Journal of Human Services: Training, Research, and Practice

Volume 3
Issue 1 *Clarifying Ethical Practice with Clients and Supervisees*

Article 1

2-2018

Practice-based conundrums and existentialist quandaries of a professional code of ethics

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Running HEAD: WHAT MAKES ADDICTION ETHICS CODES ETHICAL

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Abstract

Ethical codes have long been considered indispensable tools in defining the proper conduct of counseling professionals. Revisions reflect the ideals of the industry to accommodate the evolving needs of clients and trends in treatment models, but the essence of the code is to convert principles befitting of the profession into concrete actions or considerations that abet professional decision-making. Acculturation into the profession involves ethics training intended to improve professionals' ability to apply the code to situations that might arise in their practices, resulting in the most ethically appropriate action. However, such assumptions may be problematic. The idea of ethical competency and improvement in the code itself should be qualified to reflect the uncertainty of moral truths, including counselor training tailored to test competency, both before and during professional practice. In this article, the consideration that morals and ethics are distinct is spelled out and then challenged by drawing on Jean Paul Sartre's existentialist critique of moral decision-making reality. In light of this critique and John Stuart Mill's argument regarding the value of vigorous debate over philosophical ideas, suggestions are made regarding a potential approach to ethics competency education.

Keywords: ethics, counseling, licensure and certification, ethical decision making, code of conduct, philosophy

Professional ethics codes in the United States continue to evolve and become more elaborate (Behnke & Jones, 2012) to reflect changing times and articulate different meanings and cultural contexts (Walsh, 2015). Take for example the growing use of tele-counseling services and the ubiquitous technologies of this digital age (Addiction Technology Transfer Center Network, 2013) such as apps and virtual reality simulation systems. The newly revised code of ethics (COE) of the Association for Addiction Professionals and The National Certification Commission for Addiction Professionals (NAADAC, 2016), at twenty-one pages long, is drastically lengthened from previous versions. The overall growth and widespread acceptance of digital media in counseling and treatment services adds a whole new layer to the issue of ethical boundaries and self-disclosure. The evolution of professional codes of ethics in the United States also attempts to address ethical situations in a clear manner to obviate discussion about ethicality in concrete cases. One way this is achieved is by embedding clear-cut moral violations (e.g., no sex with clients) in the code of ethics to fetter the taking of liberties in professional conduct.

While "codified professional obligations cannot be fully explicit, precise, or straightforwardly applicable to every conceivable situation" (Martin, 2000, p. 136), without properly elucidated COEs counter arguments can ensue, in particular with respect to the legal contexts (Behnke & Jones, 2012). For example, 42 CFR Part 2 and HIPAA applications (federal laws that govern the practice of certain aspects of addiction treatment services and the protection of client confidentiality) provide a strict framework for appropriate disclosure. COEs play a seemingly indispensable role in defining the parameters of the profession and holding practitioners accountable:

> Within the addiction and mental health counseling professions, codes of ethics represent consensus standards of conduct, reflecting the professions' aspirations, expectations and obligations. They are adopted and relied upon by licensing

> boards, certification organizations, professional associations, and college and university graduate training programs. They serve to protect clients and others, educate the public, provide guidance to practitioners, provide a basis for regulatory oversight, and promote the profession's overall integrity (Hemingway & Querin, 2011, p. 18).

Hemingway and Querin (2011) go on to explain how these codes of ethics interface with the legal system—most notably, how COEs are not invoked in criminal matters (like billing for services not rendered) because they would be redundant. They are invoked, however, in civil cases of malpractice or in administrative actions by licensing/certification boards and professional associations against individuals/practices/agencies. By extension, legal concerns, about the legislative scope and consequences that relate to a counselor's intended actions, may bolster reflective thinking and instruct future behavior perhaps more often than the COE.[1]

However, boards and associations use COEs as both an educational tool and as a means of assessing and sanctioning professionals for ethics violations. Consequently, to some extent the code of ethics is liable to reductionist concepts of risk management and ethical interpretations that ultimately bend toward the ethics of risks or avoiding punishment for apparent wrongdoing. Hemingway and Querin (2011) asserted that

> clinicians cannot successfully carry out their fiduciary responsibilities to their clients or uphold the integrity of their professions without adhering to the ethical and moral principles that are found in their codes of ethics. These codes are not simply boilerplate documents that exist in the abstract. They are living, breathing documents with real-world implications, especially in the legal arena, that trigger a panoply of rights, responsibilities and consequences (p. 21).

