

# Professional and Ethical Responsibilities

## Introduction

**TAP 21 Definition:** The obligations of an addiction counselor to adhere to accepted ethical and behavioral standards of conduct and continuing professional development.

*Instructor Note: You all may be asking yourselves “Why another course about ethics and professionalism? Aren’t there more important or practical things we could be learning about?” Truthfully, from my point of view there is a short answer to these questions....No, there isn’t anything more important, useful, purposeful or practical. The reason I give this is answer is simple and basic. As a student you can read more books or articles, as a staff person you can attend trainings, sit for webinars and take part in clinical rounds, all to enhance your working knowledge of addiction and the counseling process, your clinical tool belt, and your style/techniques in working with clients. However, understanding the importance of being ethical and professional is something you must FEEL & BELIEVE is mandatory. The understanding that being responsible for helping other human beings and having those human beings trust you to enter into their lives allowing you to see their frailties and vulnerabilities requires without hesitation, without devaluing the commitment to the highest standards of quality, earnest, ethical and professional care.*

As an addiction counselor(certified or not) or behavioral health tech you are required to know, understand and adhere to the Florida Certification Board standards of Ethical Practices, Rules of Conduct and Standards of Care.

Please, **on your own**, go to the following links to read these required readings:

1. <http://flcertificationboard.org/ethics/>
2. [http://www.ecfr.gov/cgi-bin/text-idx?tpl=/ecfrbrowse/Title42/42cfr2\\_main\\_02.tpl](http://www.ecfr.gov/cgi-bin/text-idx?tpl=/ecfrbrowse/Title42/42cfr2_main_02.tpl)
3. <https://www.flrules.org/gateway/ChapterHome.asp?Chapter=65D-30>

All counselor’ and behavioral health techs will not only be held to the standards and rules of behavior and practice but they will also be subject to the ramifications of non-compliance as stated in the Florida Certification Board guidelines of ethics and professional practices.



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For additional information on what is expected of you as an addiction professional. Please go to the following link:

<http://store.samhsa.gov/product/TAP-21-Addiction-Counseling-Competencies/SMA14-4171>

In addition to following all of the professional standards, ethical guidelines, codes of conduct and scope of practice listed above, you must also have a full and complete working knowledge and understanding of client rights and responsibilities, confidentiality rules and regulations, appropriate boundaries, biases – personal & otherwise, multicultural awareness and sensitivity, trauma awareness and sensitivity and a thorough understanding of the difference between the role of the professional counselor and that of a peer counselor or sponsor.

Finally, of course, there is the clinical work, the expectation of the professional addiction counselor to be knowledgeable in a variety of intervention techniques, counseling methods, and psychoactive substance use research in order to improve client care and enhance your professional growth.

As a professional addiction counselor you will be faced with many challenges and uncertainties even with knowledge and practice. For this there are two things you, the addiction professional must do:

1. Take part in and seek out ongoing clinical supervision and consultation.
2. Develop and implement a personal self-care plan to maintain your physical and mental health.

For this class we will be examining the roles of transference, counter-transference, boundary guidelines and violations, counselor burn-out, risk assessment and management, crisis assessment and management, the potential influence of counselor personal values and biases and the counselor's personal recovery issues impact on job performance and client interactions.

# **Professional Counselor Scope of Practice, Ethical Practice, Confidentiality and Informed Consent**

## **Chapter 1**

***TAP 21 Competency: Adhere to established professional code of ethics that define the professional context within which the counselor works to maintain professional standards and safeguard the client.***

***TAP 21 Competency: Adhere to Federal and State laws and agency regulations regarding the treatment of substance use disorders.***

The ability to recognize and respond appropriately to ethical dilemmas encountered while treating addictive disorders is a complex task that cannot be taken for granted by even experienced counselors. Full caseloads and busy schedules provide few opportunities for in-depth examinations of ethical dilemmas that often demand an on-the-spot decision. This article sets forth a pragmatic set of principles that can help counselors to evaluate ethically challenging situations. While these ethical principles are relevant to almost any counseling situation, this article focuses on how they apply to the treatment of substance and behavioral addictions.

Numerous written codes of ethical conduct exist to guide the many different counseling professions. These documents may be more useful for giving clients and the public an assurance of the ethical parameters of professional behavior than in providing counselors with a useful frame of reference for dealing with day-to-day dilemmas. There is also an important difference between merely abiding by rules of conduct and embodying the ideals contained within them (Coale, 1998; Tjeltvelt, 1999). A set of common principles derived from these various codes must be sufficiently broad enough to take into account the rich variety of practice settings, counseling theories and treatment approaches in which addiction counselors operate. Any less inclusive formula for determining whether a counselor's behavior is ethically appropriate requires knowledge of the context in which it occurs. For example, vigorously challenging a client's beliefs or behaviors may be ethically justifiable under one set of circumstances but not another (Tjeltvelt, 1999). Similarly, different counselors may respond to an identical ethical dilemma in very distinct yet equally justifiable ways.

### **Informed Consent**

***Instructor Note: The Informed Consent form is typically provided to the client to read and sign during the initial intake process. This form is provided to client with stack of other important***

***forms. I have sadly seen many counselors, intake workers and admission specialists simply lay the form down in front of the client and say “here is your informed consent and this says you give us permission to treat you and work with you” etc. etc., then “just sign and date”. What is wrong with this picture?? Is this how we look out for our clients, our clients who trust that we have their best interest in mind; that we are going to help them and care for them? No, this is lazy, unprofessional and completely unethical practice! Working in addictions treatment requires professionalism, high standards of clinical and conduct practices and care and concern for the well-being of your clients. It is a betrayal of the client, the facility and ethics to do anything less. The information in this chapter details many areas that you will be expected to learn, understand and ultimately practice. Be the best you can be always.***

Informed consent is the fundamental bedrock of ethical practice, because it helps to assure the client's autonomy in matters that affect the entire course and direction of counseling. Counselors may not always fully appreciate the lengths they must go in order to insure that important decisions about treatment issues are truly made from a basis of informed choice. Rather than being a one-time event, informed consent is an on-going collaborative effort between client and counselor for establishing and continuously monitoring the goals and strategies of counseling as well as the roles, rights and responsibilities of all parties. (Tjeltveit, 1999)

A client has a right to know which treatment modalities an addiction counselor typically recommends, such as group therapy, couples therapy, family therapy, and medication, support group attendance, and so forth. Counselors often don't take the time to explicitly discuss the expected benefits and potential risks of their services, as well as any alternative treatment approaches that may be available to the client. Informed consent also includes information about the anticipated duration of treatment and any situations that could result in a counselor prematurely terminating services. In addition, clients should know the policy for resolving disputes as well as all pertinent financial aspects of the counseling relationship; counselors should also be open to discussing their background and theoretical orientation (Houston-Vega and Nuehring, 1997). This is so much information that a counselor may choose to convey it by a combination of verbal and written means.

***A client's informed consent is not in itself sufficient to determine whether a counselor's behavior is ethical. It's conceivable that clients might be willing to give their approval to any number of ethically inappropriate behaviors, so a counselor needs other core principles to guide the ethical decision-making process.***

## **Competence and Established Theory**

A counselor has an ethical responsibility to practice only within the scope of his or her professional competence. Some typical indicators of competence include education, experience, training, and certification (Pope and Vasquez, 1998). Competence in one clinical area doesn't necessarily translate to another. Counselors with extensive experience treating general psychiatric disorders aren't necessarily competent to meet the specific needs of addicted clients, just as addiction counselors without advanced training don't always adequately recognize signs of psychiatric disorders. Cross-referral between such specialists is necessary in such situations.

One often-overlooked component of competency is a counselor's ability to clearly describe the theoretical basis for providing a particular clinical service. Just because a client's case turned out all right doesn't necessarily justify a counselor's actions if they otherwise lack adequate theoretical support. It is important to do the right thing for the right reason, not just for the right result. Counselors operating without the benefit of a clear theory are likely to rely too much on a combination of intuition, habit, consensus and personal preference (Herring, 2001, Tjeltveit, 1999, Corey, Corey and Callanan, 1998). Clients deserve the knowledge and right to accept or reject treatment that represents a particular theoretical orientation. In the absence of information to the contrary, clients will assume that whatever form of counseling they are receiving is the only available or appropriate choice.

## **Confidentiality**

Another core ethical principle is for a counselor to vigilantly guard against unauthorized disclosure of client information. The assurance of confidentiality is a fundamental guarantee, but it is not an absolute one.

