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FROM TREATMENT LORE TO THEORY APPLICATION

An Introduction to Addiction Theory and Practice

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This text explores multiple theoretical approaches to both the epistemology of addiction and its treatment. It is important for the reader to understand our perspectives as editors because who we are and what we believe ultimately defines the lens through which we have edited this book. Both editors subscribe to a biopsychosocial and spiritual theoretical perspective regarding the causes and maintenance of addiction. We believe that there are crucial biological, psychological, sociological, and spiritual factors at play in the creation of addiction and in the maintenance of that addiction once it has begun. We also both believe that the treatment of addiction must necessarily include all of those aspects in order to adequately address the disease of addiction.

Additionally, we base our work on several underlying assumptions about addiction counseling. These include the following:

- Theories or models are underlying guides in clinical practice that include our beliefs about what causes problems in our lives and about how and why people change in response to those problems. In counseling, our theories reflect who we are as much as they reflect our beliefs about change. In other words, our adopted counseling theories are selected based on our own developmental process and our resulting worldview.
- We assume that counselors should be engaged in an ongoing, reflective practice concerning their biases about addiction and addicted people. Most of us have been impacted by addiction in some way. Personally speaking, after 30-plus years of practice and a strong belief that addiction is a disease that literally hijacks the person's brain, it is still difficult not to fall into moral model beliefs when a young college student is killed by a drunk driver with eight previous convictions of driving while impaired. We have to understand those judgements, accept that we will always have them (just as racism and sexism will always reside within us), and choose consciously not to act out of that place when we provide treatment.
- There is a strong connection between what a counselor believes about the causes and maintenance of addiction and how that counselor will go about treating the addicted client. Likewise, we assume that the chosen theory of counseling determines the type of treatment approach a counselor will choose to take with a client. For example, if

a counselor believes family distress is a major contributing factor to a client's addiction, then the counselor may choose family therapy or a systemic approach as a primary treatment modality. If psychological issues are seen as the underlying cause of the addiction, remedies such as stress reduction techniques or anxiety or depression medication may be sought. Regardless of the counseling theory applied to work with addicted clients, the onus is on the counselor to explore his or her own biases about addiction, addicted people, and proper treatment.

- We also assume that best practices in addiction counseling are supported by a sound theoretical approach that is evidence-based in terms of effectiveness. Whereas not all aspects of theory are "proven" to be effective, our general approaches to treatment ought to be based on empirical support for those practices.

TREATMENT LORE

Training to be a substance abuse counselor during the 1980s, when we came through our own counselor training programs, was quite different from addiction counseling training today. And yet there are many aspects of that early training that remain in today's addiction counseling curriculum. Much of this can be called treatment lore. This lore for working with addicted clients has its history within the development of the field through the 20th century. It is connected to Alcoholics Anonymous and the disease model in many ways. The concepts of treatment lore have been handed down in a way similar to an oral history. With this in mind, please note that we are not taking credit for these concepts and ideas. This is merely a presentation of accumulated lore that we have learned through the years by way of in-service training, our own clinical supervision as counselors, treatment program curricula, and psychoeducational materials used by counselors with clients. And our use of the word *lore* does not suggest that these concepts are untrue. They are simply a part of the accepted culture of addiction counseling, impacting the ways in which addiction counselors perceive and work with clients.

The use of treatment lore continues today, although we believe that in the classroom there has been a significant shift in focus toward empirically based approaches and theories that have solid foundations in the larger counseling and psychotherapy fields. Where treatment lore persists is in the multitude of professional development trainings, workshops, addiction counseling training institutes, and the addiction treatment agencies. Graduates of counseling programs obtain positions in treatment programs that work from this treatment lore approach. Granted, more and more programs are being required to demonstrate that treatment provided is theoretically and empirically grounded. However, this requirement is not universal, resulting in many treatment center and program addiction counselors mashing together ideas, beliefs, and personal experiences into how they work with clients on a day-to-day basis.

Although we do not advocate using treatment lore as the foundation for how counselors work with addicted clients, we believe it is important to present some of these concepts for two reasons. First, it is important that new counseling professionals entering the field understand some of the culture of their intended work environments. Many of these concepts are held to by working addiction counselors at almost a visceral level. We believe

this is due to some of these counselors having either come through their own recovery process or having a close family member in recovery. The result is that these beliefs are directly related to the fact that this professional is still alive and breathing today. Personally speaking, were it not for some or all of these ideas, some of our own family members would be dead due to their addiction. This belief makes for a “true believer” in those who have gone through this experience. And sometimes a true believer can be less open to alternative ways to conceptualize addiction and work with addicted clients.

The second reason for presenting this information is that much of it makes sense and can accurately describe some of the experiences and issues that addicted clients have to address in their process of recovery. This piece of lore helps counseling professionals understand these issues as well, allowing for a better understanding of their client experiences. If some of these ideas are accurate, which we believe is the case, then addiction counselors will be able to teach these ideas to clients and help them progress in their recovery.

In looking at what we consider to be common treatment lore, there are several groups of concepts, including a definition of addiction, descriptors of the illness and how it manifests in clients, and things to consider when working with an addicted client. We briefly discuss these concepts and provide examples of how they are used.

A common issue when beginning work with addicted clients is a resistance to the term *alcoholic* or *drug addict*. Both terms carry many negative connotations and negative stereotypical views. Often clients openly and defiantly state that they are neither one of these types. Our response is to agree with the client, stating that it is not our job to make that determination; it is the client’s right to decide what levels of difficulty he or she has with chemical use. We provide a *common definition* in individual, group, or psychoeducational counseling, stating that addiction is the compulsive use of a mood-altering substance or behavior, which continues even in the face of adverse consequences. One of the best known advocates of this definition has been Father Martin, who has taught this concept in his well renowned video *Chalk Talks* (Kelly Productions, 1972). An important corollary to this definition is that it is important for counselors and clients both to understand that the chemical itself (or behavior in a process addiction) is not the primary problem. Rather, it is the behaviors, cognitions, and emotions surrounding the use and abuse of the chemical (or process) that are important. In other words, it is not the alcohol that is important in alcoholism; it is the “ism” that has to be addressed. Alcoholism, cocaineism, workaholicism, hypersexism, gamblingism, and perfectionism are all about the “ism.” Each one of these “isms” is merely a different way for a person to alter his or her mood. Put another way, “A drug is a drug is a drug.”

Another treatment lore relates to how the *nature of addiction* is explained to clients so that they can understand what they are experiencing as they move through recovery. This description is commonly referred to as 3 *P*s and a *T*. This name stands for addiction being a primary illness that is progressive and persistent and if left unchecked is terminal. A primary illness is one that requires treatment before any other issues or concerns are addressed. In addiction counseling, this is related to clients who may focus on other psychological or emotional problems, bypassing dealing with their addiction problem, thus never addressing this issue. As counseling on the other problem progresses, often a client may begin self-medicating the pain that arises with chemicals or processes, rather than developing more

appropriate and healthy coping strategies. Progress is limited at best and often very temporary. Eventually the counselor may uncover what is actually happening with the client and try to address the chemical use, with varying levels of success. Thus, a successful outcome for the client is blocked due to the primary illness overshadowing any efforts by the client or counselor to make positive changes.