The issue with this conclusion is threefold: 1) where a COE can be brought to bear in penalizing misconduct, it is largely because there has been either a legal infractions or a relatively obvious

[1] Ethical thinking grounded in intentions (e.g., Kantian deontology), rather than consequences, is hard to square with 'ethical' thinking which seems primarily concerned with avoiding law suits (agencies) and getting fired (counselors). Such thinking calls into question the 'virtue' of being virtuous, or as Kant might put it, the moral worth of the action taken when the primary motivation is instrumental or in the best interest of the actor. Under this accounting of what makes ethics ethical, if the aim of the COE is avoiding negative consequences, it unwittingly undermines the values that it holds in high regard (Christie, Groarke, & Sweet, 2008).

indiscretion; 2) where a COE is intended to specify the moral and ethical constraints of the profession, it is largely a bureaucratic boilerplate document that exists only in the abstract—that is, it applies without practice understanding; and 3) no system of rules, however imbued with talk of principles and virtues, can overcome the highly theoretical nature of what makes something "the right thing to do". The right thing to do typically resets on protecting and respecting the client and protecting the welfare of the public. COEs are more than risk assessment and may be a part of non-maleficence guidance but with much broader interpretations of client welfare, ethical conduct, and best practices. Yet, as a personal guide to professional conduct, they have both advantages and disadvantages in reinforcing the theoretical nature of what makes the right thing to do (see Table 1 in the appendix).

The strengths and limitations of ethical codes in general indicate how COEs needs to continue to evolve (see Table 1), in application to the addiction professional COE, and why it is important to engage in dialogue and expound upon questions germane to ethical codes (Smythe, 2015). For instance, what knowledge must the provider possess to make the most ethical decisions possible with regard to their clients? What sort of training is sufficient to induce the ethical competence necessary to navigate reasonable ethical dilemmas? Suggesting answers to these questions can be helped by exploring the degree to which ethical dilemmas have definitively correct answers in the first place. Ultimately, the aim is to re-evaluate addiction ethical codes, and place an emphasis on the provision of ethics education.

Of course, there is a difference between "obvious" cases of wrongdoing (e.g., sex with a client) and the more typical issues that arise where the "correct" course of action seems to be a matter of weighing values and desired outcomes (e.g., discriminating against a client in judging the appropriateness of referral). In the analysis that follows, the idea that morals and ethics are

distinct is spelled out and then challenged by way of Jean Paul Sartre's existentialist critique of moral decision-making reality. In light of this critique, and John Stuart Mill's argument regarding the value of vigorous debate over philosophical ideas, suggestions are made regarding one approach to ethics education and competency for addiction professionals. This is followed by a brief overview of the addiction code of ethics; a discussion of the identity of the addiction profession and its interplay with the code of ethics; certain professional conundrums and ethical quandaries; and justification for the important distinction between morals and ethics.

The Addiction Professional Code of Ethics: A Brief Telling

Formal addiction treatment is a relatively nascent allied health subspecialty that was only recently classified as a medical discipline (White, 2014a). Historian William L. White notes that

> . . .ethical sensitivities and standards in addiction counseling have a very short history (perhaps dating from the 1987 publication of Bissell and Royce's Ethics for Addiction Professionals) and have borrowed heavily from the disciplines of psychiatry, psychology and social work. It is only recently that the field has begun to refine its ethical codes to reflect the unique vulnerabilities of its clients, service providers and service institutions. What the field has recognized is its power to do harm in the name of good, and it is that awareness that is driving the heightened emphasis on ethical decision-making in addiction counseling (White, 2004, p. 6).

The NAADAC COE is devised by its respective committee or a consortium that may (or may not) be comprised of authorities, experts, academics, scholars, practitioners, and attorneys who write the overriding principles of safety into the accepted practices or standards of the counseling industry (White, 2014b), and thus can claim that any other action is a violation of ethics. One thing to note about the NAADAC's 2016 revised code of ethics is its heft. The code is so expansive that it risks outright contradiction and redundancy: after all, every proposition logically follows from a contradiction. In the section on Professional Responsibility and Workplace Standards (NAADAC, 2016), for example, the code directs addiction professionals to both eschew "any form of dishonesty, fraud, or deceit" (p. 8) and also to refrain from all "public

comments disparaging NAADAC or the addictions profession" (p. 10). While having a voice and trying to instill change is different than disparaging, truth is subjectively perceived no matter how well one's professional voice carries the message of change. The takeaway is that when truth itself is taken as disparaging criticism, the professional's voice is contradictory to the COE and cannot comport with both viewpoints. Moreover, there is "tension between provisions regarding whistle-blowing and employee loyalty and between peer review and criticism of colleagues" (Kultgen, 1988, p. 226), and no provision against an employer imposing penalties or reprisals as treatment programs are businesses not covered by the NAADAC code of ethics. Here, Kultgen (1988) noted, "where provisions conflict, they lack clear guidelines to determine which take priority . . . [thus] if the ethical stance of professions is to be improved, detailed codes clear and precise enough to read the same way to everyone must be developed" (pp. 226-227). Thus, it might be asked if a considerably pared-down code could be more useful by giving addiction professionals a more operative benchmark for professional conduct.