Several ethical dilemmas involving confidentiality commonly arise in the treatment of addictive disorders:

### **Duty to Warn/Protect**

It is widely accepted that counselors have a general obligation to warn or protect people whom a client places in imminent harm. The right to confidential treatment is therefore balanced by the need to insure the safety of others. The beginning of the counseling relationship is the most appropriate time for a client to learn about these limits on confidentiality as well as any safeguards necessary to protect others, such as policies on notifying law enforcement personnel if a habitual DUI offender drives to a counseling appointment while intoxicated.

Clients who inject drugs or engage in sexually risky behavior while chemically impaired may expose others to the risk of HIV infection. Courts have not generally applied duty-to-warn standards to these situations (Houston-Vega and Nuehring, 1997). Balancing the counselor-client relationship with the protection of at-risk populations is a very complex and emotionally charged situation. Counselors should inform clients about their policy for dealing with HIV-related confidentiality issues, educate clients about the health risks of their specific sex and drug practices, communicate any concerns that arise during the course of treatment, offer to help communicate information to partners, and consult with colleagues as appropriate.

### **Minors and Families**

All states require counselors to report situations in which minors are in danger of harm, although specific state statutes differ (Corey, Corey and Callanan, 1998). As most counselors know, it can be difficult to distinguish potential from probable risk. For instance, a client who admits to blackouts may deny that she places her children in any danger. A counselor who decides not to notify the designated reporting agency in such a situation should document the basis for this decision in the clinical record. Consultation in these situations is again extremely valuable in helping a counselor maintain much-needed clinical objectivity.

Counselors who treat minors for substance use disorders need to clearly establish the extent to which parents have the right to information that is disclosed by their children. A minor may be reluctant to talk honestly if confidentiality boundaries are not clear, and the therapeutic alliance may be crippled if a counselor who is unclear on the limits of confidentiality later provides information to parents. Counselors should be familiar with federal law on confidentiality of alcohol and drug abuse records for minor clients (Confidentiality of Alcohol and Drug Abuse Patient Records, 1998) as well as any applicable state laws, and should seek professional consultation whenever questions arise.

A major ethical concern that arises when counseling couples or families is how to deal with the emergence of secrets that so often accompany addictive disorders. For example, consider the situation that could arise when providing marital counseling to a couple if a husband who attends a session by himself announces that he's relapsed on cocaine but is unwilling to admit this to his wife. A counselor who keeps this information secret is not fostering a climate of honesty. On the other hand, revealing information that a client reasonably presumed would remain confidential will damage that client's trust, while threatening to summarily end treatment if the client isn't honest with his

spouse is a form of coercion and potential abandonment. This again points to the necessity of informed consent: whatever approach a counselor takes in response to these types of situations needs to be thoroughly discussed at the beginning of the counseling relationship so that all clients are aware of the consequences of disclosure (Corey, Corey and Callanan, 1998; Herring, 2001).

#### **Maintaining Appropriate Boundaries**

The next core concept of ethical counseling involves the complex area of maintaining appropriate professional boundaries. Most counselors know that there are ethical risks to developing relationships outside of the therapeutic role, such as counseling a friend or pursuing business or social interactions with clients. These types of dual relationships can impair a counselor's objectivity or unintentionally exploit a client's dependence (Pope and Vasquez, 1998). Yet some subtle boundary issues present ethical dilemmas that are neither obvious nor easily avoidable.

#### **Counselor Self-Disclosure**

In order to maintain appropriate clarity of roles, a counselor should only reveal intimate personal information when doing so is clearly relevant to the client's treatment goals, carefully tailoring this information to the client and paying close attention to how such sharing affects the clinical relationship (Bloomgarden, 2000). Consultation with colleagues and supervisors can help insure that the true purpose for disclosing personal information is to meet the emotional needs of the client rather than the counselor. One helpful guideline is for a counselor to reveal information about a personal life problem only well after it has been resolved, and not while it is an ongoing issue (Hunter and Struve, 1998).

#### **Touch**

Since a significant proportion of clients with addictive disorders have a history of childhood trauma (Briere, 1992), even a simple act of touch can convey a variety of ethically ambiguous messages. The history of addiction support is replete with reassuring hugs. It's very important for a counselor who engages in any form of physical contact with clients to have a highly developed sense of boundaries and an astute awareness of the clinical implications of this behavior. The initial stages of the therapeutic relationship may not provide sufficient emotional safety to insure that a client can discuss any uncomfortable feelings involving counselor touch (Hunter and Struve, 1998).

#### **Sexual Attraction**



Sexual involvement with a client constitutes a profound ethical violation with severe emotional consequences. However, occasional sexual feelings are not in themselves either unethical or even particularly abnormal in the context of an intimate therapeutic relationship (Pope and Vasquez, 1998). Counselors must acknowledge and appropriately process the existence of these feelings when they emerge in order to successfully understand and redirect them. The presence of intense preoccupation or sexual fantasies involving client's needs to be forthrightly discussed in consultation and supervision.

### **Recovery Boundaries**

Counselors who have successfully dealt with addictive disorders in their own lives can often relate to their clients with profound understanding, empathy and clarity. However, they may also be overly devoted to the treatment approach they personally found successful (Johnson, 2000). For instance, counselors who are strongly 12-step oriented may discount non-abstinence models for addressing substance abuse, such as risk reduction strategies, which threatens to place clients into a one-size-fits-all philosophy of care.

A counselor who is candid about being "in recovery" may give clients hope and reduce the shame that inevitably accompanies addiction. However, too much disclosure can be intrusive and distracting for some clients, and can even inadvertently generate unrealistic expectations or a sense of inadequacy (Bloomgarden, 2000). Counselors should therefore carefully reveal information about their personal addiction experience only in as much detail as is necessary to meet a compelling and clearly defined clinical need.

A counselor who is treating clients with substance use disorders should not be unsuccessfully fighting the same battle. Sustained abstinence from addictive behavior is an inescapable ethical responsibility for anybody working in this field. Counselors with less than several years of recovery time may easily lose objectivity when dealing with clients whose clinical picture mirrors their own personal experience. Heightened levels of consultation and supervision are highly advisable in such circumstances.

Nobody is immune to relapse, regardless of the length of time in recovery. A counselor who reverts to a previous pattern of addictive behavior must face the ethical dilemma of whether to limit, suspend or terminate clinical duties. Abruptly withdrawing services from a client due to this (or any other) form of counselor impairment is likely to be deeply disruptive to the client's healing process (Bissell and Royce, 1994). Clients in such



situations must be given the opportunity to continue counseling with another provider. There is no one answer to the problem of counselor relapse that is completely satisfying. In this regard the difference between a temporary "slip" that can result in increased self-awareness and an unrestrained relapse may be useful in determining a counselor's overall level of clinical impairment. These decisions should be made in a process of supervision and consultation so that the counselor is not relying on his or her personal judgment which may be impaired.

All counselors who are in recovery from addictive behavior must establish whatever safeguards are necessary to insure the maintenance of a personal program of sobriety. This may include establishing boundaries around support group meetings that clients are asked not to attend. It is not ethically appropriate for counselors in 12-step recovery to sponsor their own patients or chair meetings where they are employed (Bissell and Royce, 1994).

#### **Supervision**

The next core ethical concept is for counselors to have a structured process for discussing formulations, interventions, reactions and inevitable difficulties with supervisors and colleagues. There is a heightened need for supervision and consultation for counselors who are working on the outer limits of either personal competence or established theory (Corey, Corey and Callanan, 1998). For example, a counselor attempting to implement a new technique should utilize close supervision until it becomes fully integrated into his or her set of skills.

It's an unfortunate reality that not all clinical supervisors have adequate experience or knowledge in the treatment of addictive disorders. In such cases a counselor needs to seek out additional sources for case consultation. One solution is to set up and utilize informal telephone and e-mail networks which can be established fairly easily with colleagues and contacts made through professional affiliations. When consultation is not available for discussing a clinical or ethical dilemma, a counselor should document in the clinical record a summary of the relevant issues as well as any action taken in response to it.