Addiction as a progressive problem refers to the series of negative consequences associated with compulsive unchecked use. These consequences follow a sequence from mild to moderate to severe in nature. Examples of mild consequences include an increase in tolerance to alcohol, onset of memory blackouts, and an inability to stop drinking even once others have done so. Moderate consequences include failed efforts to control intake amount or quit altogether; negative impact on work, finances, and family and friends; and the development of tremors. Severe consequences include physical and moral deterioration, lengthy episodes of intoxication, and a decrease in tolerance to alcohol, also known as reverse tolerance. Each of these levels of severity coincide with viewing addiction through a three-stage model of progression. Jellinek (1960) created a diagram called the Jellinek Curve that displays how clients progress downward through the early, middle, and late stages of addiction. The opposite side of the curve represents steps and progress markers for clients who are working up toward recovery. The two sides create the curve, or U shape, of the progression of addiction and the progression through recovery.

The concept of persistence explains the fact that this problem cannot be ignored with the hope that it will eventually go away or resolve itself. Addiction must be addressed directly, head-on, through active participation in a treatment process. Clients must understand that their work toward recovery cannot become complacent. The idea of persistence is especially difficult for parents to accept, especially when they say to a counselor that the using behavior of a child is just a phase and that the child will grow out of it. Many times this can happen. But more often, once someone's use and abuse of chemicals comes to the attention of professionals, it is well beyond the experimentation stage or phase. At this point, the addiction is present and persistent and will not go away on its own.

The final descriptor, *T*, refers to addiction being a terminal condition. If it is left unchecked, due to its persistent nature and the progression through increasingly severe consequences, then the final outcome is likely to be death. Death may come about in a variety of ways. It can be over the course of time through the physical deterioration of the body (although time here is relative based on the quantity and frequency of individual use). Or death can be a result of participating in risky behaviors due to impaired thinking, such as a traffic fatality. Many addicted people struggle with depression and so are at significant risk of chemically induced suicidal ideation and behaviors, sometimes resulting in a successful suicide.

A second group of descriptors about addicted clients are the three *Ds* of addiction: denial, delusion, and dishonesty. Denial is probably the most commonly known of these three, although the other two appear obvious once considered by the addiction counseling student. As clients progress through addiction, they begin to deny the impact of their behaviors and subsequent consequences. Often they will look to place the blame for any negative consequences on any number of other areas rather than their use and abuse of chemicals. It is common to hear clients refer to getting arrested for driving while impaired as merely having to fill a law enforcement officer's quota of citations. Disregard the fact that the client

was actually driving while impaired. Other clients will attribute their abuse of chemicals to negative or dysfunctional relationships. All of this is denial.

As the denial increases with the progression of addiction, clients will begin to develop patterns of impaired thinking, or delusions, surrounding their chemical abuse. This may include unreasonable resentments toward family and friends. As the chemical or process obsession grows, these can lead to delusional thinking. Often, this delusional thinking supports a delusional belief of persecution by people in the lives of clients.

The third characteristic, dishonesty, is connected to the first two, in that clients will often go to great lengths to avoid the truth of their addiction. This includes the dishonesty toward the self through denial and delusional thinking, as well as dishonesty in everyday interactions with the people they interact with. A system of lies is created that insulates clients from the negative consequences of their behavior. Many people close to the addicted person either openly support this dishonesty through enabling behavior or covertly support the dishonesty by creating their own “reasons” for the abusive behavior and associated consequences. Both of these compensation approaches by friends and family members share a common characteristic of not directly and honestly confronting the inappropriate abuse behavior, thus resulting in shielding, either intentionally or unintentionally, the addicted person from the appropriate negative consequences of his or her behavior. The end result of this complex level of dishonesty is usually a collapse of the delicate system of lies and alibis for the addictive behavior.

Several other treatment lore concepts should be mentioned. One of these is the idea that immediate and complete *abstinence* from all chemicals is the only way for a person to achieve recovery from addiction. Whereas there may be theoretical approaches that support this, and many addiction counselors who profess this as true, it should not be considered an absolute. It is hard to address all of the variance in people through the use of absolute thinking. Many clients have worked through their own recovery process and rebuilt their lives successfully by way of treatment approaches that do not require abstinence.

Another piece of lore is that group counseling is the only way for clients to experience any confrontation of their behaviors and that the group process needs to break through the barrier of denial for addicted clients to finally see what they have done. This is not the case and in fact has a level of paternalistic thinking that could be quite harmful to some clients. It is important for addiction counselors to develop their other awareness of their clients and of their clients' individual circumstances. Some of this paternal thinking can be linked to some counselors bringing their own recovery experiences, or family recovery experiences, into the counseling process and assuming that if it worked for them, then it should work for their clients. This can be a very Eurocentric viewpoint that does not work well in today's diverse society. In addition, it tends to lead counselors toward their own use of the term *denial*. Some counselors will resort to labeling client resistance behaviors as client denial. The client is just not ready to listen, or admit defeat, or acknowledge his or her problem, or admit that others have been harmed. This belief releases the counselor from any responsibility in adjusting his or her approach to more readily meet clients where they are and to create a safe and accepting counseling relationship/environment that fosters honest disclosure and examination of client motivations and behavior. Clients carry enough shame on their own. They do not need more piled on them from their counselors.

There are many more aspects of treatment lore that have not been presented in this brief discussion. We are only trying to give the reader an idea of a few of the concepts and belief systems embedded in the culture of the addiction treatment community. It is important that this information not be taken as an indictment of the many substance abuse professionals and programs. It is not that at all. It is merely provided as information to help new addiction counseling professionals understand the environment that they will be working in, allowing them to integrate some of these concepts into their thinking as they work toward developing a theoretical approach to addiction treatment, similar to any other counseling professional integrating any of the more general counseling theoretical approaches into his or her own personal theoretical framework.

OVERVIEW OF BOOK SECTIONS AND CHAPTERS

In this text, we have organized the chapters into a biopsychosocial framework, and in the final two sections we discuss theoretical approaches to interventions or change strategies and additional issues related to addiction treatment. We begin with a historical overview of the evolution of conceptualizations of addiction and addicted people. This discussion focuses mostly on the development of the moral model, which is not an accepted theory of addiction among counseling professionals today but is rather a societal force that underlies policies and biases that may affect treatment. In this chapter, the reader will understand how Western cultures have shifted from relatively lax positions about substance use and addiction to morally condemning positions. The evolution of addiction as sin is explored, as well as its impact on treatment providers and public policy associated with laws governing drug use. Readers are invited to explore how the moral model and dominant cultural views of addiction have influenced their beliefs. Readers are also encouraged to use this awareness to become reflective and conscious addiction counselors. This discussion is followed by Chapter 3, which presents biological and genetic theories that conceptualize addiction as a product of biology. It focuses on changes in the brain and central nervous system, issues of tolerance and withdrawal, and the body's reaction to different types of drugs, including gender differences in physiological effects. Primary to the discussion is information about pharmacology, neurophysiology, and heredity. The chapter frames addiction as a disease, supporting this perspective with the latest empirical evidence. Information about innovations and uses of medication in addiction treatment are briefly discussed.

