional Psychology: Research and Practice, 12,* 717-721.

Shaffer, H. (1986). Observations on substance abuse theory. *Journal of Counseling and Development, 65*(1), 26-30. Retrieved from http://www.eric.ed.gov

Shenton, A. K. (2004). Strategies for ensuring trustworthiness in qualitative research projects. *Education for Information, 22*(2), 63-75. Retrieved from http://www.eric.ed.gov

Sias, S. M., & Goodwin, L. R., Jr. (2007). Students' reactions to attending 12-step meetings: Implications for counselor education. *Journal of Addictions & Offender Counseling. 27*(2), 113-126. Retrieved from http://www.iaaoc.org

Sias, S. M., Lambie, G. W., & Foster, V. A. (2006). Conceptual and moral development of substance abuse counselors: Implications for training. *Journal of Addictions & Offender Counseling, 26*(2), 99-110. Retrieved from http://www.iaaoc.org

Silverman, D. (2001). *Interpreting qualitative data: Methods for analyzing talk, text and interaction.* London, England: Sage.

Sink, C. (2005). *Contemporary school counseling: Theory research and practice.* Boston, MA: Lahaska Press.

Smith, D. E., & Seymour, R. B. (2001). *Clinicians' guide to substance abuse.* New York, NY: McGraw-Hill.

Stake, R. E. (1994). Case studies. In N. K. Denzin & Y. S. Lincoln (Eds.), *Handbook of qualitative research* (pp. 236-247). Thousand Oaks, CA: Sage.

Substance Abuse and Mental Health Services Administration. (2002). *National household survey on drug abuse.* Retrieved from http://www.samhsa.gov

Substance Abuse and Mental Health Services Administration. (2003). *Results from the 2002 national survey on drug abuse and health: National findings* (NHSDA Series H-22, DHHS Publication No. SMA 03-3836). Rockville, MD: Author.

Taleff, M. J., & Swisher, J. D. (2001). *The seven core functions of a master's degree alcohol and other drug counselor*. University Park, PA: Pennsylvania State University, Counselor Education, Counseling Psychology and Rehabilitation Services Department.

Thombs, D. L. (2006). *Introduction to addictive behaviors.* New York, NY: Guilford.

Thombs, D. L., & Osborn, C. J. (2001). A cluster analytical study of clinical orientations among chemical dependency counselors. *Journal of Counseling & Development, 79,* 450-458.

Torres-Rivera, E., Wilber, M., Phan, L., Maddux, C., & Roberts-Wilber, J. (2004). Counseling Latinos with substance abuse problems. *Journal of Offender and Addiction Counseling, 25*(1), 26-42. Retrieved from http://www.iaaoc.org

U.S. Department of Health and Human Services. (1987). *Confidentiality of alcohol and drug abuse records, 42 federal regulations, 21796-21814.* Washington, DC: U.S. Government Printing Office.

U.S. Department of Health and Human Services. (2001). *Mental health: Culture, race & ethnicity*. A supplement to mental health: A report of the Surgeon General. Rockville, MD: Substance Abuse and Mental Health Services Administration, Center for Mental Health Services.

Vail-Smith, K., & Knight, S. M. (1995). Children of substance abusers in the elementary school: A survey of counselor perceptions. *Elementary School Guidance and Counseling, 29*(3), 163-176. Retrieved from http://www.eric.ed.gov

Vaillant, G. E. (1995). *The natural history of alcoholism.* Cambridge, MA: Harvard University Press.

Von Steen, P. G., Vacc, N. A., & Strickland, I. M. (2002). The treatment of substance-abusing clients in multiservice mental health agencies: A practice analysis. *Journal of Addictions & Offender Counseling, 22*(2), 61-71. Retrieved from http://www.iaaoc.org

Wertz, F. J. (2005). Phenomenological research methods for counseling psychology. *Journal of Counseling Psychology, 52*(2), 176-177. Retrieved from http://www.eric.ed.gov

West, P. L., Mustaine, B. L., & Wyrick, B. (1999). State regulations and the ACA code of ethics and standards of practice: Oil and water for the substance abuse counselor. *Journal of Addictions & Offender Counseling, 20*(1), 35-46.

Westermeyer, J., & Baker, J. M. (1986). Alcoholism and the American Indian. In N. Estes & M. Heinemann (Eds.), *Alcoholism: Development, consequences and interventions* (pp. 273-282). St. Louis, MO: Mosby.