Moreover, within the counseling field, "everyday" counselors may or may not have a voice in terms of ethical revisions. This is important because the cultural environment in which clinicians practice may exert tremendous pressure and influence upon ethical conduct. Therefore, programs—that is, executive directors, board members, managers and supervisors—have a moral responsibility to "fortify the ethical individual, bolster ethical reasoning, nourish dialogue, and inject ethical concerns into routine operations" (Lewis & Gilman, 2005, p. 247). This may involve forging systems, policy, procedures, standards, informal systems (values, norms, behaviors, forces and pressures), and use of appropriate language and tone in describing ethical transgressions. Such ethics would also be infused into staff hiring, firing, promoting, and demoting.

A concern is that ethics breaches are traditionally thought of on a clinical-individual level (i.e., blame is rapidly placed on individual "bad apples"). But blame might be better focused on ethical standards in COEs and program policies and procedures that are narrowly focused on clinical roles without addressing issues involving the demeanor of all staff members within the organizational hierarchy (i.e., a bad "barrel" of apples) (White, 1997). COEs challenge the behavior of individuals, not systemic failings or tensions.

At the same time, the NAADAC code of ethics confidently lists numerous policies regarding informed consent, non-discrimination, confidentiality and its limits, the dangers of dual relationships, the explicit prohibition of sexual relations with current and former clients, the expectation of clinical competency and referral when necessary in virtue of a client's needs, and many more similar requirements and prohibitions (NAADAC, 2016). However, many of these policies use hedge-words and phrases, like "Providers shall take reasonable precautions to…" and "shall make every effort to…" and "shall consider the inherent risks and benefits associated with…" (NAADAC, 2016, p. 3). Some flexibility in policies is obviously necessary given the reality of addiction treatment. For instance, in certain circumstances, waiting to obtain informed consent from a client who is visibly impaired is appropriate, as making life choices for a client with an alcohol addiction disorder smelling of alcohol would require their competence and self-awareness. However, in such circumstances, the code flexibly informs providers that they "recognize the need to balance the ethical rights of clients to make choices about their treatment, their capacity to give consent to receive treatment-related services, and parental/familial/representative legal rights, and responsibilities to protect the client and make decisions on their behalf" (NAADAC, 2016, pp. 2-3).

Moreover, clients transition to a particular level of care, transfer to another program, or are administratively discharged (AD)/forced termination (for discussion on AD see White, Scott, Dennis, & Boyle, 2005; Williams, 2015a; 2015b; 2016; Williams & Taleff, 2015; Williams & White, 2015), not uncommonly without full knowledge about other treatments and their right to choose alternatives. This undermines the rhetoric and importance given to informed consent in other areas of practice. As Abramson (1981) noted, "equally important is a recognition on the part of these professions that even a firmly adhered to code of ethics does not protect one from daily confrontations with ethics and value dilemmas, particularly in health care settings where crises, diminishing resources, and rapidly advancing technologies highlight competing interests" (p. 34; citing Rehr, 1978).

Furthermore, in addition to lack of practical practice understanding, the COE consortium does not offer clear articulation of how its professional code of ethics was transmuted from (intuitive, unsystematic) clinical practice in terms of the evidence (or what constitutes evidence), nor does it supply references used to support the concepts, values, principles, and assertions of the COE. The processes of creating the COE are largely unknown, especially in terms of rigor of assessment, how evidence and references are prioritized and evaluated, the generalizability of data, and how currently relevant is its literature.

The theory underlining the concepts in the COE are also unexplained and raise many questions. Does the COE require, for example, a Rawlsian (1971) conceptualization of justice in which fairness implores the counselor to put a premium on assessing and privileging the most disadvantaged in a situation and acting on behalf of that person (Abramson, 1981)? At what level of impact (clinical, client, agency, society, stakeholder, family) ought a counselor have primary obligation to reject consequentialism (Mill) and utilitarianism in weighing the ethical principle of

client autonomy? Is it better to defend ethical arguments without utilitarian justification? Is the endgame for all what makes an action ultimately right, whether this is supported by the COE or relegates it to a tertiary role? Maybe it would be possible to reject an ethics framework that aims to prevent negative consequences while accepting Aristotle's idea that ethics in general equates goodness and virtue with fulfillment. How information is sifted, filtered, and weighed in value therefore seems problematic. As a result, certain directives or implicit instructions offered by the COE, which one might expect to be empirically supported literature-based assertions and legal standards, appear to be based on unsupported professional opinion taken from experiential experience, canned ideology, or dogma (e.g., see discussion by Zur, 2005, on dual relationships).