The second section of the book presents psychological theories related to the onset, maintenance, and treatment of addiction. Chapter 4 on psychoanalytic theory describes how theorists and clinicians from various points on the psychoanalytic spectrum have understood addiction and its treatment, including historical perspectives. Psychoanalytic theory generally seeks to understand the motivation or the "why" behind addictive behavior. Addiction is seen as a symptom of internal conflict, and the goal is to bring those intrapsychic conflicts into awareness, to make the unconscious conscious. Identifying the underlying cause is key to the removal of the symptom. Contemporary psychoanalytic conceptualizations and applications to treatment of addiction are presented.

Also within the psychological factors section is Chapter 5, "Self-Psychology Theory," which presents views of addiction as a developmental failure to adequately integrate certain

qualities that lead to a cohesive self-structure. These qualities are crucial to later development and can be obtained through a structured experience that helps the addicted person internalize those qualities not received from earlier selfobjects. Information about the impact of trauma related to this theory is also discussed. Recovery, therefore, is conceptualized as a process of self-restoration. Next, Chapter 6 discusses the developmental nature of addiction. This perspective assumes that as people mature or develop, they also mature in their ability to cope with the addictive process and find ways to cope with tendencies toward relapse. The chapter describes the etiology and maintenance of addiction through a developmental lens. It also explores how developmental shifts toward higher levels of consciousness impact addiction across the life span and discusses how these shifts may relate to recovery from addiction.

Also from a psychological perspective, Chapter 7 presents attachment theory as a lens to examine the relationship between attachment style and its impact on one's ability to self-regulate. Addiction is viewed as a disorder of self-regulation (emotions, self-esteem, relationships) and is perceived as a misguided attempt to self-repair. This chapter discusses attachment theory, research, and clinical applications for addicted populations. Information about the impact of trauma related to this theory is also discussed. The ways in which attachment theory is similar and dissimilar to traditional theories of addiction and how existing mechanisms in addiction treatment may be used to increase attachment style growth are explored.

The third section of the book focuses on various sociological factors related to the epistemology and maintenance of addiction. First, Chapter 8 presents addiction through the lens of external, cultural, and contextual factors. From this viewpoint, social influences determine substance use issues, and cultural attitudes toward substances influence individual behavior. Addicted individuals are links in society that are seen as part of a problem related to the whole. Sociological functions of substance use include facilitation of social interaction, release from normal social obligations, and promotion of cohesion among members of a social or ethnic group and may be used as repudiation of "establishment" values. This chapter explores various historical and contemporary sociocultural influences on the epistemology and maintenance of addiction, including sociocultural differences between the United States and other parts of the world. A second chapter in this section, Chapter 9, presents addiction through a family systems lens. This chapter examines the function of addiction within the family system and different approaches to treating the addicted family. Some approaches view addiction as a disease and encourage family members to examine their own issues. Concepts such as codependency, enabling, and family roles are discussed. Other approaches take more of a family systems approach by focusing on how the addiction functions in the family, exploring rules, boundaries, communication, problem solving, and roles. A behavioral family model looks at behaviors of the family that precede and reinforce use, tries to change what occurs before and after use, and addresses relationships in terms of themes, communication styles, and how drug use keeps the relationship stable.

A fourth section of the book explores various theoretical approaches to interventions and change strategies including the transtheoretical model, motivational interviewing, harm reduction, cognitive-behavioral approaches, 12-step facilitation, and postmodern approaches to addiction treatment. The transtheoretical model, including the stages of change, assumes

that change happens when the right process happens at the right time. From this perspective, change is both external and internal and may be viewed as transtheoretical in nature. In Chapter 10, the transtheoretical model theory is presented and discussed in detail, including how the counselor may use change process interventions (experiences and activities) that help the client move from one stage to another. The chapter shows how clients spiral in and out of these stages and how change behavior needs to be viewed within the cultural context.

Motivational interviewing is a client-centered method for enhancing internal motivation for change by exploring and resolving ambivalence within the client. In Chapter 11, motivational interviewing is presented as a style of therapeutic intervention that focuses on developing a collaborative relationship with clients, helping the counselor to roll with client resistance and enhancing client self-efficacy. This chapter is theoretical and practice focused, helping the counselor integrate the stages of change with appropriate motivational interviewing approaches.

Chapter 12 discusses harm reduction models as an approach to addiction treatment. Harm reduction is based on the notion that lifelong abstinence from substances is extremely difficult for addicted populations and that setting incremental goals toward abstinence may be more realistic. Although complete abstinence from mood-altering chemicals or behaviors may be preferred, it may not be attainable for all clients. Examples of harm reduction models are discussed as well as client presentations where it may be preferred over other approaches. An integration of a harm reduction approach with other theoretical models is also explored.

Chapter 13 reviews empirical support of cognitive behavioral theory (CBT) and surveys its application to substance use disorders and treatment. The basic assumptions of CBT are outlined as well as its assumptions about etiology and maintenance of addiction. The goals and tasks of CBT treatment are discussed along with examples of techniques that might be used in counseling.

The history of the 12-step movement is briefly explored in Chapter 14 followed by a description of its conception of the etiology and maintenance of addiction, its integration with other theoretical models (biopsychosocial/spiritual dimensions), empirical evidence of its usefulness, and a discussion of central concepts (e.g., powerlessness, acceptance, denial, spiritual dis-ease, fellowship, time binding, sponsorship, working the steps). The chapter also discusses the use of 12-step groups as an ancillary support in conjunction with counseling and treatment.

Chapter 15 describes three constructivist or postmodern approaches to addiction treatment. Postmodern approaches such as narrative, feminist, and womanist therapy share a common philosophical stance around issues of power, justice, and advocacy. They may, however, look different in clinical application. Problem-saturated stories are common among people struggling with addictions. Narrative approaches view people as separate from their problems and assume people have many competencies, beliefs, values, and skills that will help them reduce the amount of influence problems have over their lives. Narrative concepts such as deconstructive listening, externalizing conversations, unique outcomes, thickening the plot, spreading the news, and mining for hope guide this exploration toward creating alternative stories and preferred realities in therapeutic work. Feminist and womanist approaches to addiction counseling emphasize concepts such as the intersections of personal experience and political realities, the importance of egalitarian relationships, and explorations of voice and resilience.