#### **Honoring Diverse Values**

All of the preceding ethical principles involve some specific actions for a counselor to take. However, the ethical dimension of counseling goes far beyond merely abiding by a procedural checklist. An ethical counselor consistently demonstrates respect for the client as a person by honoring diversity and appreciating the degree to which his or her personal values influence the entire process of counseling. Since counselors are in the business of



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helping clients change some aspect of their lives, the great ethical challenge is to effectively guide the process and direction of this change without undermining the client's autonomy. This ethical use of a counselor's influence is a skill that cannot be taught as much as developed.

Since every person's view of the world represents a unique combination of diverse personal and cultural perspectives, it is inevitable that counselors will sometimes hold views that are very different from their clients. No counselor is ethically justified in assuming that the way he or she views life is the way everybody else does, is the right way, or is the only way. However, some counselors act as if the way to avoid imposing their personal values is to simply not talk about them. But biases don't lose their influence just because they're not discussed; in fact they often become less amenable to change. It is often more ethically beneficial for a counselor to invite discussion about his or her personal values while conveying an ability to respect and work with many alternative positions. A counselor doesn't need to be neutral about his or her values in order to be nonjudgmental (Coale, 1998; Tjeltveit, 1999).

When a client and a counselor hold fundamentally incompatible value orientations, the counselor should either refer the case or strive to help the client achieve the goals of counseling within the context of the client's value system rather than attempting to change those values. If a counselor finds it necessary to attempt to modify a client's values, this should be done to no more extent than is necessary to address that client's particular focus of treatment.

Counselors often avoid initiating discussion with clients about the ethical dimensions of clinical issues. Sometimes this reluctance stems from the fear of appearing moralistic, but it also reflects a general tendency of the counseling profession to be ethically inarticulate. It takes considerable effort and skill to engage in thoughtful dialogue about the ethical aspects of life, but doing so can have great benefit for clients whose history of addiction is marked by diminished personal integrity. While this does not guarantee a positive clinical outcome, it does foster the kind of therapeutic environment for a client to utilize the counseling experience to its fullest potential.

These guidelines are not an exhaustive review of every ethical issue related to addictions counseling and they cannot substitute for a counselor's knowledge of his or her professional code of conduct. Many clinical situations require a more detailed examination of the ethical issues involved or compliance with specific codified procedures, such as guidelines for research involving human subjects. Although counselors almost always operate within ethical parameters, these principles can serve as a helpful reminder of some of the



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important points to consider when evaluating the proper ethical stance to take when dealing with the many complexities of addictions counseling.

## **FYI**

### **Most Frequent Claims to Ethics Boards**

1. Sexual/dual relationship— 35%
2. Unprofessional, negligence— 29%
3. Fraudulent acts—10%
4. Conviction of crimes—9%
5. Inadequate/improper supervision—5%
6. Impairment—4%
7. Improper record keeping—3%
8. Fraud in applying for credential—2%

***Instructor Note: As mentioned in the introduction, there are Federal and state guidelines specific to confidentiality; the keeping and managing of client records including computer, email and faxing; release of information; protecting client's personal health records; grievance procedures and disciplinary actions for violations. As part of this course you will be presented with three power point presentations, one of those presentations will cover all of these guidelines, rules, procedures etc. in detail.***

## **The Professional Addiction Counselor**

### **Chapter 2**

***TAP 21 Competency: Recognize the importance of individual differences that influence client behavior, and apply this understanding to clinical practice***

#### **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.

#### **Professional Counselor Attributes**

1. 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.
2. 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.
3. 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.



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4. 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.
5. Addiction professionals have a commitment to lifelong learning and continued education and skills to better serve clients and the community.
6. 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.
7. 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.

### **The Professional 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.

### **Identifying, Assessing Risk/ Self-harm**

One of the tasks that addiction counselors are often required to perform is a suicide risk assessment. Substance abuse counseling involves the knowledge of co-occurring disorders and the people who have them. Even if your client does not have a mental health issue it is not at all unusual for clients in addiction treatment to have thoughts, ideas, plans of harming themselves or someone else. To be a professional addiction counselor means to be educated, trained and practiced in recognizing the signs, symptoms and risk factors for self-harm behaviors or violent behaviors in individual clients.

### **Did You Know?**

- + Suicide is a leading cause of death among people who abuse alcohol and drugs (Wilcox, Conner, & Caine, 2004).
- + Compared to the general population, individuals treated for alcohol abuse or dependence are at about 10 times greater risk to eventually die by suicide compared with the general population, and people who inject drugs are at about 14 times greater risk for eventual suicide (Wilcox et al., 2004).
- + Individuals with substance use disorders are also at elevated risk for suicidal ideation and suicide attempts (Kessler, Borges, & Walters, 1999).
- + People with substance use disorders who are in treatment are at especially high risk of suicidal behavior for many reasons, including:
  - They enter treatment at a point when their substance abuse is out of control, increasing a variety of risk factors for suicide (Ross, Teesson, Darke, Lynskey, Ali, Ritter, et al., 2005).
  - They enter treatment when a number of co-occurring life crises may be occurring (e.g., marital, legal, job) (Ross et al., 2005).
  - They enter treatment at peaks in depressive symptoms (Ross et al., 2005).
  - Mental health problems (e.g., depression, posttraumatic stress disorder [PTSD], anxiety disorders, some personality disorders) associated with suicidality often co-occur among people who have been treated for substance use disorders.
  - Crises that are known to increase suicide risk sometimes occur during treatment (e.g., relapse and treatment transitions).

### **You Can Do This!**

Your clinical training in substance abuse counseling puts you in a solid position to perform the tasks outlined. As you will learn, the first step in addressing suicidality is to “gather information,” or to perform exactly the same kind of information-gathering tasks you do every day. For example, if a client were having trouble with craving, you would first want to know more about it. Think about the types of questions you would ask. They might include “Tell me about your craving. How often do you have it? How strong is it? What makes it worse?” These questions are precisely the type you would ask about suicidal thoughts: “Tell me about your suicidal thoughts. How often do you have them? How strong are they? What makes them worse?” In other words, even though some content areas may be less familiar to you, your training and experience in substance abuse counseling provides you with the foundation you need to address suicidal behaviors with your clients.

You will be a trained substance abuse treatment professional who works with persons with co-occurring substance use and mental disorders, but most likely, your background will not include detailed training in addressing your clients' suicidal thoughts and behaviors. The information provided here is designed to begin to fill that gap and increase your understanding of relevant mental disorders. There is tons of information available and it is your responsibility, as an addiction professional or professional of any kind for that matter, to research, read, and stay abreast of all new information related to the field of addiction counseling.

The following are recommended for professional addiction counselors:

- ✚ Clients in substance abuse treatment should be screened for suicidal thoughts and behaviors routinely at intake and at specific points in the course of treatment. Screening for clients with high risk factors should occur regularly throughout treatment.
- ✚ Counselors should be prepared to develop and implement a treatment plan to address suicidality and coordinate the plan with other providers.
- ✚ If a referral is made, counselors should check that referral appointments are kept and continue to monitor clients after crises have passed, through ongoing coordination with mental health providers and other practitioners, family members, and community resources, as appropriate.
- ✚ Counselors should acquire basic knowledge about the role of warning signs, risk factors, and protective factors as they relate to suicide risk.



- ✚ Counselors should be empathic and nonjudgmental with people who experience suicidal thoughts and behaviors.
- ✚ Counselors should understand the impact of their own attitudes and experiences with suicidality on their counseling work with clients.
- ✚ Substance abuse counselors should understand the ethical and legal principles and potential areas of conflict that exist in working with clients who have suicidal thoughts and behaviors.

### **Preparing to Assess for Suicidality/Self-harm**

It is important for you to be comfortable and competent when asking your clients questions about suicidal ideation and behavior. It may be challenging to balance your own comfort level with your need to obtain accurate and clear information in order to best help the client. Here are some suggestions to ease the process follow.

#### **Be Direct**

Talking with clients about their thoughts of suicide and death is uncomfortable. However, you must overcome this discomfort, as it may lead a counselor to ask a guaranteed conversation-ending question, such as “You don't have thoughts about killing yourself, do you?” Discomfort can also lead counselors to avoid asking directly about suicidality, which may convey uneasiness to the patient, imply that the topic is taboo, or result in confusion or lack of clarity.

#### **Increase Your Knowledge about Suicidality**

One of the best ways to become more comfortable with any topic is to learn more about it. Suicide is no exception. Knowing some of the circumstances in which people become suicidal, how suicidality manifests, what warning signs might indicate possible suicidal behavior, what questions to ask to identify suicidality, and, perhaps most important, what the effective interventions are, can increase your competence, and as a result, your comfort in addressing this issue with clients.