With the underpinning logic supporting the construction of COEs appearing opaque and difficult to recognize or pin down, professionals may question the rational justification for COEs suggesting one action over another, and they may not easily absorb content or application of the codes without knowing the moral and ethical basis of its assertions (Behnke, 2005). For example, what ethical theories (e.g., human rights) are used to bear on ethical lines of thought, and their endorsements and proscriptions, aside from a “principalis” or “principle-based” ethic? There are many possible alternatives, which include ecological ethics, relational (cultural) ethics, ethics of care or a feminist-based approach, pragmatism, virtue ethics, humanist, cognitive-behavioral, communicative ethics.

Counselors may believe that COEs offer the right ethical answers, which are reinforced and cemented in training and supervision. Yet the professional code of ethics may be at odds with “doing the right thing” in the moral sense. Moral principles underlying the COE may represent universal phenomena or moral absolutes in counseling practice. For example, counselors have a prima facie moral obligation to remain in a state of virtuous ignorance (e.g., by

not participating in gossip about clients or prying into client charts to satisfy unprofessional personal curiosity). However, certain codes of ethics may imply that the COE should be followed for the sake of conformity, to minimize legal risks, or to avoid disciplinary action from institutional bodies. For example, the Hawaii State Certified Substance Abuse Counselor Code of Ethics (Alcohol and Drug Abuse Division, 1995)—a permutation of the NAADAC COE—enjoins counselors to embody empathy as an essential skill in professional practice. Yet there is not enough information provided to explain why they should do so. This paradigm assumes that empathy should be a crucial fundamental of the ethical decision-making process despite legitimately contested dialogue to the contrary, which warns about discriminatory empathizing, emotionally laden cognitive distortion effects, and empathy-inducing compassion fatigue and provider burnout (e.g., see Bloom, 2016). Moreover, there is no clear definition suggested as to what empathy and compassion comprise. There also doesn't appear to be enough contextual standardization in meaning and measurement, let alone a basis for employee performance evaluation, within the extant addiction counseling literature base and counseling field to make a convincing case for dispensing empathy into ethical decision-making.

Importance of Professional Identity of Addiction Counselors to COEs

The professional identity of the addiction counselor profession is rooted in the witnessed potential for long-term addiction recovery and the belief that the addiction counselor and allied professionals can play important supportive roles achieving recovery for individuals, families, and communities (White, 2014b).

How certain codes are interpreted and adopted in practice rests in part on how counselors conceive of their job. One counselor conceived his role as trying, "to help get all the other voices out of the way for the clients, so they can hear their own and begin to have some faith in it"

(Jennings, Sovereign, Bottorff, Mussell, & Vye, 2005, p. 115). The flexible approach of that professional to practice standards clearly accepted the realities faced by clients in treatment while also crediting the importance of client autonomy for achieving change. This realistic approach acknowledges that chronic and severe mental/health disorder (i.e., drug addiction as a phenomenon standing as a cluster of distinct symptoms) may initially impair client capacity to appreciate choices and hamper their ability to exercise autonomy (Satel & Lilienfeld, 2016; Volkow, Koob, & McLellan, 2016). Nevertheless, a counselor moved by respect for autonomy will recognize a client's inherent right to see the world differently and to make decisions of their own about how to live (Taleff, 2006). In contrast, if a counselor conceives his or her role as having a heavy paternalist flavor[2]— as a parent to an "adult child"—this enables unilateral decisions to be made on behalf of the client, however temporarily, and forestalls the client's autonomy (commonly regarded as a moral cornerstone of ethics) by implying the counselor has the right to make decisions for the client.