The fifth section presents additional issues for consideration related to addiction, including process or behavioral addictions, theory and practice of group work with addictions, and relapse prevention approaches. Chapter 16 explores theoretical approaches to process or behavioral addictions and connects the reader to treatment strategies associated with those theories. Assessment, diagnostic issues, and co-occurring issues are also discussed. Current trends and special issues in treatment of process addictions are explored.

Chapter 17 reviews the theoretical basis and efficacy for using group work in addiction treatment. It includes a discussion of the following: the roots of addiction counseling in 12-step groups and communities; the impact of vicarious learning, social support, feedback, hope for change, and how having a common problem can facilitate a common vigilance against relapse; therapeutic factors in groups; stages of group development; effective leadership styles; and special issues in addiction group work (e.g., boundaries around relapse, denial, merging honesty with respect). Practical strategies and techniques are presented that are specific to group work with addicted clients.

Chapter 18 describes relapse as a common occurrence in addiction treatment and recovery. Counselors should understand the etiology and dynamics of relapse so that they are able to design effective prevention strategies. This chapter presents an overview of varying models of relapse prevention, along with empirical support for each model. A discussion of common relapse warning signs and how relapse can be used to enhance treatment is also included.

It is important to note that the fifth edition of the *Diagnostic and Statistical Manual of Mental Disorders (DSM-5)* now combines addictive disorders from two categories in the *DSM-IV* (substance dependence and substance abuse) into a single disorder measured on a continuum from mild to severe. Because of this change in language, terms that have been commonly used in addiction counseling such as *substance abuse* and *chemical dependency* may not fit the new nomenclature of the *DSM-5*. We have chosen to include all current descriptions (not just *DSM-5* language) in the chapters presented by our authors in this book, as they are experts in addiction counseling from across the United States. Likewise, the reader may notice a variety of terms used by different authors to describe individuals struggling with addiction, such as *substance abusers*, *addicted people*, *addicts*, or *people with a substance use disorder*. We felt it was more representative of the profession to be inclusive of all current terminology, rather than be limited by one conceptualization.

As an aid to readers in applying and comparing the various theoretical approaches described in this book, a case study is presented next. Authors respond to the case study based on the theoretical approach being presented. The reader is encouraged to reread the case study with each chapter in order to fully conceptualize the key concepts of each approach. We also encourage the reader to consult the National Association of Alcohol and Drug Abuse Counselors (NAADAC) Code of Ethics provided in the appendix and the American Society of Addiction Medicine (ASAM) placement criteria and levels of care while considering the responses to the case study by each of the chapter authors. Examining each of the responses presented within the context of the ethical guidelines will strengthen the reader's understanding of the practical application of these various clinical approaches.

ADDICTION COUNSELING CASE STUDY

All authors were given the same case study to use as a teaching example. Our intent is to provide one set of client circumstances so that readers may see how the various addiction theories and approaches are similar and different based on application. With all authors addressing the same case study from their particular theoretical approach, readers should be able to easily identify both strengths and weaknesses of the theories, allowing for a more informed decision by addiction counselors in determining their chosen theoretical orientation(s). This is the case study, followed by questions that guide each author's response to the case study.

Gabriel is a biracial male, age 26, single, with no children. He identifies as heterosexual but also states he may be questioning his sexual orientation. His mother is African American and his father is Native American (Cherokee). He was born and raised in a small town in rural Appalachia. Gabriel states his preferred drug is either marijuana or alcohol. He says he has tried some other drugs, including cocaine variants, but has not used IV drugs. His drug use is 2 to 3 times daily; however, he does occasionally go for periods of 2 to 3 days without using. Gabriel reports that he has attempted to stop using several times, including two inpatient hospitalizations. His longest period of abstinence from all chemicals has been 7 weeks, which came after his second inpatient stay. During that time he worked with a sponsor in Alcoholics Anonymous whom he described as a "hard but caring man." He started using again and stopped going to meetings after a breakup with a girlfriend. The most Gabriel has used in a 24-hour period was a full baggie of marijuana and approximately one case of beer. He has many episodes of passing out from drinking/drugging, along with several blackouts. The longest blackout lasted approximately 36 hours.

Gabriel has one older sister who has a history of relationships with men with anger problems and who abuse substances. Her 10-year-old daughter looks up to Gabriel and has begged him to stop using many times. They enjoy playing sports together, and he tries to avoid being around his niece if he has been using. Gabriel reports a strong family history of chemical dependence, including several aunts and uncles with substance use problems. His father has used alcohol and other drugs for as long as he has known him. When Gabriel was an adolescent, he used numerous times with his father. As a matter of fact, his father introduced him to cocaine. He remembers lots of arguing in his home and at times having to physically defend his mother and sister when his father was on a binge. Although he loves his father, he has never had a sober relationship with him and he has never felt completely accepted by him.

Since his parents' divorce 4 years ago, Gabriel has lived with his mother. He is very close to his mother, but he states she has recently started attending Al-Anon meetings and has made recent attempts at setting boundaries around his substance use behavior.

Gabriel has one driving while impaired (DWI) conviction and one marijuana possession conviction. He did not serve time for these offenses, choosing to participate in court-mandated assessments and outpatient education/treatment programs. He is not currently on probation, having completed all requirements for these charges.

Gabriel describes other mental health symptoms consistent with obsessive-compulsive disorder and anxiety disorder. He describes his relationship pattern as going from one

woman to the next. Relationships last up to 6 months, generally, but then end when he learns of the girlfriend's infidelity. Gabriel admits to being unfaithful in these relationships himself. He reports having sexual relationships with two women during his most recent inpatient treatment stay, while being in a "committed" relationship. He feels a great deal of shame about his earliest sexual encounter at age 15, which was with a teenage male friend. He has come for treatment again at the request of his sister and his mother.

The following questions guide authors' responses to the case study:

1. How would you conceptualize this client's problems, needs, issues, and strengths based on the theoretical approach from your chapter?
2. How would you work with this client and/or his family based on the theoretical approach from your chapter?
3. What would be some of the key techniques or strategies consistent with the theoretical approach you would use in treatment?
4. What weaknesses or challenges of your theoretical approach would be highlighted by this particular client's circumstances?
5. What strengths of your theoretical approach would be highlighted by this particular client's circumstances?

In each chapter, authors describe the basic tenets of the theory or approach, discuss the philosophical underpinnings and key concepts of the theory, present how the theoretical approach is used by practitioners, explore implications for assessment and prevention of addiction problems, define the strengths and weaknesses of the theory, apply the theory to the case study, and provide readers with sidebars that will stimulate discussion and deeper understanding of the theory. We believe this unique book expands the understanding of diverse approaches to addiction counseling. Our hope is that it will enhance counseling services provided to individuals and families struggling with addiction.

