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Professional Ethics

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Introduction

The goals of this chapter are to: 1) introduce you to some of the basic terms and concepts related to professional ethics in addiction counseling, 2) increase your ethical sensitivities by orienting you to the ethical terrain of addiction counseling, 3) enhance your ethical decision-making abilities through exposure to one model of ethical decision-making, and 4) provide you with guidelines about how to reduce your ethical vulnerability as an addictions counselor. I encourage you to apply the ethical standards of your own agency and your state certification/licensure board in your reflections on the dilemmas discussed in this chapter. Standards from two national bodies will be referenced in our discussions: NAADAC, The Association for Addiction Professional's ethical standards for counselors (www.naadac.org), and the International Certification & Reciprocity Consortium/Alcohol & Other Drug Abuse, Inc.'s (ICRC) codes of ethics for clinical supervisors and for prevention specialists (www.icrcaoda.org).

What do we mean when we use terms like “ethics” “ethical” and “unethical”?

There are many judgments that others can make about what you as an addictions counselor do or fail to do. A single act could be judged by others to be immoral, illegal, professionally inappropriate, or unethical, with each of these terms springing from very different frameworks of reference. Striving for a high level of ethical conduct is at its most aspirational level about *beneficence*—promoting the health of all parties touched by the counseling process. At its most basic level, it is about preventing harm to: 1) your clients/families, 2) yourself, 3) your agency, 4) your profession, 5) and your community. The best interests of these multiple parties can conflict within one another, which is what makes ethical decision-making difficult. Three terms help distinguish the ethical from other frameworks of judging professional conduct.

The first term, *iatrogenic*, is a medical term that means physician-caused, or treatment-caused, harm or injury. The term suggests that actions you initiate as an addictions counselor with the most noble of intentions could have unintended and harmful effects. In the past 200 years, there have been many such iatrogenic practices within addiction treatment: multi-year

legal commitments, mandatory sterilizations, invasive psychosurgeries, drug insults of numerous varieties (e.g., treating morphine addiction with cocaine), emotional and sexual exploitation of clients, and financial exploitation of clients and their families.

In professions where there is a potential for such harm, services to clients are delivered within the context of a *fiduciary relationship*. This means that as an addictions counselor, you take on a special duty and obligation for the care of the client/family, and that this relationship must be governed by the highest standards of competence and objectivity. Most importantly, it means that the needs and interests that drive decision-making in this relationship are those of the client/family. Unlike most other relationships in your life, the fiduciary relationship is not a relationship of equal power nor is it reciprocal like most family and social relationships. Everything you do as a counselor should flow out of this special duty and obligation.

Another term governing the relationship between you and your clients is that of *boundary*. Boundary management reflects the relative pace and degree of intimacy in your service relationship with a client. If we were to construct a continuum of intimacy within the relationship between yourself and your clients, three zones could be plotted: 1) a zone of safety for both you and your clients (actions that are always okay), 2) a zone of vulnerability in terms of increased attachment or disengagement (actions that are sometimes okay and sometimes not okay), and 3) a zone of abuse in terms of harmful intimacy or detachment (actions that are never okay) (Milgrom 1992). The boundaries between these zones are not well-marked and may vary with different clients and even with the same client at different stages of the service relationship.

What distinguishes what is ethical from what is legal?

Ideally, standards of legal and ethical conduct are congruent (what is ethical is also legal and what is unethical is also illegal). But the relationship between ethics and law is actually quite complex. There are situations in which: a) what is ethical is illegal (breaking an unjust law), b) what is unethical is legal (complying with an unjust law), and situations in which c) what is ethical or unethical is alegal (not addressed in law) (Thompson, 1990). The question of what is ethical or unethical is thus a more complicated issue than the question of what is legal or illegal. To rely only on the latter would constitute a process of legal reductionism that shrinks ethical complexities to the arena of legal interpretation. The best models of ethical decision-making integrate questions of ethics and law within the decision-making process.

What are the major zones of ethical vulnerability in the practice of addiction counseling?