From an ethical perspective, such action cuts against the grain of ideas in the counseling profession. Whether the counselor conceptualizes addiction as a brain disease, a moral choice, maladaptive behavior, or otherwise, will inform his or her decision-making and ethical rationale. For example, the notion that drug addiction is purely choice may lead counselors to advocate hardline approaches to program rule infractions and harsh consequences such as administrative discharge or forced termination (Williams, 2016). Thus, it is incumbent upon the professional to keep in mind the client's potentially impaired autonomy (particularly under the influence) while simultaneously balancing beneficence, paternalism, and autonomy (among other principles) so

[2] Nowadays paternalism is ripe with negative connotation; though a form of beneficence, it is often conceived to denounce a counselor's action and directly assert or covertly allege violation of a moral rule and the denying or rejecting of the client's good. While codes recognize client autonomy as a central ethical obligation and value, interestingly enough, "provisions protecting the client from exploitation are more definite than those prohibiting paternalistic encroachments on autonomy" (Kultgen, 1988, p. 232).

that one ethical principle is not ideologically or dogmatically believed to be absolute and privileged with primacy in decision-making irrespective of the situation.

With regard to professional identity in the counseling profession, for example, Handelsman, Gottlieb, and Knapp (2005) proposed an ethical acculturation model based on the original work of Berry (1980), concluding that ethics training and clinical supervision might be optimized to help counselors integrate their own values and identity within the professional value systems. The ultimate goal is for the counselor to embrace an integrated adaptation strategy. Here, integration involves the clinician forming a deep relationship with the professional context and culture (role duties, values, virtues of justice and honesty, etc.) in a way that synergistically reinforces the sincerity of both personal and professional identities. In other words, becoming a true professional goes beyond mere certification or licensing, but requires a strength of commitment to the professional ideal and self-reflection that sees its virtues incorporated into one's character (Knapp, Gottlieb, & Handelsman, 2017; Kultgen, 1988). In their summary of findings, Handelsman et al. (2005) believed integrated acculturation into the counseling profession could improve ethical decision-making, and they float the possibility of incorporating an acculturation model of ethics training into the process of educating counselors.

Professional Conundrums and Ethical Quandaries in Practice

In "The Dark Side of Professional Ethics," Knapp, Handelsman, Gotlieb, and VandeCreek (2013) illustrate a number of scenarios in which ethical conflicts arise. The following is one example:

> A psychologist was treating a medical student suffering from anxiety and loneliness. The student learned from another source that a local church sponsored an organization for young singles which was open to members of the community who were not members of the church. The psychologist discouraged the student from joining this group because the psychologist was a member of that church and there was a possibility, albeit remote, that

> her patient could become more involved in the church and that their paths might eventually cross (p. 374).

According to Knapp et al. (2013), the therapist interpreted the code without any clearly specific ethical decision-making model employed, at the expense of "prudence" and "compassion" (p. 374). While the scenario's limited information is inadequate to fully illustrate the therapist's interpretation of the situation or determine the framing of her decision-making model, there is enough information to reveal a dilemma for the therapist on the basis of commitments to various principles including confidentiality. Here the COE enjoins counselors to avoid dual relationships, that is, relationships outside the context of clinician and client.

Consider another type of scenario in which a client on parole is dealing drugs to pay for rent on transition housing in outpatient addiction treatment. The client intends to make enough money this way to remain housed and meet additional expenses not covered by insurance, one of which is child care. This behavior may both represent a possible addiction-related flare-up and risks resumption of drug use requiring continued treatment and legal sanction, but also puts the client at risk of losing access to housing and treatment, not to mention legal consequences. Any responsible counselor in this case faces a potential ethical dilemma of his or her own because the code enjoins clinicians to make decisions for the well-being and health of clients, to keep client identity and information confidential, and "to accurately, honestly and objectively report to appropriate third parties, including parole boards" (NAADAC, 2016, p. 11). At first glance, there might appear to be a clear-cut answer to the counselor's dilemma: maintain respect for client autonomy/self-determination and confidentiality under the banner of beneficence. This is the view of Counselor A, who knows that the client is selling drugs, but does not recognize this as presenting a dilemma. Breaking the requirement for client confidentiality is a legal breach and ethical offence itself and must only be for reasons described in HIPAA Privacy Rule and 42 CFR