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APPENDIX

NATIONAL ASSOCIATION OF ALCOHOL AND DRUG ABUSE COUNSELORS

Code of Ethics

I. THE COUNSELING RELATIONSHIP

It is the responsibility of the addiction professional to safeguard the integrity of the counseling relationship and to ensure that the client is provided with services that are most beneficial. The client will be provided access to effective treatment and referral giving consideration to individual educational, legal and financial resources needs. Addiction professionals also recognize their responsibility to the larger society and any specific legal obligations that may, on limited occasions, supersede loyalty to clients. The addiction professional shall provide the client and/or guardian with accurate and complete information regarding the extent of the potential professional relationship. In all areas of function, the addiction professional is likely to encounter individuals who are vulnerable and exploitable. In such relationships he/she seeks to nurture and support the development of a relationship of equals rather than to take unfair advantage. In personal relationships, the addiction professional seeks to foster self-sufficiency and healthy self-esteem in others. In relationships with clients he/she provides only that level and length of care that is necessary and acceptable.

Standard 1: Client Welfare

The addiction professional understands that the ability to do good is based on an underlying concern for the well-being of others. The addiction professional will act for the good of others and exercise respect, sensitivity and insight. The addiction professional understands that the primary professional responsibility and loyalty is to the welfare of his or her clients, and will work for the client irrespective of who actually pays his/her fees.

1. The addiction professional understands and supports actions that will assist clients to a better quality of life, greater freedom and true independence.
2. The addiction professional will support clients in accomplishing what they can readily do for themselves. Likewise, the addiction professional will not insist on pursuing treatment goals without incorporating what the client perceives as good and necessary.
3. The addiction professional understands that suffering is unique to a specific individual and not of some generalized or abstract suffering, such as might be found in the understanding of the disorder. On that basis, the action taken to relieve suffering must be uniquely suited to the suffering individual and not simply some universal prescription.
4. Services will be provided without regard to the compensation provided by the client or by a third party and shall render equally appropriate services to individuals whether they are paying a reduced fee or a full fee or are waived from fees.

Standard 2: Client Self-Determination

The addiction professional understands and respects the fundamental human right of all individuals to self-determination and to make decisions that they consider in their own best interest. In that regard, the counselor will be open and clear about the nature, extent, probable effectiveness and cost of those services to allow each individual to make an informed decision about his or her care. The addiction professional works toward increased competence in all areas of professional functioning; recognizing that at the heart of all roles is an ethical commitment contributing greatly to the well-being and happiness of others. He/she is especially mindful of the need for faithful competence in those relationships that are termed fiduciary—relationships of special trust in which the clients generally do not have the resources to adequately judge competence.

1. The addiction professional will provide the client and/or guardian with accurate and complete information regarding the extent of the potential professional relationship, including the Code of Ethics and documentation regarding professional loyalties and responsibilities.
2. Addiction professionals will provide accurate information about the efficacy of treatment and referral options available to the client.
3. The addiction professional will terminate work with a client when services are no longer required or no longer serve the client's best interest.
4. The addiction professional will take reasonable steps to avoid abandoning clients who are in need of services. Referral will be made only after careful consideration of all factors to minimize adverse effects.
5. The addiction professional recognizes that there are clients with whom he/she cannot work effectively. In such cases, arrangements for consultation, co-therapy or referral are made.
6. The addiction professional may terminate services to a client for nonpayment if the financial contractual arrangements have been made clear to the client and if the client does not pose an imminent danger to self or others. The addiction professional will document discussion of the consequences of nonpayment with the client.
7. When an addiction professional must refuse to accept the client due to inability to pay for services, ethical standards support the addiction professional in attempting to identify other care options. Funding constraints might interfere with this standard.
8. The addiction professional will refer a client to an appropriate resource when the client's mental, spiritual, physical or chemical impairment status is beyond the scope of the addiction professional's expertise. The addiction professional will foster self-sufficiency and healthy self-esteem in others. In relationships with clients, students, employees and supervisors, he/she strives to develop full creative potential and mature, independent functioning.
9. Informed Consent: The addiction professional understands the client's right to be informed about treatment. Informed consent information will be presented in clear and understandable language that informs the client or guardian of the purpose of the services, risks related to the services, limits of services due to requirements from a third party payer, relevant costs, reasonable alternatives and the client's right to refuse

or withdraw consent within the time frames covered by the consent. When serving coerced clients, the addiction professional will provide information about the nature and extent of services, treatment options and the extent to which the client has the right to refuse services. When services are provided via technology such as computer, telephone or web-based counseling, clients are fully informed of the limitations and risks associated with these services. Client questions will be addressed within a reasonable time frame.

10. Clients will be provided with full disclosure including the guarantee of confidentiality if and when they are to receive services by a supervised person in training. The consent to treat will outline the boundaries of the client-supervisee relationship, the supervisee's training status and confidentiality issues. Clients will have the option of choosing not to engage in services provided by a trainee as determined by agency policies. Any disclosure forms will provide information about grievance procedures.

Standard 3: Dual Relationships

The addiction professional understands that the goal of treatment services is to nurture and support the development of a relationship of equals of individuals to ensure protection and fairness of all parties.

Addiction professionals will provide services to clients only in the context of a professional setting. In rural settings and in small communities, dual relationships are evaluated carefully and avoided as much as possible.

1. Because a relationship begins with a power differential, the addiction professional will not exploit relationships with current or former clients, current or former supervisees or colleagues for personal gain, including social or business relationships.
2. The addiction professional avoids situations that might appear to be or could be interpreted as a conflict of interest. Gifts from clients, other treatment organizations or the providers of materials or services used in the addiction professional's practice will not be accepted, except when refusal of such gift would cause irreparable harm to the client relationship. Gifts of value over \$25 will not be accepted under any circumstances.
3. The addiction professional will not engage in professional relationships or commitments that conflict with family members, friends, close associates or others whose welfare might be jeopardized by such a dual relationship.
4. The addiction professional will not, under any circumstances, engage in sexual behavior with current or former clients.
5. The addiction professional will not accept as clients anyone with whom they have engaged in romantic or sexual relationships.
6. The addiction professional makes no request of clients that does not directly pertain to treatment (giving testimonials about the program or participating in interviews with reporters or students).
7. The addiction professional recognizes that there are situations in which dual relationships are difficult to avoid. Rural areas, small communities and other situations necessitate discussion of the counseling relationship and take steps to distinguish the counseling relationship from other interactions.

8. When the addiction professional works for an agency such as department of corrections, military, an HMO or as an employee of the client's employer, the obligations to external individuals and organizations are disclosed prior to delivering any services.
9. The addiction professional recognizes the challenges resulting from increased role of the criminal justice system in making referrals for addiction treatment. Consequently he/she strives to remove coercive elements of such referrals as quickly as possible to encourage engagement in the treatment and recovery process.
10. The addiction professional encourages self-sufficiency among clients in making daily choices related to the recovery process and self care.
11. The addiction professional shall avoid any action that might appear to impose on others' acceptance of their religious/spiritual, political or other personal beliefs while also encouraging and supporting participation in recovery support groups.

Standard 4: Group Standards

Much of the work conducted with substance use disorder clients is performed in group settings. Addiction professionals shall take steps to provide the required services while providing clients physical, emotional, spiritual and psychological health and safety.