A review of the two primary texts on ethical issues in addiction treatment (Bissell & Royce, 1987 and White & Popovits, 2001) reveal seven zones of vulnerability in the practice of addiction counseling: 1) personal conduct, 2) conduct related to business practices, 3) professional conduct unrelated to clinical services, 4) conduct in relationships with clients and families, 5) conduct in professional peer relationships, 6) conduct involving threats to safety, and 7) ethical issues in special roles/functions, e.g., prevention, early intervention, training, and research.

When examined in terms of their prevalence within the field of addiction counseling (as measured by complaints regarding ethical breaches filed with state licensing boards), the three most common complaints are sexual exploitation of a current client, personal impairment due to substance use or another condition, and practicing addiction counseling without a certificate (St. Germaine, 1997).

What factors must be considered in ethical decision-making?

There are many models of ethical decision-making that you might find helpful in your role as an addictions counselor (Wagner, 2001). The model proposed by myself and Renée Popovits (2002) involves three steps. The first step is to analyze the situation in terms of who will potentially benefit and who could potentially be harmed. This requires detailing both the probability and degree of benefit and harm to multiple parties. This first step also examines whose interests in the situation might be in conflict, e.g., what is best for the client in a particular situation may not be what is best for you or your agency.

The second step asks you to examine whether there are any universal or culturally-relevant values that apply to the situation, and what actions those values might dictate that you take in the situation (See table later in this chapter). The question of culturally-relevant values suggests that ethical standards might differ across different cultural contexts, e.g., that an action that could be beneficial in one cultural context might do harm or injury in another context.

The third step asks you to explore how existing ethical codes, laws, regulations, organizational policies or historical practices apply to the situation in question. This model provides a framework for individual decision-making, but also underscores the need for seeking consultation on ethical dilemmas.

What are the major codes of ethical conduct governing the practice of addiction counseling?

As an addictions counselor, you may be accountable to multiple codes of ethics. You may be bound by codes of ethics linked to a) national and/or state addictions counselor certification/licensure systems, b) state and national professional associations, e.g., NAADAC, c) professional licenses/certificates held in addition to addiction counseling, e.g., ethical codes for psychologists, social workers, professional counselors, employee or student assistance professionals, and d) agency codes of ethics that are a condition of your employment. The existence of multiple and qualitatively different standards to which you may be held accountable raises the question of which standards apply in particular situations. To afford the greatest protection for your clients, yourself, your employing agency, the addiction counseling profession and the public, it is generally best to be guided by the more stringent standard, except where the application of the more stringent standard would do harm to the client/family to whom we have pledged fiduciary responsibility.

What ethical principles underlie the practice of addiction counseling?

The codes of ethics that have evolved to guide the practice of addiction counseling draw heavily upon earlier traditions of ethical standards development in the fields of medicine, psychology and social work. Typical of the principles that undergird addiction counseling are the following twelve principles within the NAADAC Code of Ethics: 1) non-discrimination; 2) responsibility (for objectivity and integrity); (3) competence; (4) legal and moral standards; (5) public statements; (6) publication credit; (7) client welfare; (8) confidentiality; (9) client relationships; (10) interprofessional relationships; (11) remuneration; and (12) societal obligations (NAADAC, 1994).

The universal values considered within the White/Popovits (2001) model of ethical decision-making are displayed below.

Exhibit 10-A: Universal Professional Values*
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Autonomy (Freedom over one's destiny)
Obedience (Obey legal and ethically permissible directives)
Conscientious Refusal (Disobey illegal or unethical directives)
Beneficence (Do good; help others)
Gratitude (Pass good along to others)
Competence (Be knowledgeable and skilled)
Justice (Be fair; distribute by merit)
Stewardship (Use resources wisely)
Honesty and Candor (Tell the truth)
Fidelity (Keep your promises)
Loyalty (Don't abandon)
Diligence (Work hard)
Discretion (Respect confidence and privacy)
Self-improvement (Be the best that you can be)
Nonmaleficence (Don't hurt anyone)
Restitution (Make amends to persons injured)
Self-interest (Protect yourself)

* From White, W., & Popovitz, R. (2001). *Critical Incidents: Ethical Issues in the Prevention and Treatment of Addiction*. Bloomington, IL: Chestnut Health Systems. Used with permission.