White, W. L. (1993). *Critical incidents: Ethical issues in substance abuse prevention and treatment.* Bloomington, IL: Lighthouse Training Institute.

White, W. L., (2008). Alcohol, tobacco, and other drug use by addictions professionals: Historical reflections and suggested guidelines. *Alcoholism Treatment Quarterly, 26,* 500-535. Retrieved from http://www.williamwhitepapers.com/pr/2008ATOD Use%26AddictionProfessionals.pdf

Zinnbauer, B. J., & Pargament, K. I. (2000). Working with the sacred: Four approaches to religious and spiritual issues in counseling. *Journal of Counseling & Development, 78,* 162-171. doi: 10.1002/j.1556-6676.2000.tb02574.x

APPENDIX A: SEMI-STRUCTURED INTERVIEW PROTOCOL

Participant Code_____

Date of interview ____/____/_____ M/F Age____ LAC/LCAC

1. What specific job duties do you perform as an addictions counselor?
2. What was your training and education to become a licensed addictions counselor?
3. What academic course work in your degree of study prepared you to work in addictions?
4. How relevant was your course work in the application of your duties as an addiction counselor?
5. What courses or experiences would you have liked in your academic program to prepare you to work as an addictions counseling?
6. What suggestions would you have for future counselors in their preparing for their careers?
7. What areas of continuing education would be helpful to you in your work as an addictions counselor?
8. What are the future needs in the addictions profession?

APPENDIX B: SURVEY OF ADDICTIONS COUNSELING PROGRAM

Participant Code_____

Instructions: Below are 18 course titles with course descriptions for consideration in a graduate degree program in addictions counseling. As you read each course title and description circle one of the five choices under each course and move on to the next course. Your answers should be based upon the relevance you deem the course would have in educating someone in performing the duties of an addiction counselor. A score value of 5 will be given for Highly Relevant and descend to a value of 1 for selection of Highly Irrelevant.

1. Multicultural Counseling-The study of the social and cultural foundations of the behavior of individuals, families, and diverse groups. Strategies that promote understanding and effective intervention will be stressed.

Highly Relevant Somewhat Relevant Neutral Somewhat Irrelevant Highly Irrelevant

2. Theory and Techniques in the Helping Relationship- An investigation of the major counseling theories and their applications to the helping relationship. Major therapeutic techniques are studied, practiced, and applied to various theories.

Highly Relevant Somewhat Relevant Neutral Somewhat Irrelevant Highly Irrelevant

3. Theory and Techniques in Group Counseling- The study of group theories, dynamics, process and stages. Group roles and leadership are examined as well as basic and advanced group interventions. Students are required to participate in a therapy group while enrolled in this class.

Highly Relevant Somewhat Relevant Neutral Somewhat Irrelevant Highly Relevant

4. Appraisal of Individuals and Groups- Provide an understanding of the evaluation of individuals and groups. An investigation of appraisal methods that include validity, reliability, and psychometric statistics. Students will be completing several instruments on themselves which will facilitate self-awareness.

Highly Relevant Somewhat Relevant Neutral Somewhat Irrelevant Highly Relevant

5. Research and Evaluation of Methods and Practice -Studies that provide a broad understanding of quantitative and qualitative research designs, research reporting, evaluation, with the use of computers in data collection and analysis.

Highly Relevant Somewhat Relevant Neutral Somewhat Irrelevant Highly Irrelevant

6. Legal, Ethical and Professional Issues-An examination of professional roles and responsibilities with regard to the counseling profession. Includes ethical and legal standards for conduct, professional organizations, credentialing, and developing a plan for lifelong professional and personal development and integrity.

Highly Relevant Somewhat Relevant Neutral Somewhat Irrelevant Highly Irrelevant

7. Issues in Addictions and Recovery- An introduction and general overview to the major areas of substance abuse counseling and behavioral syndromes. This course will focus on areas of pharmacology, neurology, assessment, treatment protocol documentation, and differentiation between process and substance addictions. The course will also review gender, developmental, group and family counseling dynamics, and program administration. Special addiction issues will examine cultural, gambling, eating disorders, sexual addiction, and co-occurring disorders.