Part 2 (i.e., medical emergencies, immediate threat to the health of safety/others related to a crime on program premises, child abuse or neglect, court order, etc.), unless other reasons are agreed as reportable under client consent (SAMHSA, 2016). Although the client in this example is engaging in criminal offending and violation of parole, Counselor A sees this as outside their professional liability of action to the extent of notifying the criminal justice system. But more importantly, consent forms signed at the start of treatment may not accurately reflect at present the client's power of choice to knowingly provide consent to the disclosure. Thus, Counselor A conceptualizes the meaning of client consent as a process that doesn't overstep the client. This counselor may encourage the client to consider his or her actions within contexts of counseling and treatment planning, but may not take any further action of their own. Counselor B agrees that information released to third parties is clearly defined in the client consent-to-release information form and is typically limited to diagnoses, treatment planning, and compliance. But believes that compliance reports made to the client's parole officer (third party) should default to any-and-all information that the parole officer and judicial system would want to know in order to establish compliance with the court's terms of parole. This is because Counselor B stresses the importance of truth-telling and transparency in relationship to addiction recovery and in developing and sustaining a mutually healthy provider rapport and therapeutic alliance. Counselor A understands compliance reports may indeed include additional information but only the minimum further information should be disclosed if necessary. Counselor A therefore defaults to a stringent reading of 42 CFR and HIPAA, places a premium on client autonomy, and considers the drug dealing a treatment issue for all potentially affected clients to be addressed therapeutically. Counselor B has a more inclusive view of the risk of harm to be a great threat to the health and

safety of other clients in treatment, especially those living in the same recovery residence or "clean and sober house" as well as clients attending the same outpatient treatment program.

A counselor in the above predicament must weigh compelling and conflicting principles, but the principles recommended by the COE do not appear to help. Does the situation warrant respect for client autonomy and confidentiality over what might be an issue of safety? Or does not reporting the incident constitute a moral failure on the part of the counselor by overvaluing client autonomy to the point where client accountability and responsibility are (legally) disavowed. Here it can surely be argued from the nature of addiction counseling that a counselor is not immediately obligated in the name of justice to report to legal authorities every infraction concerning where or when their clients may illegally obtain or use their choice of illicit drugs.

Justice is a virtue that directs a moral agent to treat persons fairly and equally in a profession that also demands great care in establishing boundaries. Is justice then compatible with, for example, a clinical supervisor discouraging a counselor from attending AA meetings that are also attended by clients, especially when the client perceives his or her counselor's presence at their AA home group as intrusive? Is it ethical if the supervisor is trying to help the counselor avoid a possible breach of confidentiality or harmful bias effects from information divulged by the client in AA meetings and carried by the counselor into the clinical setting? Yet multiple relationships in-and-of themselves are not an infraction of ethics as the codes allows for boundary crossings. So, what does justice really mean here and what is its exact nature if it requires curtailing the counselor's needs?

No doubt justice makes its way into the code as a directive to treat all clients fairly and equally. It arguably follows from this that one ought not (unfairly) discriminate, for example, on the basis of race or sex when agreeing to provide care. But is it unjust to discriminate on the

basis of, say, a client's proclivity to propound racist and misogynistic ideology even if it isn't directly threatening to the counselor? When does the counselor's self-interest ("To protect yourself and your personal interests") (NAADAC, 2016, p. 2) override directives to help others (beneficence) and allow them to choose their own destinies (autonomy)? If the counselor harbors personal prejudices against sex offenders and lacks the capacity to establish a therapeutic alliance with the client, the counselor should not have an ethical obligation to work with the client. Though the code of ethics provides guidelines on what constitutes appropriately respectful behaviors as covered in ethical codes, this dilemma is an ethically gray matter. Client autonomy demands that counselors are under ethical obligation to respect the client (while reserving their own autonomy). With this, the ethical thing to do is for the counselor to try and work through the self-conflict (e.g., seek supervision).

However, a counter argument can be made to not work with the client in accordance with the NAADAC codes. To refer the client because of said conflict is not a paternalistic act or imposition of values but a decision based on practical and pragmatic concerns of the counselor to maintain a therapeutic stance with the client that comes as close as possible to unconditional positive regard. This would seem to resonate with client rights and reflect prudent due diligence of knowing one's own limitations, competency, and fidelity to the duty of care. The reaction of the counselor for which the client challenges the development and integrity of a therapeutic alliance is not necessarily a (countertransference) psychological reaction or easily corrected by means of cognitive restructuring, as if simply due to faulty, irrational reasoning and false beliefs. Even a client-centered definition of autonomy would seem amenable to supporting the counselor's clinical judgment and in knowing his or her deontological limits. Here then it is appropriate to action a client referral with a notice that the client should see a better-suited

counselor, who—if need be—may challenge the client in an ethically and therapeutically grounded manner if the client's viewpoints cause the new counselor distress. A practitioner subject to the COE can reasonably be perplexed by the selection of principles that make their way into the code, how these principles work in supporting the requirements they are intended to support, and how they ought to be weighed when faced with a dilemma where reasonable principles seem in conflict.