What professional duties and obligations do you have as an addictions counselor during non-working hours?

As an addictions counselor, you have rights to privacy—areas of your life that are not open to professional scrutiny or accountability, but you also have duties and obligations that transcend an 8-hour work shift. The question then is where and how one draws this line between your rights to privacy and your professional duties and obligations. The concept of “nexus” has been used to define this boundary. The principle upon which it is based is that what you as an addictions counselor do in your own private life is exactly that—PRIVATE—until such time as there is an inextricable nexus—linkage or connection—between that private behavior and your professional performance. What you implicitly pledge when you enter this field is to not do anything in your personal life that destroys your ability to function as an addictions counselor. You must, for example, avoid private conduct (e.g., illegal or immoral behavior) that threatens your reputation and the reputation of your employing agency (e.g., making clients/families less comfortable seeking services with you or the agency). This principle also calls upon you to notify your supervisors when any issue in your private life threatens to compromise your professional performance (e.g., the existence of pre-existing relationships or other conflicts of interests with persons seeking service).

What ethical issues arise related to the professional conduct of the addictions counselor (outside the arena of relationships with clients)?

There are a wide variety of ethical and professional practice issues for addiction counselors that occur outside the context of relationships with clients and families. Some of the more troublesome issues you could encounter include:

- misrepresenting your education, training or experience via self-report, resumé or failing to correct others who mistakenly inflate your credentials,
- practicing beyond the boundaries of your education, training and experience,
- misusing agency resources,
- conflicts over ownership of work products, and
- conflicts of interest involving secondary employment.

NAADAC Principle 5 explicitly calls upon you to respect the limits of present knowledge and to “state as facts only those matters which have been empirically validated as fact.” This is not to say that you can never express your opinion, but that you must be very clear in your separation of fact and opinion in communications to clients/families, to professional colleagues and to the public and express what those opinions are based upon.

What are some of the most critical ethical issues that will arise in your relationships with clients and families?

There are virtually hundreds of ethical and boundary issues that can arise within your relationships with clients and their families. While there is a tendency to define appropriate responses to many of these issues in very prescriptive terms, subtler and sometimes dramatic changes occur in what is ethically appropriate as we move across the boundaries of cultures, different client populations, and even across different developmental stages of the same counselor-client relationship.

What follows is a discussion of some of the most troublesome areas within the ethical territory of the counselor-client relationship.

A. Definition of Client Helping professionals are bound by all kinds of regulations and standards defining what they should and should not do in their relationships with clients, but many of these regulations and standards fail to define client. When does a person’s status as a client begin and end? Does a client always remain a client? Does the term “client” include family members of those being counseled? Do addiction counselors working in non-clinical positions (e.g., prevention, training, research, supervision) have clients?

There are several trends relating to the definition of client. One is the position of “once a client, always a client.” This stance, which takes the position that you as a counselor never lose the power to potentially exploit the counseling relationship, is reflected in NAADAC’s Principle 9d: “The NAADAC member shall not under any circumstances engage in sexual behavior with current or *former* clients” (emphasis added). This position may be particularly apt for the addiction counselor given the chronic, relapsing nature of addiction. The ethical codes of some other helping professions and some criminal statutes prohibit sexual contact before a prescribed period (usually two years) following service termination. A growing number of these codes are also explicitly including family members in the definition of client. As for the application of ethical codes to non-clinical staff, a growing number of agencies are developing codes of professional practice that apply to all board members, staff, consultants and volunteers, and some professional organizations are developing standards that apply specifically to those in specialty roles, e.g., prevention (e.g., the IC&RC Code of Prevention Ethics).

B. Informed Consent The goal of the informed consent process is to assure that all persons considering entry into treatment are fully informed of the exact nature of the treatment

and, having been appraised of all potential benefits and potential risks of treatment, are free to participate or refuse to participate. The ethical prerequisites of informed consent are that the client is competent to provide informed consent (e.g., developmental maturity, absence of cognitive impairment), is free from coercion in providing informed consent, has been given objective information related to the potential risks and benefits of treatment and treatment alternatives, and is informed that he or she is free to revoke informed consent and withdraw from treatment at any time (McCrary & Bux, 1999).