Highly Relevant Somewhat Relevant Neutral Somewhat Irrelevant Highly Irrelevant

8. Psychopharmacology-The basic classifications and indications of commonly prescribed psychopharmacological medications. The study of the appropriate uses of these medications, as well as the identification of their effects and side effects.

Highly Relevant Somewhat Relevant Neutral Somewhat Irrelevant Highly Irrelevant

9. Psychopathology-The principles of etiology, diagnosis, treatment, and prevention of mental and emotional disorders. An examination of the assessment and interpretation of mental disorders as outlined in the Diagnostic and Statistical Manual of Mental Disorders (DSM IV).

Highly Relevant Somewhat Relevant Neutral Somewhat Irrelevant Highly Irrelevant

10. Theories and Treatment of Addiction-The major theories and accepted treatment options of addiction and other compulsive behavior syndromes will be examined. Students will critically evaluate the major theories and treatment methods of addiction counseling to formulate their own working theory and treatment approaches of addictions counseling.

Highly Relevant Somewhat Relevant Neutral Somewhat Irrelevant Highly Irrelevant

11. Counseling Addicted Families-The family systems approach to therapy with addicted people in the context of their families, from the perspectives of addiction and recovery. This will require an understanding of family systems and addictions, and a blending of the two.

Highly Relevant Somewhat Relevant Neutral Somewhat Irrelevant Highly Relevant

12. Human Growth and Development-The study of individual and family development across the life span. An examination of cognitive, affective, personality, and moral development throughout life and family life-cycle stages. Attention is given to cultural, gender, and spiritual influences on development.

Highly Relevant Somewhat Relevant Neutral Somewhat Irrelevant Highly Irrelevant

13. Theory and Techniques in Career Counseling-An investigation of career development theory including career decision-making; gender, family, and social/cultural issues, and the use of techniques and assessment instruments that facilitate lifelong career development.

Highly Relevant Somewhat Relevant Neutral Somewhat Irrelevant Highly Irrelevant

14. Foundations in Clinical Mental Health Counseling-This course offers students a comprehensive introduction to clinical mental health counseling. The history and philosophy of mental health counseling, including professional identity, legal and ethical considerations, and credentialing are explored. Students gain an understanding of models and theories related to mental health counseling as well as the operation of mental health services and programs.

Highly Relevant Somewhat Relevant Neutral Somewhat Irrelevant Highly Irrelevant

15. Clinical Mental Health Assessment and Intervention-This course provides students with the knowledge and skills necessary to complete clinical mental health assessments and diagnostic interviews. Students learn various assessment techniques for individuals, couples, families, children, and adolescents. Emphasis will be placed on mental status examinations and procedures for ensuring the safety of suicidal clients. This course will also explore theory and practice of various crisis intervention models and the use of emergency management systems. Culturally responsible interventions for clients and communities will also be explored.

Highly Relevant Somewhat Relevant Neutral Somewhat Irrelevant Highly Irrelevant

16. Ecological Counseling and Prevention-This course is designed to provide students with an understanding of the impact of ecological systems on consumers of mental health services. An examination of preventive counseling and positive psychological theories will be explored. The ecological view of diagnosis and assessment will be emphasized and a wellness model of counseling is considered. In addition, theoretical models of consultation and advocacy within the community and clinical mental health settings are presented.

Highly Relevant Somewhat Relevant Neutral Somewhat Irrelevant Highly Irrelevant

17. Supervised Practicum-A supervised counseling experience in the graduate counseling clinic providing the opportunity to practice individual and group counseling skills. The 100-hour practicum includes a minimum of 40 direct contact hours and weekly individual and group supervision.

Highly Relevant Somewhat Relevant Neutral Somewhat Irrelevant Highly Irrelevant

18. Supervised Internship-The opportunity to practice and provide a variety of counseling related activities in an off-campus setting that would normally be expected of a regularly employed staff member. The 300-hour practicum includes a minimum of 120 hours of direct service and weekly individual and group supervision.

Highly Relevant Somewhat Relevant Neutral Somewhat Irrelevant Highly Irrelevant

APPENDIX C: LETTER TO ADDICTIONS PROVIDER

Communication Disorders
and Counseling, School, and
Educational Psychology

Terre Haute, Indiana 47809
Phone: 812-237-2880
Fax: 812-237-2729

July 1, 2013

Dear Addictions Provider,

My name is Don P. Osborn, and I am a doctoral candidate in Counselor Education and Supervision at Indiana State University. I would like to invite you to participate in my research dissertation on addictions counseling. The research will evaluate academic course work related to preparation to do addictions counseling. Through my research I hope to provide a better understanding of the adequacy of academic course work relative to the workforce duties, and competencies of addiction counseling. Your facility has given permission for the study to be conducted.