#### **Do What You Already Do Well**

Good counselors are empathic, warm, and supportive, and trust their experience and intuition. However, on encountering suicidal thoughts and behaviors, counselors sometimes unwittingly employ counter-therapeutic practices, such as aggressively questioning the client about his or



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her thoughts and feelings, demanding assurance of safety when a client cannot provide such assurance, becoming autocratic and failing to collaborate with the client, and/or avoiding sensitive topics so as not to engender sadness. These counter-therapeutic practices can be the consequence of anxiety and unfamiliarity with the issue, along with fear of litigation if the client does make a suicidal act. Given these fears and issues, it is easy to see how otherwise highly skilled counselors can fall into the trap of becoming “the suicide interrogator.” Your option? Deliberately choose another path. Stay grounded and make use of your therapeutic skills when dealing with suicidal behaviors, as that is the most important time to fall back on (and not veer away from) your therapeutic abilities, experience, and training. Collect objective data, just as you would collect objective data about a client's substance use, but don't lose your empathy or concern in the process.

### **Practice, Practice, Practice**

Nothing reduces anxiety more than practice. The same holds true about talking with your clients about suicidal thoughts and behaviors. If you need to reduce your initial discomfort on the topic, practice with another counselor or your clinical supervisor. You may also consider attending a workshop or getting additional training specific to the topic of suicidality.

### **Get Good Clinical Supervision and Consultation**

Getting clinical supervision is a great way to learn and practice new skills.

### **Work Collaboratively With Suicidal Clients**

Just as you involve clients in developing a treatment plan for recovery, so too should you involve them in suicide prevention planning. You will be most effective if you ask them about suicide with concern (but not alarm), just as you would with any other area of concern. Explain the reason(s) for your concern and any action(s) that you take, elicit their input as to what may help them be safe, and (with your supervisor), consider their input as much as possible in determining the actions that you take.

### **Realize Limitations of Confidentiality and Be Open with Your Clients About Such Limits**

You should understand existing ethical and legal principles and potential areas of conflict (including the possible limits of confidentiality) because safety and protection of the client trumps confidentiality in certain crisis situations. When you first meet clients and as appropriate during the course of treatment, explain that, in the event of suicide risk, you may take steps to promote the client's safety (including the potential for breaking confidentiality, arranging for an emergency evaluation over the client's objections, and involving emergency personnel). Clients should not be given the false impression that everything is confidential or that all types of treatment are always voluntary.

### **Maintain Positive Attitudes**

Before working with clients who are suicidal, counselors are advised to conduct their own suicidal attitude inventory. The goal of the inventory is not to change your views but rather to help you understand what your views are and how those views can positively or negatively affect your interactions with clients. Some of the items you might consider in an inventory include:

- + What is my personal and family history with suicidal thoughts and behaviors?
- + What personal experiences do I have with suicide or suicide attempts, and how do they affect my work with suicidal clients?
- + What is my emotional reaction to clients who are suicidal?
- + How do I feel when talking to clients about their suicidal thoughts and behaviors?
- + What did I learn about suicide in my formative years?
- + How does what I learned then affect how I relate today to people who are suicidal, and how do I feel about clients who are suicidal?
- + What beliefs and attitudes do I hold today that might limit me in working with people who are suicidal?

These views may also need to be further clarified by consultation with your clinical supervisor or with your peers.

As noted, your attitudes about suicide are strongly influenced by your life experiences with suicide and similar events. Needless to say, your responses to suicide and to people who are

suicidal are highly susceptible to attitudinal influence, and these attitudes play a critical role in work with people who are suicidal. An empathic attitude can assist you in engaging and understanding people in a suicidal crisis. A negative attitude can cause you to miss opportunities to offer hope and help or to overreact to people in a suicidal crisis.

Below are some attitudinal issues to consider in working with people who are suicidal:

**Positive Attitude and Behavior 1:** People in substance abuse treatment settings often need additional services to ensure their safety

**Positive Attitude and Behavior 2:** All clients should be screened for suicidal thoughts and behaviors as a matter of routine.

**Positive Attitude and Behavior 3:** All expressions of suicidality indicate significant distress and heightened vulnerability that require further questioning and action.

**Positive Attitude and Behavior 4:** Warning signs for suicide can be indirect; you need to develop a heightened sensitivity to these cues.

**Positive Attitude and Behavior 5:** Talking about a client's past suicidal behavior can provide information about triggers for suicidal behavior.

**Positive Attitude and Behavior 6:** You should give clients who are at risk of suicide the telephone number of a suicide hotline; it does no harm and could actually save a life.

***Instructor Note: It is extremely important to remember that even when you believe a client is “manipulating or attention seeking” by stating they are experiencing suicidal thoughts, of desire to hurt themselves in some way, you MUST take them seriously. Counselors need to realize that even in rare circumstances where clients appear to be purposefully using reports of suicidal thoughts or plans to manipulate their treatment regimen, expressions of suicidality must be taken seriously. Thus, when clients appear to “use” suicidality, it should be recognized as a very limited approach to coping. Indeed, there is often more than one reason for an act of suicide (e.g., one may simultaneously want to die and elicit attention). You must address clients “where they are” and not impose your own agenda. If suicidal thoughts or behaviors occur, addressing suicidality must be a priority. Even if a client really does not want to die, if his or her reports of suicidal ideation are not taken seriously, the client may act on them to “save face.”***

### **Warning Signs for Suicide**

Warning signs are defined as acute indications of elevated risk. In other words, they signal potential risk for suicidal behavior in the near future. Warning signs may be evident at intake or may arise during the course of treatment. Warning signs always require asking follow-up; warning signs can be direct or indirect. **Direct** indications of acute suicidality are given the highest priority. They are:

- ✚ **Suicidal communication:** Someone threatening to hurt or kill him- or herself or talking of wanting to hurt or kill him- or herself.
- ✚ **Seeking access to a method:** Someone looking for ways to kill him- or herself by seeking access to firearms, available pills, or other means.
- ✚ **Making preparations:** Someone talking or writing about death, dying, or suicide, when these actions are out of the ordinary for the person.

Warning signs are often in evidence following acute stressful life events. Among people who abuse substances, break-up of a partner relationship is most common. It is also important to look for warning signs in your clients when relapse occurs and during acute intoxication.

Stressful life events include:

- ✚ Break-up of a partner relationship.
- ✚ Experience of trauma.
- ✚ Legal event.
- ✚ Job loss or other major employment setback.
- ✚ Financial crisis.
- ✚ Family conflict or disruption.
- ✚ Relapse.
- ✚ Intoxication.

Each of the **direct** warning signs indicates potential for suicidal behavior in its own right, and, if present, requires rigorous follow-up. The **indirect** warning signs may or may not signal risk for acute suicidal behavior (for example, “substance abuse” is the norm among your clients). In all cases, they require further follow-up questions to determine if they may indeed indicate acute suicidality.

## **Risk Factors**

Risk factors are defined as indicators of long-term (or ongoing) risk. They are different from warning signs, which signal immediate risk. Risk factors for suicidal thoughts and behaviors among individuals with substance use disorders have been well researched (Conner, Beautrais, & Conwell, 2003; Conner et al., 2007; Darke & Ross, 2002; Ilgen et al., 2007; Murphy et al., 1992; Preuss et al., 2002; Roy, 2001; Schneider et al., 2006). The list below, although not exhaustive, is informed by these studies.

### **Risk factors for suicidal thoughts and behaviors include:**

- + Prior history of suicide attempts (most potent risk factor, although it should be remembered that about half of all deaths by suicide are first-time attempts).
- + Family history of suicide.
- + Severe substance use (e.g., dependence on multiple substances, early onset of dependence).
- + Co-occurring mental disorder:
  - Depression (including substance-induced depression).
  - Anxiety disorders (especially PTSD).
  - Severe mental illness (schizophrenia, bipolar disorder).
  - Personality disorder (best researched are borderline and antisocial personality disorders).
  - Anorexia nervosa.
- + History of childhood abuse (especially sexual abuse).
- + Stressful life circumstances:
  - Unemployment and low level of education, job loss, especially when nearing retirement.
  - Divorce or separation.
  - Legal difficulties.
  - Major and sudden financial losses.
  - Social isolation, low social support.
  - Conflicted relationships.
- + Personality traits:
  - Proneness to negative affect (sadness, anxiety, anger).
  - Aggression and/or impulsive traits.
- + Firearm ownership or access to a firearm.