C. Confidentiality Special procedures (federal and state statutes) have been developed to assure the confidential nature of addiction counseling. The ethics textbooks and major journals in the addictions field have paid special attention to the issue of confidentiality, and this issue is also addressed in chapter 24 of this book. It is the responsibility of every addictions counselor to clearly inform every client of the scope and exceptions to confidentiality and to rigorously adhere to these boundaries. There are quite subtle areas in which confidentiality can be commonly violated. (Edit Note: Coordinate revisions based on what is covered in Chapter 24)

1. Internal Confidentiality Disclose information inside the agency only to those in a “need to know” situation and disclose only role-appropriate information. Communications beyond these boundaries constitutes professional gossip and violates the ethical principles of privacy and discretion. NAADAC principle 8d calls upon the addictions counselor to “discuss the information obtained in clinical, consulting or observational relationships only in the appropriate settings for professional purposes that are in the client’s best interest.”

2. Casual Inter-agency Encounters There are a growing number of multiple-problem clients and families who bring extensive service histories with many community agencies. Shared experience with these clients and families breeds an informality of communication across agency boundaries that can lead to non-malicious breeches in confidentiality. Avoiding such breeches requires discipline and rigorous self-monitoring.

3. Casual Encounters with Clients in Public Another potential area in which confidentiality can be violated is during encounters with clients outside of the professional setting. For counselors residing in smaller communities, such encounters are common. Problems resulting from these encounters can be minimized by talking about the possibility of such encounters with each client and working out a mutually agreeable etiquette for such situations.

D. Dual Relationships Dual relationships occur when you agree to counsel someone with whom you have another relationship or connection that could compromise your objectivity or the client’s comfort. Most professional associations and certification/licensure bodies prohibit or strongly discourage entering into counseling relationships with persons with whom one has a pre-existing, non-clinical relationship or connection. NAADAC, for example, prohibits its members from entering into counseling relationships with family members, current or former intimate partners, friends, close associates and “others whose welfare might be jeopardized by such a dual relationship.”

The fact is that dual relationships will be inevitable for many addiction counselors, particularly those working in isolated rural communities or whose practice focuses on members of a “small town” within a larger community, e.g., a gay therapist working primarily with gay, lesbian, bisexual and transgender clients. Prohibiting all dual relationships would be impractical under those circumstances and would deny many people access to services. Such relationships must be individually evaluated based on their degree of intimacy and the extent to which the nature of the relationship would compromise your effectiveness and the client’s psychological safety and comfort.

1. Pre-existing relationships A good working principle is that you should declare any pre-existing relationship with a client to your supervisor and use the supervision process to determine whether this client should be transferred to another counselor or another agency. Where such

transfer is not possible, e.g., where no other service alternatives exist, it is possible that counseling will need to be done in spite of such dual relationships. In this case other protections must be used to minimize the potential harm, e.g., informed consent (including a discussion of the pre-existing relationship and its potential effect on counseling), increased supervision, and more meticulous documentation of the counseling process.

2. Social/business relationships Addiction counselors are discouraged from working with people with whom they have social or business relationships and to not initiate such relationships with clients. Such relationships compromise the counseling relationship by shifting the fiduciary relationship (decisions made in the best interest of the client) to a reciprocal relationship (decisions made to meet the mutual interests of both parties). Such dual relationships inevitably spill clinical material into the social relationship and social interactions into the clinical relationship, leaving both counselor and client confused as to which roles they are occupying at any point in time. Such confusion usually produces poor friendship and poor counseling.

3. Recovery peer relationships One of the most frequent dual relationship questions that arises in the field of addiction counseling is the question of contacts between a recovering counselor and his or her clients in outside-of-work recovery activities. The most common questions include: How should I handle social contact with clients at recovery meetings? How should I respond when current or former clients ask for a ride to a meeting or ask me to sponsor them? How should I handle my own disclosures at meetings in which current or former clients are present?