There are two main criteria to participate in the study. The first is employment as an addictions provider, and the second is that you have either an undergraduate or graduate licensure as an LAC or LCAC. To give you a brief overview, the research will be conducted at your location, consisting of a single semi-structured audio recorded interview, and short paper/pencil survey, of approximately 75 to 120 minutes. To ensure confidentiality of responses all participants will be given a research code. You will also be asked to read and sign consent to participate. Audio recordings will be transcribed by a transcriptionist who will also sign a confidentiality statement.

To conduct the research, I will be coordinating schedules and communication through a staff member, who will also sign a confidentiality agreement. If you wish to participate give your contact information to your administrative assistant, or contact me at the information below along with any questions you may have.

The deadline to indicate your participation is July 21. Date and time for the interview will be coordinated and you will be notified. Thank you for your consideration to assist me in this research.

Appreciatively,

Don P. Osborn Doctoral Candidate in Counselor Education
Indiana State University
Department of Communication Disorders and Counseling,
School and Educational Psychology
(317)-774-2211 Home
(317)-997-1975 Cell
dposborn@hotmail.com
dosborn3@sycamores.indstate.edu

Tonya Balch PhD
Assistant Professor of Counseling
Department of Communication Disorders and Counseling, School, and Educational Psychology
Bayh College of Education
University Hall Room 302 A
Indiana State University
Terre Haute, IN 47809
(812)- 237-3459 Office
(812)- 237-7613 Fax
tonya.balch@indstate.edu 2013

APPENDIX D: LETTER TO ADMINISTRATION

Communication Disorders
and Counseling, School, and
Educational Psychology

Terre Haute, Indiana 47809
Phone: 812-237-2880
Fax: 812-237-2729

July 1, 2013

Dear Mark,

From our recent phone call I want to thank you for your interest and opportunity to initiate my doctoral research at *Fairbanks*. For some brief information my name is Don Osborn, and I am completing my doctoral degree in Counselor Education at Indiana State University. My dissertation chair is Tonya Balch Ph. D Assistant Professor in the Department of Communication Disorders and Counseling, School and Educational Psychology, in the College of Graduate and Professional Studies at Indiana State University in Terre Haute Indiana. The title of my research is *Evaluating the Academic Preparation of Addictions Counselors in Indiana for Professional Practice.*

To conduct my research I am seeking to meet with interested volunteers from your staff who are addiction providers, and possess an undergraduate or graduate licensure as a LAC or LCAC. I would like to conduct the study on site, in a private place, conducive to meeting with staff in a one on one, one-time-only meeting to conduct an interview and survey of approximately 75 to 120 minutes. The interview will consist of ten questions that will be audio recorded. The survey will be paper and pencil. Participants will sign consent prior to the study and research materials will be coded to protect participant confidentiality.

I am asking your assistance for the following details to conduct the study.

1. A letter of permission on your facility letterhead, from you or appropriate administrator sent to me, indicating that I can come to conduct the study. The letterhead stationery should contain the following: a.) Agreement for the study to be conducted. b.) Identification of someone at the site who will provide information about appropriateness for its population. c.) Assurance of adequate capabilities to perform the research as approved by the IRB. d.) and, if applicable, Assurance that facility personnel involved in data collection have appropriate expertise and will follow IRB approved procedures. I will need the response in the next 7 business days to meet research timelines. Please send an electronic copy and mail a signed hardcopy with signature to me at my contact information below.

2. Include in your letter an administrative assistant, or staff member with their contact information, that you have designated to be apprised of my research. I will need such an individual to coordinate schedules for interviews, and communicate with addictions staff. This will resolve ethical issues related to research, as I will need the administrative assistant or designated staff to sign a confidentiality agreement.
3. I would ask that you announce the study at your facility and see that Announcement of Study flyers are distributed to addiction providers. In doing so please indicate the appropriate contact person at your facility for volunteers to sign up. My contact information is included for those interested in participating should they have questions.
4. Upon receiving your response I will contact the administrative assistant to determine next steps and timelines for volunteers, and schedule a date to arrive to conduct the research including the place for the interview.