1. Confidentiality standards are established for each counseling group by involving the addiction professional and the clients in setting confidentiality guidelines.
2. To the extent possible, addiction professionals will match clients to a group in which other clients have similar needs and goals.

Standard 5: Preventing Harm

The addiction professional understands that every decision and action has ethical implication leading either to benefit or harm, and will carefully consider whether decisions or actions have the potential to produce harm of a physical, psychological, financial, legal or spiritual nature before implementing them. The addiction professional recognizes that even in a life well lived, harm may be done to others by thoughtless words and actions. If he/she becomes aware that any word or action has done harm to anyone, he/she readily admits it and does what is possible to repair or ameliorate the harm except where doing so might cause greater harm.

1. The addiction professional counselor will refrain from using any methods that could be considered coercive such as threats, negative labeling and attempts to provoke shame or humiliation.
2. The addiction professional develops treatment plans as a negotiation with the client, soliciting the client's input about the identified issues/needs, the goals of treatment and the means of reaching treatment goals.
3. The addiction professional will make no requests of clients that are not necessary as part of the agreed treatment plan. At the beginning of each session, the client will be informed of the intent of the session. Collaborative effort between the client and the addiction professional will be maintained as much as possible.
4. The addiction professional will terminate the counseling or consulting relationship when it is reasonably clear that the client is not benefiting from the exchange.

5. The addiction professional understands the obligation to protect individuals, institutions and the profession from harm that might be done by others. Consequently there is awareness when the conduct of another individual is an actual or likely source of harm to clients, colleagues, institutions or the profession. The addiction professional will assume an ethical obligation to report such conduct to competent authorities.
6. The addiction professional defers to review by a human subjects committee (Institutional Review Board) to ensure that research protocol is free of coercion and that the informed consent process is followed. Confidentiality and deceptive practices are avoided except when such procedures are essential to the research protocol and are approved by the designated review board or committee.
7. When research is conducted, the addiction professional is careful to ensure that compensation to subjects is not as great or attractive as to distort the client's ability to make free decisions about participation.

II. EVALUATION, ASSESSMENT AND INTERPRETATION OF CLIENT DATA

The addiction professional uses assessment instruments as one component of the counseling/treatment process taking into account the client's personal and cultural background. The assessment process promotes the well-being of individual clients or groups. Addiction professionals base their recommendations/reports on approved evaluation instruments and procedures. The designated assessment instruments are ones for which reliability has been verified by research.

Standard 1: Scope of Competency

The addiction professional uses only those assessment instruments for which they have been adequately trained to administer and interpret.

Standard 2: Informed Consent

Addiction professionals obtain informed consent documentation prior to conducting the assessment except when such assessment is mandated by governmental or judicial entities and such mandate eliminates the requirement for informed consent.

When the services of an interpreter are required, addiction professionals must obtain informed consent documents and verification of confidentiality from the interpreter and client. Addiction professionals shall respect the client's right to know the results of assessments and the basis for conclusions and recommendations. Explanation of assessment results is provided to the client and/or guardian unless the reasons for the assessment preclude such disclosure or if it is deemed that such disclosure will cause harm to the client.

Standard 3: Screening

The formal process of identifying individuals with particular issues/needs or those who are at risk for developing problems in certain areas is conducted as a preliminary procedure to determine whether or not further assessment is warranted at that time.

Standard 4: Basis for Assessment

Assessment tools are utilized to gain needed insight in the formulation of the most appropriate treatment plan. Assessment instruments are utilized with the goal of gaining an understanding of the extent of a person's issues/needs and the extent of addictive behaviors.

Standard 5: Release of Assessment Results

Addiction professionals shall consider the examinee's welfare, explicit understanding of the assessment process and prior agreements in determining where and when to report assessment results. The information shared shall include accurate and appropriate interpretations when individual or group assessment results are reported to another entity.

Standard 6: Release of Data to Qualified Professionals

Information related to assessments is released to other professionals only with a signed release of information form or such a release from the client's legal representative. Such information is released only to persons recognized as qualified to interpret the data.

Standard 7: Diagnosis of Mental Health Disorders

Diagnosis of mental health disorders shall be performed only by an authorized mental health professional licensed or certified to conduct mental health assessments or by a licensed or certified addictions counselor who has completed graduate level specific education on diagnosis of mental health disorders.

Standard 8: Unsupervised Assessments

Unless the assessment instrument being used is designed, intended and validated for self-administration and/or scoring, addiction professional administered tests will be chosen and scored following the recommended methodology.

Standard 9: Assessment Security

Addiction professionals maintain the integrity and security of tests and other assessment procedures consistent with legal and contractual obligations.

Standard 10: Outdated Assessment Results

Addiction professionals avoid reliance on outdated or obsolete assessment instruments. Professionals will seek out and engage in timely training and/or education on the administration, scoring and reporting of data obtained through assessment and testing procedures. Intake data and other documentation obtained from clients to be used in recommending treatment level and in treatment planning are reviewed and approved by an authorized mental health professional or a licensed or qualified addiction professional with specific education on assessment and testing.

Standard 11: Cultural Sensitivity Diagnosis

Addiction professionals recognize that cultural background and socioeconomic status impact the manner in which client issues/needs are defined. These factors are carefully considered

when making a clinical diagnosis. Assessment procedures are chosen carefully to ensure appropriate assessment of specific client populations. During assessment the addiction professional shall take appropriate steps to evaluate the assessment results while considering the culture and ethnicity of the persons being evaluated.

Standard 12: Social Prejudice

Addiction professionals recognize the presence of social prejudices in the diagnosis of substance use disorders and are aware of the long term impact of recording such diagnoses. Addiction professionals refrain from making and/or reporting a diagnosis if they think it would cause harm to the client or others.

III. CONFIDENTIALITY/PRIVILEGED COMMUNICATION AND PRIVACY

Addiction professionals shall provide information to clients regarding confidentiality and any reasons for releasing information in adherence with confidentiality laws. When providing services to families, couples or groups, the limits and exceptions to confidentiality must be reviewed and a written document describing confidentiality must be provided to each person. Once private information is obtained by the addiction professional, standards of confidentiality apply. Confidential information is disclosed when appropriate with valid consent from a client or guardian. Every effort is made to protect the confidentiality of client information, except in very specific cases or situations.