The folk wisdom that has grown up over the years is designed to protect the integrity of the counseling relationship and the sobriety of the counselor. Such folk wisdom has been canonized within the *A.A. Guidelines for A.A. Members Employed in the Alcoholism Field*. These guidelines emphasize the importance of separating one's role as an A.A. member from one's role as an addictions counselor. To do this, A.A. members are encouraged to avoid using professional jargon in their A.A. role, speaking for A.A. in their professional role, and sponsoring people with whom they have a professional relationship. (The ICRC code of ethics specifically prohibits sponsorship of current or former clients or their family members.) They are encouraged to clarify with clients and their fellow professionals when they are speaking as a counselor and when they are speaking as an A.A. member.

Individuals whose personal recoveries have been aided by their affiliation with A.A., N.A. or other recovery mutual aid groups bring assets that can contribute to their effectiveness as counselors, but such affiliations can also create areas of blindness and bias. It is essential that the recovering counselor not push all clients into his or her own pathway or style of recovery. This requires developing knowledge, tolerance and respect for alternative frameworks of recovery.

4. Sexual Relationships A sexual relationship between a counselor and a client can emerge from a confluence of conditions: unmet needs in the counselor's personal life, the counselor's manipulation of the work environment to meet these needs, weak or non-existent clinical supervision, and "closed, incestuous organizations" that poorly define boundaries between staff and clients (White, 1995, 1997). Sexual intimacies between a counselor and client are best viewed as processes rather than events--acts that are the last stages of a progressive violation of intimacy barriers within the service relationship. This understanding provides an opportunity for self-monitoring of early drift within the counseling relationship (see Sidebar).

Warning Signs of Boundary Drift (Over-involvement)
Preoccupation with/possessiveness of client
Resistance to referral when clinically indicated
Increased frequency/duration of sessions
Sexualization of session content
Excessive self-disclosure
Escalation of touch
Evidence of client dependency
Resistance to supervision
Contact outside the professional setting
Courtship behaviors (e.g., increased phone contact, dressing up for appointments, personal gifts)

E. Self-Disclosure There is an extensive body of professional literature on the question of whether and when counselor self-disclosure is an effective clinical technique. The question we will address here is under what conditions your self-disclosures could actually do harm to the client, to yourself or your organization. Such harm can occur when your self-disclosure breaks the fiduciary promise by shifting the focus of the counseling session to yourself, or when the nature of your disclosure (by its nature or timing) injures the service relationship. In general, self-disclosure should be used sparingly, selectively, and strategically. When used, self-disclosures should be brief, appropriate to the developmental stage of the client and the client-counselor relationship, end with an opening for the client to link the disclosure to their own experience, and involve only material over which the counselor has achieved distance and emotional control. In terms of potential threat to you and your agency, you should also understand that confidentiality is not reciprocal. Clients are under no obligation to hold secret what you share with them, and the re-disclosure (and frequent misinterpretation) of this information could result in unanticipated harm to your reputation and the reputation of your agency.

F. Disengagement While problems of over-involvement between the addictions counselor and his or her clients have garnered much attention in the ethics literature, little attention has been paid to the ethical issues inherent in a counselor's under-involvement in such relationships. Significant harm can occur from the failure to engage a client or from the premature disengagement of the counselor from the helping relationship (clinical abandonment). Such acts can result many conditions, e.g., personal depletion or impairment of the counselor, excessive caseloads, or negative counter-transference in the counselor-client relationship. Warning signs of disengagement are illustrated in the accompanying table.

Warnings Signs of Disengagement
Lack of preparation for interviews
Drift of counselor attention during interviews
Aversion to seeing particular clients
Failure or delays in returning client phone calls
Decreased frequency/length of sessions
Unfocused, superficial content of sessions
Disrespect of clients
Adversarial relationships with clients
Depersonalization of clients (e.g., use of labels)
Precipitous, unprocessed terminations

G. Experimental Techniques New techniques that are lauded for their clinical effectiveness but which lack empirical support raise two issues for the addiction counselor: 1) practicing within the boundaries of competence in the mastery of such techniques, and 2) the potential iatrogenic (harmful) effects of these techniques even when competently executed. Counselors should maintain a critical skepticism regarding fads in treatment/counseling; popularly reported breakthroughs in the treatment of addiction have been notoriously unreliable for more than 200 years.