Ethics Versus Morals

Whenever talk arises of doing the right thing, distinction may arise between ethics and morals. Yet, in everyday discourse, it is difficult to peel these two notions apart. Dictionary definitions variously treat these concepts as being mutually dependent, overlapping, or identical. But in arguments where ethics and morals play a role—like those here—a more useful distinction is needed. Thus, the following explication is provisionally adopted:

> Ethics and morals relate to "right" and "wrong" conduct. While they are sometimes used interchangeably, they are different: ethics refer to rules provided by an external source, e.g., codes of conduct in workplaces or principles in religions. Morals refer to an individual's own principles regarding right and wrong (Diffen, 2016, para. 1).

According to this distinction, ethics may be imposed, as in a COE that one must agree to adopt in the course of certification or licensure for a particular title; whereas morals are more or less consistent personal attitudes about right and wrong. As such, one's moral convictions may be in conflict with one's ethical obligations at any given time (Teo, 2015). If, for example, a certified counselor is held by a COE to "not practice, condone, facilitate, or collaborate with any form of discrimination against any client on the basis of race, ethnicity, color, religious or spiritual beliefs, age, gender identification, national origin, sexual orientation or expression, marital status, political affiliations, physical or mental handicap, health condition, housing status,

military status, or economic status" (NAADAC, 2016, p. 2), yet that counselor finds the ideas of homosexuality, transgenderism, and gay marriage morally unacceptable, then there is a potential conflict for this person between ethics and morals.

Such conflicts might be dismissed as a kind of ethical (or logical) error because the notion of consensus standards of conduct has an air of objectivity about it. One may be tempted to talk of codes of ethics as attempts to depict the correct set of morals for the duties of the profession. Indeed, while ethics codes are considered to be aspirational in message and serve as a framework for acceptable practice, it is commonplace to find claims that COEs discount ethical codes themselves: that is, that they act to sort possible moral convictions into those that do bestow honor upon the person or profession from those that do not, or as Hatcher (2010) put it, "Codes of ethics tend to be idealistic and are a statement of the behaviors to which a profession aspires" (para. 4). Accordingly, in the example of a morals-versus-ethics conflict, the counselor who refers a sex offender to a different program or to alternative resources that purport to help as a form of treatment might face sanctions for unethical conduct, even if said counselor has personal moral reasons for taking this initiative. The potential for reprimand conveys the fact that some morals don't make the cut for being a "good" (i.e., virtuous) certified or licensed counselor.

The implication is that when one is sufficiently acculturated into the profession, which includes its code of ethics, all professional members operate from the same prescribed set of standards. Hence, professional associations concern themselves not only with establishing the COE but also with the best means of inculcating the "right" values in its members, since professional education and certification come well after one has established a moral code of one's own (Knapp & VandeCreek, 2006).

This suggestion presupposes the idea that students' moral attitudes should improve after ethics training. Such expectation of improvement also presupposes there is a definite answer to whether certain scenarios amount to moral or ethics violations. Of course, ethics does not always provide one single, correct answer to conflicting issues and so two thoughtfully articulated answers can be better (e.g. an improvement), even if neither one is definitely right. There is a reason for such gray areas existing in the codes—and that is to respect the context and individuality of the specific situation. But we can still ask: On what grounds can a supposition be made that there is a single answer to ethics issues and that more ethics training can help tease that answer out? This is an important question because studies across professions that use COEs focus on examining what sort of training "improves students' ethical attitudes" and how far it can result in professionals "actually acting in a more ethical manner" (Cameron & O'Leary, 2015, p. 278). Does such training introduce a set of shared principles that guide the ethical decisions of so-called master therapist in the field (Jennings et al., 2005)? Can it resolve whether the virtues characteristic of ethical agents are more or less important than principles or rules (morals) to which one commits (Meara, Schmidt, & Day, 1996)?

But this is an age-old problem in a discipline that goes back at least as far as Plato (i.e., what determines the right thing to do? It cannot simply be law, since we can hold, as Gandhi did, that some laws are unjust and should be resisted, flouted, and (or) abandoned. Similarly, it cannot be cultural norms, since these can alter over time, as we see with institutions like slavery or marriage that are abandoned or reformed in the name of moral progress. Nor can it simply be the principles deemed objectively true by the individual who holds them, since this sort of relativism flies in the face of almost universal injunctions against many acts, such as murder and child abuse, for example.

Indeed, the farther we get from obvious cases of wrongdoing (such as misrepresentation of credentials, false advertising, over-billing, sexual and other types of exploitation, etc.), the more trouble we have justifying an action, from any theoretical perspective, as either absolutely right or absolutely wrong. Yet, in spite of hedge-phrases used in COEs (as noted earlier), and the clear necessity of latitude in judgment given the nature and reality of addiction treatment, knowledge of objective moral truths is precisely what is expected of members bound by codes of ethics.