- ✚ Probable risk factors (although greater certainty requires more research in people with substance use disorders):
  - Inflexible/rigid personality characteristics.
  - Sexual orientation (lesbian, gay, or bisexual).
  - Chronic pain.

### **Protective Factors**

Protective factors are defined as buffers that lower long-term risk. Unlike risk factors, factors that are protective against suicidal behavior are not well researched (Goldsmith, Pellmar, Kleinman, & Bunney, 2002). Fewer protective factors than risk factors have been identified among people who abuse substances and other populations. Reasons for living are perhaps the best researched protective factors in the literature (Linehan Goodstein, Nielsen, & Chiles, 1983; Oquendo Dragasti et al., 2005).

The following are known and likely protective factors:

- ✚ Reasons for living.
- ✚ Being clean and sober.
- ✚ Attendance at 12-Step support groups.
- ✚ Religious attendance and/or internalized spiritual teachings against suicide.
- ✚ Presence of a child in the home and/or childrearing responsibilities.
- ✚ Intact marriage.
- ✚ Trusting relationship with a counselor, physician, or other service provider.
- ✚ Employment.
- ✚ Trait optimism (a tendency to look at the positive side of life).

***A caution about protective factors: If acute suicide warning signs and/or multiple risk factors are in evidence, the presence of protective factors does not change the bottom-line assessment that preventive actions are necessary, and should not give you a false sense of security. Although protective factors may sustain someone showing ongoing signs of risk (e.g., due to chronic depression), they do not immunize clients from suicidal behavior and may afford no protection in acute crises.***

Protective factors vary with cultural values. For example, in cultures where extended families are closely knit, family support can act as a protective factor. Others include a strong affiliation with a clan, tribe, or ethnic community; faith in and reliance on traditional healing methods;



strong spiritual values shared among community members; and absence of cultural trauma such as that of families of Holocaust survivors and American Indians who were sent unwillingly to boarding schools to be acculturated.

### **Definition of Professional Counselor Characteristics**

- + Empathy - the ability to identify with and understand another person's feelings or difficulties.
- + Genuineness - honest and open in relationships with others.
- + Respect - a feeling or attitude of admiration and deference toward somebody or something
- + Warmth - affection and kindness, fond or tender feeling toward somebody or something
- + Immediacy - moving away from the contents of the sharer's problems and placing the emphasis on the process going on in the moment between the helper and the one seeking help.
- + Concreteness - certain and specific rather than vague or general
- + Potency - successful, especially in producing a strong or favorable impression on people
- + Self-actualization - the successful development and use of personal talents and abilities
- + Understanding - a sympathetic, empathetic, or tolerant recognition of somebody else's nature or situation
- + Transparent - completely open and frank about things
- + Tolerant - accepting the differing views of others
- + Patient - able to endure waiting or delay without becoming annoyed or upset or to persevere calmly when faced with difficulties
- + Validating - to provide somebody with moral support, or inspire somebody with confidence
- + Flexible - able to change or be changed according to circumstances
- + Curious - eager to know about something or to get information
- + Open-minded - free from prejudice and receptive to new ideas
- + Clarification - to make something clearer by explaining it in greater detail

- ✚ Paraphrasing - to restate something using other words, especially in order to make it simpler or shorter
- ✚ Reflection - careful thought, especially the process of reconsidering previous actions, events, or decisions
- ✚ Neutral - not possessing any particular quality or revealing a particular attitude or feeling

### **Try to Avoid**

- ✚ Assumptions - something that is believed to be true without proof, the tendency to expect too much
- ✚ Preconceived Ideas - formed in the mind in advance, especially if based on little or no information or experience and reflecting personal prejudices
- ✚ Biases - an unfair preference for or dislike of something

### **Advice for the Professional Counselor**

#### **Tips to Avoid Increasing Resistance**

Behaviors to avoid as they damage rapport, increase resistance, and create conflict between client and counselor.

- ✚ Arguing for change
- ✚ Assuming the expert role
- ✚ Criticizing, shaming, or blaming
- ✚ Labeling the client's behavior
- ✚ Being in a hurry
- ✚ Claiming to know what is best

### **What a Professional Counselor Needs To Know**

#### **Show your Professionalism**

- ✚ Express empathy
- ✚ Develop discrepancy
- ✚ Avoid argumentation and direct confrontation
- ✚ Roll with resistance



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- + Support self-efficacy and optimism

### **Professional Counselor Presentation**

- + Attending Behavior
- + Encourages client talk
- + Active Listening
- + Eye contact: interested, alert, awake, processing
- + Cultural differences: Be aware & sensitive
- + Attentive body language
- + Vocal qualities – even, soothing
- + Verbal tracking—keep to the client’s topic
- + Silence

## **Counselor Attitudes and Values**

### **Chapter 3**

***TAP 21 Competency: Conduct self-evaluations of professional performance applying ethical, legal and professional standards to enhance self-awareness and performance.***

***TAP 21 Competency: Recognize the importance of individual differences that influence client behavior, and apply this understanding to clinical practice.***

#### **Clarification of Values**

Individually, we work within standards of care to support our professional role in the helping professions.

#### **We may ask ourselves:**

- + Where is my knowledge and skills best used?
- + Am I getting the support I need to help the people we serve? Am I getting the support I need to help the people we serve?
- + Do my individual practice standards/values conflict the organization's expectations?
- + What is our overall agency mission and goals?
- + Who's needs are being met? Ours or the clients'?
- + How can we improve upon our services to meet the clients' needs?
- + Commitment to Clients
- + Promote the well-being of clients. In general, clients' interests are primary.
- + Self-Determination
- + Respect and promote the right of clients to self-determination and assist clients in their efforts to identify and clarify their goals.

#### **As a REMINDER:**

#### **Definition of Culture:**

***The word ‘culture’ describes the integrated pattern of human behavior(s) that includes thoughts, communications, actions, customs, beliefs, values, and institutions of a racial, ethnic, religious, or social group.***

**Some General Cultural Considerations:**

- + Lack of confidentiality (trust)
- + Lack of social services (rural/reservation/poorly developed area)
- + Limited access to comprehensive health care
- + Unresolved trauma(s): historical or otherwise (ex Urban Unresolved trauma(s): historical or otherwise (ex. Urban relocation program, history of abuse –sexual or otherwise)
- + Racism – Homophobia – Xenophobia

**Cultural Humility:**

- + Incorporates a lifelong commitment to self-evaluation and critique, to redressing the power imbalances in the physician patient dynamic.
- + Acknowledges that we can never become truly competent in another’s culture
- + Requires simultaneous process of ongoing self-reflection and commitment to lifelong learning

**Building Trust:**

- + Foundation for any and all that we work with...
- + Non-judgmental: No “right or wrong” – setting aside biases.
- + Strengths-based: Identifying behaviors that support healthy lifestyle (ex. scheduling an appointment).
- + Authenticity: Personal connection helps build the therapeutic relationship:
- + Important to take time to establish a connection before work can be done, specific with Native clients.
- + Introductions are important.
- + Make no assumptions regarding sexual behavior (ageism).
- + Make no assumptions regarding sexual orientation (straight vs. gay identified).

**Engagement:**

- + Can be as simple as offering a glass of water



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- + Meeting at a place of their choice (creating ease for the client) Consider outdoors/park, client home
- + Offer extended hours to meet
- + If possible rearrange the furniture (remove any barriers to open communication).
- + Professional use of self: ex. humor.
- + Utilizing supportive family/connections.
- + Accessing cultural knowledge and spiritual practices.

**Service providers work from a positive-service delivery model:**

- + Strengths-based approach: collaborate, identify and exemplify strengths as a way to empower.
- + Convey authentic/real interest (mindfulness)
- + Acknowledge and provide support for positive steps already made! Ex. scheduling an intake appointment (support)

***Instructor Note: In my classroom I have the students complete a few different self-evaluations that take a look at their feeling about clients, various populations they may serve, their own values, biases and judgments. These exercises always turn out to be the highlight of the course. When the student is honest in answering the self-evaluations they are able to discover things about themselves that set them up to explore these thoughts and feelings and how they may help or hinder their work with clients. As an instructor it is a joy for me to watch students come to different realizations about themselves and how they see things. I suggest that you do a search on the internet, they are plenty of counselor self-evaluations to be printed out and completed. See what you can learn and what that learning provides for you and your idea of counseling. Go on, explore, learn, and grow.***

# Counselor Know Thyself: Boundaries and Burn Out

## Chapter 4

*TAP 21 Competency: Develop and use strategies to maintain one's physical and mental health.*

*TAP 21 Competency: Use a range of supervisory options to process personal feelings and concerns about your clients*

### Understanding Transference and Counter-transference

What does the terms transference and counter-transference mean?