NAADAC Principle 3a demands that the addiction counselor “recognize boundaries and limitations of the member’s competencies and not offer services or use techniques outside of these professional competencies.” Even where experimental procedures are delivered with a level of assured fidelity, procedures need to be taken to prevent potential harm to clients. These steps include the use of informed consent prior to implementation of the procedure, rigorous supervisory review, and reasonable efforts to assess the degree of effectiveness of the procedures and the presence of any harmful side effects of the intervention.

H. Documentation There are several ethical issues related to documentation that you may encounter over the course of a career as an addiction counselor. Some of the most common and more difficult of these include:

- failure to adequately document service activity.
- breaches of confidentiality related to inadequate security of documents (e.g., loss of an appointment book, briefcase or laptop containing client information).
- documentation of clinically irrelevant information that could do potential harm to the client, e.g., details of criminal activity.
- unethical and fraudulent service documentation/billing.

This list underscores the potential ethical problems inherent in under-documentation, over-documentation, and undue attention to the disposition of any information about clients whether that information is in the form of paper, electronic documents, audio/video-tapes or photographs. Special care must be taken to assure the security of clinical information stored and transmitted via computer.

What are the most common ethical issues that arise within the professional peer relationships of the addiction counselor?

Some of the most frequent ethical issues that arise within professional peer relationships include the following: responding to allegations of unethical conduct of a peer, impairment of a professional peer, intra-agency confidentiality, intra- and inter-agency conflict management, fee-splitting (accepting financial or other incentives for referrals), abuses of power in supervisory relationships, dual relationship conflicts involving supervisors and supervisees, and whistleblowing.

NAADAC’s ethical Principle 2d calls upon the addiction counselor to report allegations or observations of unethical conduct by other service professionals to appropriate authorities. It is NOT the counselor’s responsibility to determine whether such an allegation is true or not true before reporting it.

The NAADAC code of ethics (Principle 10c) explicitly prohibits addiction counselors from emotionally, sexually or financially exploiting relationships of unequal power, e.g., with supervisees, student interns, research participants or volunteers. Addiction counselors have a responsibility to ethically manage sexual feelings toward those they supervise in the same way they would be expected to manage such feelings toward clients. The principles governing dual relationships with clients have direct applicability to the supervisor-supervisee relationship. The ICRC Code of Ethics for Clinical Supervisors, for example, explicitly prohibits entering into

dual relationships in supervision, exploiting the supervision relationship, or transforming clinical supervision into psychotherapy. Regarding the latter, the Code states: “personal issues should be addressed in supervision only in terms of the impact of these issues on clients and professional functioning.”

How should you respond when you encounter situations in which a client poses a threat to themselves or others?

Situations involving potential harm to self or others requires a clinical response (assessment or degree of risk and interventions to lower risks) and an ethical response (interventions to protect the interests of multiple parties). The latter often involves weighing the clients right to confidentiality versus the potential threat of imminent harm to other parties. Two terms are invoked in the literature of law and ethics regarding such situations. Duty to report is a phrase used to denote the counselor’s responsibility to disclose to a responsible authority either self-reported or observed injury by a client to another party (e.g., the abuse of a child or an elder). Addiction counselors are defined as “mandatory reporters” in most states, which means that promises of confidentiality do not include client disclosure of or observation of abuse of the client’s children or aging relative. In this case, the child or elder’s right to be protected outweigh the client’s right to confidentiality. To manage these co-existing loyalties to the client and other parties, it is important for each client to know when the rights of others take precedent over their own. This is managed through discussions of the exclusions to confidentiality with each client.

A second term, duty to warn, describes the addiction counselor’s responsibility to intervene to thwart a threat of harm by the client to other individuals. Such interventions, like duty to report, pit the client’s rights of confidentiality against the threatened parties’ rights to be warned of the threats to their safety. This is an area in which legal and ethical interpretations of counselor responsibilities can differ dramatically. A literal interpretation of most confidentiality statutes would preclude the counselor’s breaking confidentiality to disclose such a threat. Ethicists, however, often argue that the counselor has a responsibility to prevent harm to others and that this responsibility supercedes the right to confidentiality when two conditions are met: 1) there is a clear target of the threat (one or more persons have been named) and 2) the threat of harm to the individual is judged to be imminent.