1. The addiction professional will inform each client of the exceptions to confidentiality and only make a disclosure to prevent or minimize harm to another person or group, to prevent abuse of protected persons, when a legal court order is presented, for purpose of research, audit, internal agency communication or in a medical emergency. In each situation, only the information essential to satisfy the reason for the disclosure is provided.
2. The addiction professional will do everything possible to safeguard the privacy and confidentiality of client information, except where the client has given specific, written, informed and limited consent or when the client poses a risk of harm to themselves or others.
3. The addiction professional will inform the client of his/her confidentiality rights in writing as a part of informing the client of any areas likely to affect the client's confidentiality.
4. The addiction professional will explain the impact of electronic records and use of electronic devices to transmit confidential information via fax, email or other electronic means. When client information is transmitted electronically, the addiction professional will, as much as possible, utilize secure, dedicated telephone lines or encryption programs to ensure confidentiality.
5. Clients are to be notified when a disclosure is made, to whom the disclosure was made and for what purposes.
6. The addiction professional will inform the client and obtain the client's agreement in areas likely to affect the client's participation including the recording of an interview,

the use of interview material for training purposes and/or observation of an interview by another person.

7. The addiction professional will inform the client(s) of the limits of confidentiality prior to recording an interview or prior to using information from a session for training purposes.

IV. PROFESSIONAL RESPONSIBILITY

The addiction professional espouses objectivity and integrity and maintains the highest standards in the services provided. The addiction professional recognizes that effectiveness in his/her profession is based on the ability to be worthy of trust. The professional has taken time to reflect on the ethical implications of clinical decisions and behavior using competent authority as a guide. Further, the addiction professional recognizes that those who assume the role of assisting others to live a more responsible life take on the ethical responsibility of living a life that is more than ordinarily responsible. The addiction professional recognizes that even in a life well-lived, harm might be done to others by words and actions. When he/she becomes aware that any work or action has done harm, he/she admits the error and does what is possible to repair or ameliorate the harm except when to do so would cause greater harm. Professionals recognize the many ways in which they influence clients and others within the community and take this fact into consideration as they make decisions in their personal conduct.

Standard 1: Counselor Attributes

1. Addiction professionals will maintain respect for institutional policies and management functions of the agencies and institutions within which the services are being performed, but will take initiative toward improving such policies when it will better serve the interest of the client.
2. The addiction professional, as an educator, has a primary obligation to help others acquire knowledge and skills in treating the disease of substance use disorders.
3. The addiction professional, as an advocate for his or her clients, understands that he/she has an obligation to support legislation and public policy that recognizes treatment as the first intervention of choice for non-violent substance-related offenses.
4. The addiction professional practices honesty and congruency in all aspects of practice including accurate billing for services, accurate accounting of expenses, faithful and accurate reporting of interactions with clients and accurate reporting of professional activities.
5. The addiction professional recognizes that much of the property in the substance use disorder profession is intellectual in nature. In this regard, the addiction professional is careful to give appropriate credit for the ideas, concepts and publications of others when speaking or writing as a professional and as an individual.
6. The addiction professional is aware that conflicts can arise among the duties and rights that are applied to various relationships and commitments of his/her life. Priorities are set among those relationships and family, friends and associates are informed to the priorities established in order to balance these relationships and the duties flowing from them.

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7. When work involves addressing the needs of potentially violent clients, the addiction professional will ensure that adequate safeguards are in place to protect clients and staff from harm.
8. Addiction professionals shall continually seek out new and effective approaches to enhance their professional abilities including continuing education research, and participation in activities with professionals in other disciplines.
9. Addiction professionals have a commitment to lifelong learning and continued education and skills to better serve clients and the community.
10. The addiction professional respects the differing perspectives that might arise from professional training and experience other than his/her own. In this regard, common ground is sought rather than striving for ascendance of one opinion over another.
11. Addiction professionals, whether they profess to be in recovery or not, must be cognizant of ways in which their use of psychoactive chemicals in public or in private might adversely affect the opinion of the public at large, the recovery community, other members of the addiction professional community or, most particularly, vulnerable individuals seeking treatment for their own problematic use of psychoactive chemicals. Addiction professionals who profess to be in recovery will avoid impairment in their professional or personal lives due to psychoactive chemicals. If impairment occurs, they are expected to immediately report their impairment, to take immediate action to discontinue professional practice and to take immediate steps to address their impairment through professional assistance. (See Standard 2, item 3 below.)

Standard 2: Legal and Ethical Standards

Addiction professionals will uphold the legal and ethical standards of the profession by being fully cognizant of all federal laws and laws that govern practice of substance use disorder counseling in their respective state. Furthermore, addiction professionals will strive to uphold not just the letter of the law and the Code, but will espouse aspirational ethical standards such as autonomy, beneficence, non-maleficence, justice, fidelity and veracity.

1. Addiction professionals will honestly represent their professional qualifications, affiliations, credentials and experience.
2. Any services provided shall be identified and described accurately with no unsubstantiated claims for the efficacy of the services. Substance use disorders are to be described in terms of information that has been verified by scientific inquiry.
3. The addiction professional strives for a better understanding of substance use disorders and refuses to accept supposition and prejudice as if it were the truth.
4. The impact of impairment on professional performance is recognized; addiction professionals will seek appropriate treatment for him/herself or for a colleague. Addiction professionals support the work of peer assistance programs to assist in the recovery of colleagues or themselves.
5. The addiction professional will ensure that products or services associated with or provided by the member by means of teaching, demonstration, publications or other types of media meet the ethical standards of this code.
6. The addiction professional who is in recovery will maintain a support system outside the work setting to enhance his/her own well-being and personal growth as well as promoting continued work in the professional setting.

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7. The addiction professional will maintain appropriate property, life and malpractice insurance policies that serve to protect personal and agency assets.

Standard 3: Records and Data

The addiction professional maintains records of professional services rendered, research conducted, interactions with other individuals, agencies, legal and medical entities regarding professional responsibilities to clients and to the profession as a whole.

1. The addiction professional creates, maintains, disseminates, stores, retains and disposes of records related to research, practice, payment for services, payment of debts and other work in accordance with legal standards and in a manner that permits/satisfies the ethics standards established. Documents will include data relating to the date, time and place of client contact, the services provided, referrals made, disclosures of confidential information, consultation regarding the client, notation of supervision meetings and the outcome of every service provided.
2. Client records are maintained and disposed of in accordance with law and in a manner that meets the current ethical standards.
3. Records of client interactions including group and individual counseling services are maintained in a document separate from documents recording financial transactions such as client payments, third party payments and gifts or donations.
4. Records shall be kept in a locked file cabinet or room that is not easily accessed by professionals other than those performing essential services in the care of clients or the operation of agency.
5. Electronic records shall be maintained in a manner that assures consistent service and confidentiality to clients.
6. Steps shall be taken to ensure confidentiality of all electronic data and transmission of data to other entities.
7. Notes kept by the addiction professional that assist the professional in making appropriate decisions regarding client care but are not relevant to client services shall be maintained in separate, locked locations.

Standard 4: Interprofessional Relationships

The addiction professional shall treat colleagues with respect, courtesy, fairness and good faith and shall afford the same to other professionals.

1. Addiction professionals shall refrain from offering professional services to a client in counseling with another professional except with the knowledge of the other professional or after the termination of the client's relationship with the other professional.
2. The addiction professional shall cooperate with duly constituted professional ethics committees and promptly supply necessary information unless constrained by the demands of confidentiality.
3. The addiction professional shall not in any way exploit relationships with supervisees, employees, students, research participants or volunteers.