**Transference** refers to clients' placement of feelings originally directed towards significant others in their life onto the counselor (Wallin, 2007). For example, clients might project feelings related to their mother or father figure onto the counselor. In some cases this may lead to a belief that the counselor is nurturing and loving; in other situations feelings of anger and mistrust may arise. In the clients' mind the counselor may also come to represent their ideal partner or friend; this may lead to platonic, romantic, or sexual attraction.

Due to the clients' complicated thoughts, beliefs, and emotions entangled with the issue of transference developing ways to guide a counselor to work with these issues will be discussed so that clients may gain deeper insight and to preserve the therapeutic relationship.

**Counter-transference** - occurs when counselors' emotions, beliefs, and biases are projected onto their client; as with transference this is typically related to the counselor's life history. Counter-transference involves an emotional connection with the client beyond what other counselors would deem as appropriate within the therapeutic relationship. The counselor's acceptance of the client's transference is another example of counter-transference (Gelso & Hayes, 2007). For example, when clients project feelings related to their parental figure onto their counselors, the counselors may find themselves wanting to protect the clients and reach beyond their boundaries to assist the clients. In such cases it is important to explore issues of both transference and counter-transference in order to rebalance the therapeutic relationship, re-establish boundaries, and promote client growth. Again, there are many ways to recognize and respond to counter-transference during individual and group supervision. When not





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addressed, counter-transference can lead to violations of boundaries and potential harm to clients.

Although these are issues which are present in every form of counseling and therapy, some areas are more influential regarding the level of transference and counter-transference experienced in particular by developing Alcohol and Drug Counselors. Two of these areas include a higher potentiality for the client to have similar life experiences as the counselor (i.e., history of alcohol and other drug (AOD) use, treatment history, legal issues, etc) and the degree of confidence the counselor feels working with co-occurring issues (depending on education, training, and experience). As with all other developing counselors, it is imperative to acknowledge what stage the individual counselors are in regarding their professional development and base the intensity of supervision and oversight on their level of development.

### **Maintaining awareness**

Management of transference and counter-transference is critical to effective counseling and the prevention of compassion fatigue and ultimately burnout. The intensity of my reaction to a client serves as my personal trigger for counter-transference awareness. When I really like and enjoy (or dislike and don't enjoy) a client, I realize that this is most likely a counter-transference reaction. Experience has taught me to seek supervision when I suspect that counter-transference is percolating in the therapeutic relationship.

Ongoing clinical supervision that allows counselor honesty offers the best method for addressing counter-transference. Counter-transference is an inevitable and desired component of the therapeutic relationship and often serves as the vehicle for professional and personal growth for both recovering and non-recovering counselors. However, these reactions must be addressed, because if they are ignored, they usually reappear more intensely. Unaddressed counter-transference can have a destructive impact on the client, the counselor, and the therapeutic relationship. Some-times a resolution of the situation requires a break from working with the population that is causing the counter-transference. Giving counter-transference prominence in a burnout prevention plan is critical to counselor survival.

Counter-transference that is not managed via supervision and personal therapy can be acted out in ways that never help the therapeutic process. When the counselor becomes the good parent and tries to rescue the client or is overprotective, mothering/smothering, and enmeshed, the therapeutic relationship is compromised and the client is encouraged to stay

dependent. When the counselor forms an alliance with the client, he/she demonstrates counter-transference by avoiding negative feelings and protecting the client from confrontation; this ultimately can divide staff members. Whichever way counter-transference plays out, it has gone too far and never will encourage client growth.

The recovering counselor is particularly vulnerable to counter-transference reactions, compassion fatigue, and burnout because of the double-edged sword of personal experience. Counselors in recovery have the strength of knowing that addiction can be managed by significant lifestyle and philosophic changes. However, heightened sensitivity to the issues surrounding addiction can occasionally pierce the protective shell of even the best-trained professional. Because 12-Step programs suggest we are equal and can learn from honest sharing, recovering counselors must establish firm role boundaries for themselves. Hyper-vigilance to personal reactions to the stories and issues of clients helps counselors improve quality of care.





### **Boundaries**

**Boundary** - Edge of appropriate behavior at a given moment in a relationship between patient/provider, governed by the therapeutic context & contract.



**Boundary crossing** - Benign deviations from standard practice, harmless, non-exploitative, may advance therapy goals, i.e., helping a falling patient, giving patient ride home in a blizzard.

**Boundary violation** - Significant deviations from standard practice, harmful, exploitative, takes therapist out of professional role.

### **Why are Boundary Issues Important?**

-  Blurred boundaries distort therapy bond
-  Can impair counselor's judgment
-  Conflict of interest
-  Exploitation of client

### **Codes to Practice By:**

-  The responsibility for setting & maintaining boundaries always belongs to the counselor.
-  The patient should not be blamed or stigmatized for violating a boundary.



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## **Touch**

- + 59% of counselors hugged, kissed, or affectionately touched clients
- + When we touch all patients the same then we know it is therapeutically supportive
- + Do nothing in private that you wouldn't do in public

## **Dual Relationships**

Dual or multiple relationships occur when professionals assume two or more roles at the same time or sequentially with a client.

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.

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.

### **Examples of Dual Relationships**

- + Counselor and friend
- + Counselor and business partner
- + Bartering therapy for goods and / or services
- + Providing therapy to a relative or a friend's relative.
- + Socializing outside of therapy sessions
- + Combining the roles of supervisor and therapist
- + Becoming emotionally involved with a client or former client.
- + Becoming sexually involved with a client or former client

### **Counselor Self-Disclosure**

During your CAP courses there has been a lot of discussion clients' disclosure, but what about counselors' disclosure?

The counselor should avoid too much self-disclosure. While occasional appropriate self-disclosure can help the client to open up or motivate the client by providing a role model, too much self-disclosure removes the focus from the client's recovery. A good rule regarding self-disclosure, if the counselor is so inclined, is that the counselor first has a clear purpose or goal for the intervention and then think about why he or she is choosing self-disclosure at this time.

The counselor should be aware of when his or her own issues are stimulated by a client's problems and therefore refrain from responding to the client out of his or her own dynamics. For example, if a counselor in recovery feels it extremely important to break ties with addicted peers, but a particular client with an addicted spouse or partner cannot break free of the relationship, it is imperative that the counselor respond flexibly and creatively to the client's perception of the situation and not rigidly adhere to the notion that breaking ties with all addicts is the only way to recovery.

Research summations have indicated cautions on counselor disclosure. The conclusions generally indicate that counselor self-disclosure is rarely associated with counseling outcomes, and when it was, the influence was often negative. However, a fine distinction has been made between disclosing (information that is associated with a counselor's past) versus self-involvement, which is associated with the current counseling situation (e.g. how you, the counselor, feel the counseling is proceeding; and your feelings about the client and process). The latter is associated more with positive outcomes, and rates higher with clients.

In terms of strict counselor disclosure, it would appear that too much is not a good idea. If repeatedly used as a mainstay of counseling, the client may begin to think, "Who has the problems here?" Yet, utilizing self-involved statements may bring about benefits of rapport and warmth.

Kottler (1991) outlined the following questions for the counselor to consider prior to any disclosure:

- What will this accomplish?
- Is there another way to make my point?
- Is the timing right?
- Am I trying to meet some of my own needs?
- How can the client personalize and use what I share?