What ethical issues arise in the performance of special roles within the addictions field?

Over your career, you may work in many different roles and different modalities of addiction treatment and in such specialty roles as prevention, early intervention (student assistance, employee assistance), training, or research. These specialty areas differ from arenas in which ethical responsibilities are more clearly defined. They may involve areas where elaborate structures of ethical compliance exist (such as in human research) or areas in which very little of the ethical territory has been charted (such as prevention). When you move into such specialty areas, you have a responsibility to prepare yourself for the ethical issues that can arise in this new professional territory. (Those addiction counselors who are also working in the prevention arena are strongly encouraged to review ICRC’s Prevention Ethics Standards.) Mastering the ethical nuances within these specialty roles requires reading, seeking out training, interviewing peers experienced in the area, and actively pursuing supervision and consultation.

What steps can help the addiction counselor elevate his or her level of ethical practice and what strategies can be used to proactively manage areas of potential ethical vulnerability?

If I were to offer some closing advice to the aspiring addiction counselor, it would include these key points.

- Take care of yourself! Effective self-care is an essential precursor to ethical conduct; it is the physically, emotionally and spiritually depleted counselor who is most vulnerable to using clients to meet these unmet needs.
- Get ethically educated! Ethical decision-making is as much about skill as it is about character. Seek out self-instructional reading and training that provides a safe environment for rehearsing and sharpening your basic ethical decision-making skills.
- Utilize Mentors! Develop a small cadre of consultants that can provide a sounding board and objective advice on difficult ethical dilemmas.
- Know thyself! Practice rigorous self-monitoring in order to identify when you are moving into periods of heightened personal vulnerability and when you are entering a zone of ethical vulnerability in your relationship with one or more clients,
- Ask for help! Seek formal consultation when you are in a zone of vulnerability and when there appears to be an exception to the normal ethical prescriptions.
- Protect yourself! There are times that it is clinically warranted to be in the zone of vulnerability we have described. Just don't be there alone, and create a paper trail (e.g., a journal) within zones of vulnerability that document your ethical decision-making processes and decisions.
- Finally, respect your clients, your co-workers, your craft and yourself by adhering to the ultimate ethical mandate, "First, do no harm!"

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Glossary

Boundary: demarcation of the level of intimacy in the counselor-client relationship.

Code of Professional Practice: an organizational code of standards that defines aspirational values, ethical mandates (Thou shall or shall not...), folk wisdom (It has been our experience that...), procedural directives, and organizational etiquette.

Conscientious refusal: refusal to comply with a directive to commit an unethical or illegal act.

Dual Relationship: simultaneous or sequential involvement in two or more roles between a counselor and a client, e.g., counselor-client relationship, counselor and client are also next door neighbors, and client-neighbor is also the teacher of the counselor's child.

Duty to Report: the ethical obligation to report harm to others that has already occurred, e.g., reporting the abuse of a child.

Duty to Warn: the ethical responsibility to report the threat of harm to another person.

Ethics/Ethical: a body of values, principles and standards developed by a profession to guide its member's fiduciary service relationships.

Ethical dilemma: a situation in which the ethical course is unclear and which different course of action could be ethically justified.

Fiduciary: the assumption of professional responsibility for the care of another

Iatrogenic effect: interventions that produce inadvertent harm or injury to a client, family or community.

Informed Consent: the process through which potential clients are educated about the risk and benefits of addiction counseling prior to their decision to participate or not participate in such counseling.

Nexus: the linkage between private behavior and professional role performance.

Whistle-blowing: a counselor's disclosure of unethical or illegal activity within their organization to an outside investigative body.

Zone of Abuse: a zone in which the service relationship (either from too little or too much intimacy) has the potential of doing great harm to the client, the counselor and the agency.

Zone of Safety: a zone of routine service delivery in which a high degree of physical and psychological safety exists for the client and the counselor.

Zone of Vulnerability: a zone of heightened or diminished intimacy in the client-counselor relationship in which the vulnerability of both parties has increased.