Warmly,

Don P. Osborn Doctoral Candidate
Indiana State University
Mailing Address
5903 Crosscut Lane
Noblesville, Indiana 46062-6587
Home 317-774-2211
Cell 317-997-1975
dposborn@hotmail.com
dosborn3@sycamores.indstate.edu

APPENDIX E: FLYER FOR DISTRIBUTION

Addictions Professionals Needed For Research Study

Purpose of the Study: Evaluate the academic preparation of addictions professionals in Indiana for professional practice.

Criteria for Interested Participants: Staff who actively provide addiction services, and hold undergraduate or graduate level license as a LAC or LCAC.

How to Participate: *Your participation is voluntary*. If you meet the criteria, please leave name and contact information with your facilities program administrative assistant or supervisor. 2) Or connect with the researcher at contact information below. Please be sure to give your name, contact number and email.

Procedures of the Study: You will be contacted by the researcher to set up an appointment to conduct the study. The appointment will be 75-120 minutes in length at your location. You will be informed of the purpose of the study, risks, benefits, confidentiality, data collection, review and have the opportunity to review and sign the informed consent. Data collection will involve a one on one 10 question audio recorded interview, and a short paper/pencil survey with the researcher.

Researcher: Don P. Osborn is a PhD Candidate in Guidance and Psychological Services, specializing in Counselor Education and Supervision at Indiana State University in Terre Haute. The research is for completion of a doctoral dissertation. Tonya Balch PhD serves as his dissertation chair.

To participate or ask questions contact Don at:

Phone: **317-774-2211** or Cell **317-997-1975**
Email: **dposborn@hotmail.com** or
dosborn3@sycamores.indstate.edu
Deadline: **August 9, 2013**

APPENDIX F: CONSENT TO PARTICIPATE IN RESEARCH

CONSENT TO PARTICIPATE IN RESEARCH

Evaluating the Academic Preparation of Addiction Counselors in Indiana for Professional Practice

You are asked to participate in a research study conducted by Don P. Osborn, who is a doctoral student from the Department of Communication Disorders and Counseling, School and Educational Psychology at Indiana State University. Mr. Osborn is conducting this study for his doctoral dissertation. Dr. Tonya Balch is his faculty sponsor for the project. Your participation in this study is entirely voluntary. Please read the information below and ask questions about anything you do not understand, before deciding whether or not to participate.

You have been asked to participate in this study because you have met the criteria of working in the area of addictions counseling and possessing either a bachelor's or master's degree license.

• PURPOSE OF THE STUDY

The purpose of this study is to evaluate the undergraduate and graduate academic preparation of those currently working as an addictions counselor.

• PROCEDURES

If you volunteer to participate in this study, you will be asked to do the following things:

You will take part in an interview where you will be asked questions related to your academic preparation and your work experiences as an addictions counselor. You will also be given a survey on courses related to level of significance to addictions counseling. The time involved will be 75 to 120 minutes. The interview will be audio taped and the interview will be paper and pencil responses.

• POTENTIAL RISKS AND DISCOMFORTS

There are at least two possible risks. The first is risk of embarrassment or discomfort, but this risk is not likely greater than normal counseling conversations similar to those participated in everyday by addictions counselors. Further, if participants are uncomfortable they may refuse to answer questions, discontinue participating, or completely withdraw from the study. The second risk is due to the fact that confidentiality cannot be guaranteed. However, the likelihood of breach is being minimized because I am using password protected servers/software and limiting who has access to the tapes (only the transcriber and PI) and transcripts (only the transcriber, PI, and doctoral advisor). The probability and magnitude of harm or discomfort anticipated in the research are not greater in and of themselves than those ordinarily encountered in the daily life of addictions counselors. The risks involved with this study are no more than

risks entailed in a regular conversation or discussion on personal issues. It is possible that some parts of the interview or survey could bring to your awareness some general uneasiness related to your preparation and performance as an addictions counselor. If you are made uncomfortable you may refuse to answer any question, discontinue your participation, or completely withdraw from the study. Another possible risk is that confidentiality cannot be guaranteed. However, I will use password protected servers/software and limit who has access to the tapes (only the transcriber and me) and transcripts (only the transcriber, me, and my doctoral advisor).