## **Stress Management & it's Relationship to Professional Burn Out**

### **Bio-Psycho-Social Stress:**

**Biological:** Brain, muscles, skin, limbic—emotions, endocrine—glands/hormones, autonomic nervous— expending and conserving energy, cardiovascular, gastrointestinal

**Psychological:** Thoughts and feelings

**Sociological:** Surrounding environment

**Stress Symptoms:**

- + Diminished or over-stimulated sense of humor.
- + Skipping rest and food breaks
- + Binge eating
- + Increased overtime and no vacation
- + Increased physical complaints
- + Social withdrawal: church, family, friends
- + Changed job performance
- + Increase in time away from work (illness, family, and environment)
- + Self-medication
- + Sleep: too much or lack of
- + Emotional Changes (low self-esteem, depression, anxiety, irritation, anger)
- + Physiological Changes (Hypertension--high blood pressure, ulcers, migraine or chronic tension headaches, ulcers, acid reflux, skin irritations)

**Stress   ➡   Burnout**

**Recognize that you can take action in managing your stress and prevent burn-out:**

1. Is your efficiency at work declining?
2. Do you have frequently changing or depressing moods?
3. Have you lost some of your initiative at work?
4. Are you easy to anger?
5. Have you lost interest in your work?
6. Do you get frustrated easily?
7. Does work stress get to you more than it used to?
8. Are you more suspicious than you used to be?
9. Do you feel fatigued or run-down?
10. Do you feel more helpless than you used to?
11. Do you get headaches, stomach aches or back aches?
12. Are you using too many mood altering drugs (sleep aids, alcohol...)



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13. Have you lost or gained weight recently?
14. Are you becoming more inflexible?
15. Do you find yourself eating to replace emotion?
16. Are you becoming more critical of your own and others' competencies?
17. Do you have trouble sleeping?
18. Are you working more but feeling that you are getting less done?
19. Do you experience shortness of breath?
20. Have you lost some of your sense of humor

Compassion Fatigue, Burnout and Vicarious Trauma are all terms that are used within the helping profession. Often Compassion Fatigue is confused with Burnout and it's important that helping professionals understand the difference.

**Burnout:** Burnout refers to the physical and emotional exhaustion that comes from prolonged stress and frustration. When we feel we have too many demands, and not enough resources, we begin to feel powerless to reach our goals. This can lead to a reduced feeling of personal accomplishment and diminished self-care. Burnout can happen in any field/job. It results in significant negative impacts on health and outlook on life.

**Vicarious Trauma:** When a person is continuously exposed to other people's traumatic experiences through witnessing and/or hearing others' stories, vicarious trauma can be experienced. Vicarious trauma (VT) means that you have not been the direct victim of a trauma, but you have experienced it second hand from clients through their stories of pain. Clinicians may begin to experience posttraumatic stress symptoms similar to the person who experienced it. This can include intrusive imagery (images of trauma popping into your head) dreaming about the traumatic situation or avoiding certain activities and so on.

Ongoing vicarious trauma can result in a shift in the helper's world view and sense of meaning, for example, someone who may regularly feel safe can begin to doubt their safety if they work with victims of crime and hear numerous stories of crimes and trauma. If a helper has a previous history of trauma (and many have as more than 70% of the population has experienced one or more event significant enough to be traumatic) that is unresolved, then you are more likely to experience VT. Vicarious trauma is something that people experience on a continuum, you may leave the job but you will still have that foundation of VT within you.





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**Compassion Fatigue:** Compassion Fatigue is applied to people who suffer as a result of being in the helping profession. If helpers experience both burnout and VT they are more vulnerable to developing Compassion Fatigue (CF). Compassion Fatigue is when someone who regularly hears/witnesses very difficult and traumatic stories begins to lose their ability to feel empathy for their clients, loved ones and co-workers. This deep physical and emotional exhaustion has been described as “having nothing left to give” and “an occupational hazard”. Compassion Fatigue can show as a variety of symptoms presenting behaviorally, emotionally, relationally, physically and spiritually. Sometimes CF is misdiagnosed as depression.

Compassion Fatigue is developed because of the helper’s strong ability to care for their clients in the first place. It is the most caring individuals who are most likely to develop CF. The best helping professionals are able to connect with their clients because of their strong ability to empathize with them. It is this gift of empathy that can also lead them to develop CF. By learning about CF and developing ways to manage it, these helpers can continue to do the work they love, and are good at, while still being able to thrive personally. Simply leaving one helping job and moving into another will not reduce one’s CF.

So how do we remain in the helping profession while limiting our Compassion Fatigue? One strategy is to **Empathize With Care!** One way to manage Compassion Fatigue is to be aware of the effects of empathizing. We empathize with our clients so that we can connect with them and help them in their suffering and struggles. In her book, *Help for the Helper*, Babette Rothschild explains the neuroscience behind empathy and discusses emotional contagion. In order to do our jobs well, we need to be able to maintain awareness of what feelings are ours and what feelings belong to the people we are working with.

One way to ensure we maintain awareness is to be mindful about our own internal experiences while we are hearing our client’s stories. We can do this by picking up on sensations in our bodies, noticing images or sounds that come into our minds, note our breath and muscle tension, as well as any emotions that arise or any thoughts that occur. This will enable us to ensure that we engage in conscious empathy, thereby, allowing us to empathize while still caring for ourselves, managing our own internal experience and being the best helper we can

be. The next time you are working with a client who is sharing a difficult story, take a moment to check in with your whole self and ensure you are empathizing with care!

### **More on Burn Out**

- ✚ An emotional exhaustion in which the professional no longer has any positive feelings, sympathy, or respect for clients.
- ✚ An adverse work stress reaction with psychological, physiological, and behavioral components often associate with:
  - stress
  - fatigue
  - frustration
  - apathy (an absence of emotion or enthusiasm)

### **Stages of Burnout Development:**

Stage One: the honeymoon – satisfied with the job

Stage Two: fuel shortage – fatigue sets in

Stage Three: chronic symptoms – physical effects

Stage Four: crisis – actual illness can develop

Stage Five: hitting the wall – physical and psychological problems can become severe enough to cause illness that is life-threatening.

### **Burn-Out Simply Put:**

Sustained, unmanageable, painful stress.

**Your response is your responsibility.**

- ✚ Burnout has implications for ethical practice.
- ✚ Burnout compromises your physical and mental health and social relationships (work, family and friends).

### **Interventions:**

- + Seek help!
- + Set limits
- + Manage symptoms
- + Seek deeper meaning in your work
- + Ex. new interests, new areas, new challenges
- + Implications of burnout for ethical practice
- + Your response is your responsibility

## **Stress Management**

Interventions or activities designed to block a stressor from resulting in negative consequences such as illness or disease.

Stress management consists of the use of interventions (diet, exercise, activities, laughter, reading, medication, music, etc.).

- + Humor
- + Time management – Too little occupational stress is almost as unhealthy as too much
- + Meditation
- + Prayer/Spirituality
- + Volunteer
- + Setting goals, prioritizing, scheduling, saying “no”, maximize your rewards, delegate, evaluate, limit interruptions
- + Volunteer
- + Progressive Relaxation Techniques – nerve/muscle
- + Exercise – make it fun!

***Instructor Note: Recognizing, following and respecting these guidelines creates your clinical and professional foundation for a healthy, ethical, successful, clinical practice. Understanding the impact of countertransference and taking care of any unresolved issues you may have is of the utmost importance if you want to help clients, do no harm to your clients and work in this field for a long, long time without burning out and without compromising your ethics or your clinical judgment.***

## Supervision

### Chapter 5

#### ***TAP 21 Competency: Participate in on-going supervision***

#### **General Description of Supervision**

Ongoing supervision is a necessary part of counselor training and support. Lack of adequate supervision can contribute to counselor stress and burnout, both of which are seen frequently.

The ultimate goal of supervision is to enhance the quality of client care. Focus to achieve this goal is twofold. First, it is centrally important that the supervisor provide support and encouragement to the counselor along with the opportunity to expand his or her skills. Second, it is important that the supervisor have the opportunity to review the clinical status of clients and offer suggestions or corrections.

The format of supervision is for each individual to have a supervisor and meet with that supervisor for 1 hour once a week to review counseling sessions. Individual counseling sessions are audio-taped, and the supervisor is responsible for listening to a percentage and rating them for adherence to the counseling manual. This feedback is then given to the counselor.

#### **Counseling Supervision and Training**

The counselor's job is a demanding one, and clinical supervision is required to sharpen clinical skills, ensure consistency in treatment approach, and provide the counselor with emotional support and encouragement. Clinical supervisors use various reports to monitor each counselor's client caseload and work performance. These reports also include data on client treatment plans and updates, progress notes, attendance at sessions, urine test results, and treatment plan goal attainment levels.