V. WORKING IN A CULTURALLY DIVERSE WORLD

Addiction professionals understand the significance of the role that ethnicity and culture plays in an individual's perceptions and how he or she lives in the world. Addiction professionals shall remain aware that many individuals have disabilities which may or may not be obvious. Some disabilities are invisible and unless described might not appear to inhibit expected social, work and health care interactions. Included in the invisible disabled category are those persons who are hearing impaired, have a learning disability, have a history of brain or physical injuries and those affected by chronic illness. Persons having such limitations might be younger than age 65. Part of the intake and assessment must then include a question about any additional factor that must be considered when working with the client.

1. Addiction professionals do not discriminate either in their professional or personal lives against other persons with respect to race, ethnicity, national origin, color, gender, sexual orientation, veteran status, gender identity or expression, age, marital status, political beliefs, religion, immigration status and mental or physical challenges.
2. Accommodations are made as needed for clients who are physically, mentally, educationally challenged or are experiencing emotional difficulties or speak a different language than the clinician.

VI. WORKPLACE STANDARDS

The addiction professional recognizes that the profession is founded on national standards of competency which promote the best interests of society, the client, the individual addiction professional and the profession as a whole. The addiction professional recognizes the need for ongoing education as a component of professional competency and development.

1. The addiction professional recognizes boundaries and limitations of their own competencies and does not offer services or use techniques outside of their own professional competencies.
2. Addiction professionals recognize the impact of impairment on professional performance and shall be willing to seek appropriate treatment for oneself or for a colleague.

Working Environment

Addiction professionals work to maintain a working/therapeutic environment in which clients, colleagues and employees can be safe. The working environment should be kept in good condition through maintenance, meeting sanitation needs and addressing structural defects.

1. The addiction professional seeks appropriate supervision/consultation to ensure conformance with workplace standards.
2. The clerical staff members of the treatment agency hired and supervised by addiction professionals are competent, educated in confidentiality standards and respectful of clients seeking services.
3. Private work areas that ensure confidentiality will be maintained.

VII. SUPERVISION AND CONSULTATION

Addiction professionals who supervise others accept the obligation to facilitate further professional development of these individuals by providing accurate and current information, timely evaluations and constructive consultation. Counseling supervisors are aware of the power differential in their relationships with supervisees and take precautions to maintain ethical standards. In relationships with students, employees and supervisees he/she strives to develop full creative potential and mature independent functioning.

1. Addiction professionals must take steps to ensure appropriate resources are available when providing consultation to others. Consulting counselors use clear and understandable language to inform all parties involved of the purpose and expectations related to consultation.
2. Addiction professionals who provide supervision to employees, trainees and other counselors must have completed education and training specific to clinical and/or administrative supervision. The addiction professional who supervises counselors in training shall ensure that counselors in training adhere to policies regarding client care.
3. Addiction professionals serving as supervisors shall clearly define and maintain ethical professional, personal and social relationships with those they supervise. If other professional roles must be assumed, standards must be established to minimize potential conflicts.
4. Sexual, romantic or personal relationships with current supervisees are prohibited. Supervision of relatives, romantic partners or friends is prohibited.
5. Supervision meetings are conducted at specific regular intervals and documentation of each meeting is maintained.
6. Supervisors are responsible for incorporating the principles of informed consent into the supervision relationship.
7. Addiction professionals who serve as supervisors shall establish and communicate to supervisees the procedures for contacting them, or in their absence alternative on-call supervisors.
8. Supervising addiction professionals will assist those they supervise in identifying counter-transference and transference issues. When the supervisee is in need of counseling to address issues related to professional work or personal challenges, appropriate referrals shall be provided.

VIII. RESOLVING ETHICAL ISSUES

The addiction professional shall behave in accordance with legal, ethical and moral standards for his or her work. To this end, professionals will attempt to resolve ethical dilemmas with direct and open communication among all parties involved and seek supervision and/or consultation as appropriate.

1. When ethical responsibilities conflict with law, regulations or other governing legal authority, addiction professionals should take steps to resolve the issue through consultation and supervision.

2. When addiction professionals have knowledge that another counselor might be acting in an unethical manner, they are obligated to take appropriate action based, as appropriate, on the standards of this code of ethics, their state ethics committee and the National Certification Commission.
3. When an ethical dilemma involving a person not following the ethical standards cannot be resolved informally, the matter shall be referred to the state ethics committee and the National Certification Commission.
4. Addiction professionals will cooperate with investigations, proceedings and requirements of ethics committees.

IX. COMMUNICATION AND PUBLISHED WORKS

The addiction professional who submits for publication or prepares handouts for clients, students or for general distribution shall be aware of and adhere to copyright laws.

1. The addiction professional honestly respects the limits of present knowledge in public statements related to alcohol and drug abuse. Statements of fact will be based on what has been empirically validated as fact. Other opinions, speculations and conjectures related to the addictive process shall be represented as less than scientifically validated.
2. The addiction professional recognizes contributions of other persons to their written documents.
3. When a document is based on cooperative work, all contributors are recognized in documents or during a presentation.
4. The addiction professional who reviews material submitted for publication, research or other scholarly purposes must respect the confidentiality and proprietary rights of the authors.

X. POLICY AND POLITICAL INVOLVEMENT

Standard 1: Societal Obligations

The addiction professional is strongly encouraged to the best of his/her ability to actively engage the legislative processes, educational institutions and the general public to change public policy and legislation to make possible opportunities and choice of service for all human beings of any ethnic or social background whose lives are impaired by alcoholism and drug abuse.

1. The addiction professional understands that laws and regulations exist for the good ordering of society and for the restraint of harm and evil and will follow them, while reserving the right to commit civil disobedience.
2. The one exception to this principle is a law or regulation that is clearly unjust, where compliance leads to greater harm than breaking a law.
3. The addiction professional understands that the determination that a law or regulation is unjust is not a matter of preference or opinion but a matter of rational investigation, deliberation and dispute, and will willingly accept that there may be a penalty for justified civil disobedience.

Standard 2: Public Participation

The addiction professional is strongly encouraged to actively participate in community activities designed to shape policies and institutions that impact on substance use disorders. Addiction professionals will provide appropriate professional services in public emergencies to the greatest extent possible.

Standard 3: Social and Political Action

The addiction professional is strongly encouraged to understand that personal and professional commitments and relationships create a network of rights and corresponding duties and will work to safeguard the natural and consensual rights of each individual within their community. The addiction professional understands that social and political actions and opinions are an individual's right and will not work to impose their social or political views on individuals with whom they have a professional relationship.

This resource was designed to provide an ethics code and ethical standards that will be used by counseling professionals. These principles of ethical conduct outline the importance of having ethical standards and the importance of adhering to those standards. These principles can help professionals face ethical dilemmas in their practice and explore ways to avoid them.