The information provided from you may provide information regarding new courses or content in academic preparation specific to the education and training of addictions counselors. The field of addictions counseling with stronger academic standards may become more professional with regard to treatment methods and ethics.

- **POTENTIAL BENEFITS TO SUBJECTS AND/OR TO SOCIETY**

Your participation in this study will not result in any personal or professional benefit to you individually. Your participation could add to the academic and professional competencies of the addictions counseling workforce, from which future counselors and their clients could benefit.

- **CONFIDENTIALITY**

Any information that is obtained in connection with this study and that can be identified with you will remain confidential, and will be disclosed only with your permission or as required by law. Confidentiality will be maintained by means of the following.

An administrative assistant from your facility will assist in the coordination of your participation in the research. The administrative assistant will be aware of your identity to participate, but not aware of the content of your responses.

Each audio tape/recording of the interview and the paper pencil survey will be given a letter, and number code to maintain confidentiality. The code will be known to the researcher and a transcriptionist. The transcriptionist will also sign a confidentiality statement.

All materials that have been coded will be kept in a secure briefcase, in a locked cabinet behind a locked door that is accessible only to the researcher. All coded materials of an audio nature will be erased and all paper pencil documents will be shredded three years after completion of the dissertation by the researcher.

- **PARTICIPATION AND WITHDRAWAL**

You can choose whether or not to be in this study. If you volunteer to be in this study, you may withdraw at any time without penalty or consequences of any kind or loss of benefits to which you are otherwise entitled. Should you do so the audio tape will be erased and paper documents shredded. You may also refuse to answer any questions you do not want to answer. If you decide to not participate after the one-time meeting, please contact me via email or telephone to say “I wish to withdraw from this study.”

. IDENTIFICATION OF INVESTIGATORS

If you have any questions or concerns about this research, please contact the following. Principal Investigator Don P. Osborn at Email dposborn@hotmail.com Home phone 317-774-2211 Cell Phone 317-997-1975 Address 5903 Crosscut Lane Noblesville, Indiana 46062. Faculty Sponsor Dr. Tonya Balch Assistant Professor Email tonya.balch@indstate.edu Office 812-237-3459 Address Indiana State University Bayh College of Education Department of Communication Disorders and Counseling, School and Educational Psychology, Terre Haute, Indiana, 47809.

• RIGHTS OF RESEARCH SUBJECTS

If you have any questions about your rights as a research subject, you may contact the Indiana State University Institutional Review Board (IRB) by mail at Indiana State University, Office of Sponsored Programs, Terre Haute, IN 47809, by phone at (812) 237-8217, or e-mail the IRB at irb@indstate.edu. You will be given the opportunity to discuss any questions about your rights as a research subject with a member of the IRB. The IRB is an independent committee composed of members of the University community, as well as lay members of the community not connected with ISU. The IRB has reviewed and approved this study.

I understand the procedures described above. My questions have been answered to my satisfaction, and I agree to participate in this study. I have been given a copy of this form.

_____
Printed Name of Subject

_____ _____
Signature of Subject Date

APPENDIX G: CONFIDENTIALITY AGREEMENT FOR TRANSCRIPTIONIST

I, _____, will for professional or educational purposes be participating as a transcriptionist in the proposed dissertation research of **Donald P. Osborn** Doctoral Candidate from the Department of Communication Disorders and Counseling, School, and Educational Psychology at Indiana State University. Regardless of my role, I understand and agree that the information and documentation that I will be exposed to during and related to my participation with the proposed research project is confidential. I further acknowledge and agree that I will not, without appropriate authorization, access information that is considered privileged or confidential, release or discuss such privileged or confidential information to anyone other than the primary investigator, Donald P. Osborn, or use such information for unauthorized purposes.

I understand that such authorized purposes only include discussions about the participants and/or the transcription process with the primary investigator while in a secure and private location. I recognize that all transcription of the recorded interviews will occur in a private and secure location while under the supervision of the primary investigator, Donald P. Osborn. I also agree that I will not copy or otherwise take any recordings, documentation or written information from the research project without express permission from the primary investigator.

Regardless of my association with Donald P. Osborn, the research participants, or Indiana State University, I further understand and agree that this confidentiality agreement continues after the end of my affiliation with Donald P. Osborn's dissertation research project and all related parties.

Signature: _____

Date: _____