Measures of all counselors' work performance should include data on quantity of clinical services provided to clients (i.e., numbers of sessions), responses to positive urine test results and missed sessions, timeliness of follow-up on clients who fail to show up for sessions, and counselors' compliance with chart-noting requirements. Supervisors pay special attention to client treatment response, since progress and retention are key factors in determining treatment success. Supervisors may sit in on counselors' group sessions to directly observe their therapeutic skills in action. In addition to supervisory meetings, best practices recommend



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at least a twice monthly case conference attended by all counselors for discussing special problems. Clinical supervisors may also want to develop a series of in-service trainings for counselors to augment and/or refresh their skills as clinicians in areas related to the client population.

## **What counselors should learn from supervision**

### **Clinical supervisors ought to be training counselors to:**

- Be attuned to the client's feelings, how to establish rapport, and how to demonstrate caring, compassion, and empathy.
- Find a collaborative rather than combative metaphor for treatment; they must learn the more subtle interpersonal aspects of the therapeutic relationship.
- Learn how to develop and monitor the therapeutic alliance, how to assess difficulties with that alliance, and how to repair alliance ruptures.
- Become familiar with social support networks, community services, family, and community resources to enhance the potential for success.
- Reconsider the conventional wisdom suggesting that it is the client's fault when treatment does not meet the desired outcome. To break from this conventional wisdom, counselors must embrace the attitude that if there is any magic in treatment, it is the magic brought by the client and not the counselor.
- Promote the client's sense of personal control and empowerment. By encouraging clients to see their own gains, counselors can convey positive expectations and hope, helping the client to find his or her own solutions.
- Focus on the future, especially on the client's ability to overcome the past; they must develop an attitude that the client is capable of finding his or her own solutions, always expecting the client to get better. Far too often in the addictions field, we predict relapse and failure instead of the possibility of success.
- Learn effective intervention with clients needing fewer than 10 sessions (the majority of the clients seen); often, simply scheduling an appointment begins the change process.

Although a certain number of clients (20-30 percent) need treatment for more than 25 sessions, counselors need to be adept at working with short-term and long-term clients, and have the ability to know the difference.

- Learn diagnostics, but not too soon. As important as diagnostics are, supervisors must delay teaching them for fear that counselors will too quickly begin assessing and making value judgments about clients. Diagnostics should be taught after the basic affective qualities for counselors are well established.
- Be able to adapt the relationship to different clients and their needs. The most important question a counselor can ever ask a client is, “What do you want?” followed by “How can I help you get there?”
- Remember that the earlier change happens in treatment, the more likely the outcome will be positive; it is not the counselor who can make the client work, but the client who makes the counselor work.

### **Developmental Stages of Counselors**

Counselors are at different stages of professional development. Regardless of the model of supervision the supervisee’s level of training, experience, and proficiency must taken into account. Different supervisory approaches are appropriate for counselors at different stages of development. An understanding of the supervisee’s (and supervisors) developmental needs is an essential ingredient for any model of supervision.

It is important to keep in mind several general cautions and principles about counselor development, including:

***There is a beginning but not an end point for learning clinical skills; be careful of counselors who think they “know it all.”***

There is a logical sequence to development, although it is not always predictable or rigid; some counselors may have been in the field for years but remain at an early stage of professional development, whereas others may progress quickly through the stages.

### **Facilitator of Professional Growth**



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The clinical supervisor can be a source of professional growth for all the members of an agency. This is done by behaving in a professional manner at all times. This can also be orchestrated by creating, and maintaining a safe, and supportive learning environment. In other words, the clinical supervisor is a team player who is willing to share her or his expertise to any staff member who asks.

Professional growth can also be obtained when the clinical supervisor engages in activities that increase knowledge, skill, attitudes, and values. Defining the goals and path of the supervisor/supervisee relationship are part of the activities the supervisor can engage in.

***Instructor Note: Not much to add here, only this: WHEN IN DOUBT SEEK SUPERVISION, FOR CLINICAL GROWTH AND GUIDANCE SEEK SUPERVISION, WHEN HAVING DIFFICULTIES WITH A CASE, A PEER SEEK SUPERVISION, WHEN CONFRONTED WITH AN ETHICAL DILEMA SEEK SUPERVISION!!***

***Just in case my message isn't clear....SEEK SUPERVISION!***

## **Professional Growth**

### **Chapter 6**

***TAP 21 Competency: Obtain appropriate continuing professional education***

***TAP 21 Competency: Interpret and apply information from current counseling and psychoactive use research literature to improve client care and enhance professional growth.***

So, you have completed all your coursework, you have amassed all of your direct practice hours, you filed your application, you took the CAP exam and YES!!!! YOU DID IT!! YOU PASSED!! Now what?

Well hopefully you find a great job as a counselor in a facility you are proud to work for with clients you care about. You are also ethically and professionally bound to continue your professional and clinical growth. Part of this continuing education is mandated by the Florida Certification Board as part of your recertification process. But that is not the only reason/purpose to continually challenge yourself.

Attending professional trainings, watching webinars, staying on top of articles related to the newest research in addiction treatment, understanding addiction, new street drugs, new therapeutic techniques etc. makes you prepared, professional, clinically astute and an asset to your clients.

Just as in any other behavioral health discipline addiction professionals have their own association that you can become a member of and take part in all they have to offer in the form of education, research, professional information, trainings etc.

NAADAC, the Association for Addiction Professionals, is the largest national organization for addiction-focused health care professionals with 8,000 members. NAADAC is dedicated to the professional growth and development of addiction specialists.

### **Credential Maintenance and Renewal**





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Maintaining a credential in good standing is very important. To further our mission of public safety, the FCB maintains a public-access database allowing verification of an individual's certification status and ethical history. To remain in good standing, certified professionals must:

1. Actively participate in annual continuing education to maintain a current knowledge and skill base.
2. Follow the FCB Code of Ethical and Professional Conduct.
3. Complete the renewal process in a timely manner, every June.

Please carefully read this section to ensure you understand maintenance and renewal requirements.

### **Continuing Education Requirement:**

Certified Addiction Professionals must complete 20 hours of continuing education units (CEUs) per year. One CEU is equal to 50 minutes of instruction.

Training content must be related to at least one of the Transdisciplinary Foundations and CEU hours must be non-repetitive (i.e., the same course cannot be claimed more than one time during each credentialed period, even if the course was taken annually.)

Continuing education units must be earned from a FCB recognized or approved CEU training provider: some training providers hold approval from other entities that is recognized by the FCB, other training providers apply for and hold FCB Training Provider Status.

**FCB Recognized Education and Training Providers:** The FCB will honor CEUs issued by any of the following providers:

1. FCB approved training providers
2. International Certification and Reciprocity Consortium (IC&RC) member board approved providers
3. College or university coursework offered by institutions holding Federal Department of Education and/or Council of Higher Education Accreditation (CHEA) recognized accreditation.



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4. Training providers approved to offer CEUs by other state or national professional licensing or certification boards. FCB Approved Education and Training Providers: The FCB will award FCB Education and Training Provider status and a number to approved applicants.

A list of approved FCB Education and Training Providers is maintained on our webpage at [www.flcertificationboard.org](http://www.flcertificationboard.org).

### **Credential Renewal Requirement:**

The Certified Addiction Professional (CAP) credential and the IC&RC Alcohol and Drug Counselor (ADC) credentials each must be renewed annually, no later than June 30 of the renewal year.

### **Renewal Notice Process:**

The FCB will send out renewal notices in April and May of the renewal year. Renewal fees must be paid and, if audited, CEU documentation must be approved no later than June 30th of the renewal year.

Individuals who DO NOT meet renewal requirements by June 30th may pay the renewal fee, a \$30 late fee and must submit CEU (regardless of audit status) no later than July 31st of the renewal year.

Individuals who DO NOT meet renewal requirements by August 1st of the renewal year will be automatically placed in inactive status and must complete the FCB Reinstatement Process to recertify.

***Instructor Note: DO NOT rest on your laurels, do not be satisfied you know enough. Find what interests you, what sparks your mind to thinking and research it, learn it and practice it. You and your clients will benefit.***



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## Conclusion

As an addiction counselor you will be called upon to help many people in deep distress during your career. These people will count on you to have some answers, some care and concern, empathy, clinical knowledge and more. But the most important things you can be is ethical and professional.

Your sense of professional moral responsibility to those you serve is what will guide through a long and successful career. Standing solidly on ethical and professional ground keeps you on a path of growth, clinically and personally.

Never mind the others around you, you stick to your ethical and professional guns and feel pride and self-fulfillment.



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