Our Existentialist Quandary: Whose Code is "The" Code?

Practitioners may espouse (or feign) allegiance to the COE and pay lip service to it while simultaneously endorsing another code (based on personal values and grounded in practice experience) when confronted with problematic situations (Van Hoose & Kottler, 1985). This distinction between "espoused theories" and "theories-in-use" was originally made by Argyris and Schon (1974) to describe the incongruence between ethical theory and practice (Van Hoose & Kottler, 1985). As first illustration of this, we can imagine that counselors might agree on the importance of client follow-up after a client misses a treatment session or is discharged. Yet actual professional practice may indicate the such follow-ups lack value as few clients receive this evidence-based prescribed treatment. Similar points could be drawn about other differences between ethical requirements and professional practice (Van Hoose & Kottler, 1985).

Second, in addition to the formal norms and rules that standardize behaviors, there exists the presence and use of "informal norms", though harder to identity. These are "embedded in the stories employees tell, the euphemisms they use, the socialization methods they encounter, and the informal enforcement of norms felt and heard and seen as true values of the organization" (Bazerman & Tenbrunsel, 2011, pp. 122-123). Such informal cultures may either reinforce or

eschew certain ethical behavior, raising a number of implications and concerns. For example, does the underlying cultural subsystem of the organization counteract the code of ethics? Here, what is (or is not) informally talked about in the corridors of the agency—at informal de facto staff meetings, behind closed doors in the supervisor and executive director offices, and in exclusive boardroom conferences—is as significant for practice culture, or more so, than formal policy and procedures (Bazerman & Tenbrunsel, 2011). This informal culture reveals the true hidden values and morals that are encouraged, rewarded, and socially reinforced. For example, the executive director of a treatment program vaunting about working 12 hour days, or the clinical operations director announcing he hasn't taken a vacation in twelve months, are testaments to their loyalty and commitment to their job. However, though not directly communicated, the subtext is an expression of the agency's "hidden" ethics code and implies (even encourages) poor work boundaries and scant concern for healthy self-care. The message, conveyed by those wielding administrative power, suggests that this is "the right thing to do", with expectations that others should follow.

Third, regulation of all counselor behavior is based entirely on a belief system concerning what is right for a particular client. Since the core of a counselor's system of what is right and wrong, good and bad, effective and ineffective, appropriate and inappropriate is based on a philosophical ethical system. Recalling the distinction between "espoused theories" and "theories-in-use", it is important to note the qualitative difference between "attitudinal morality" and "behavioral morality", as reflected in divergence between what we actually believe, what we claim we believe, and how we act on our beliefs (Van Hoose & Kottler, 1985, p. 25).

Is it then reasonable to suppose that any ethics code or ethics education can teach professionals to choose correctly—in the face of ethical dilemmas or in responding to questions—when there seems an impossibility of one correct view? In "Existentialism is a Humanism" (Sartre, 1975), Jean-Paul Sartre observed that in the face of ethical dilemmas, there is no objective truth upon which one could rely to generate the right course of action. We are each, in his words, "condemned to be free"—that is, we have no choice but to make a choice. And the choice we make, if authentic, is recognized as both a personal value judgment and an imposition of that value on the rest of humanity.

In Sartre's (1975) reckoning of our moral situation, persons are at all times in this state of duality: subjected to the values of others, yet choosing whether to accept or reject them. If a person believes he must act according to the moral code of his religion, for example, this is in effect his personal endorsement of a value system imposed from outside, which becomes in that moment of endorsement a value system imposed on the world from inside. It is the latter judgment, necessary to action, that makes externally imposed ethics a myth. All value is chosen.

The ramifications of Sartre's (1975) argument are hard to accept, but the argument itself is compelling. Sartre (1975) recounts the story of a man trying to decide between staying home at the request of his mother or joining the French resistance to fight the advancement of Nazi occupation. On the one hand, his mother's request is morally compelling in light of his obligation to her and the real protection and comfort he might provide her by staying. On the other hand, fighting Nazism is morally urgent too. Where the man can do the most good is much less certain. If the man consults another for advice—a priest, a philosopher, a clairvoyant, a military recruiter—whatever advice he gets he can choose to heed or not. The same may be said for any method he might employ to help him decide, right down to asking for a sign or flipping a

coin—signs must be interpreted, and coin flips can be rejected (two out of three?). An interesting detail of Sartre's (1975) use of his example is that even the people from whom we solicit advice are chosen on the basis of what we expect they will say. And gut-level instincts about what one ought to do are similarly challenging to external authority, since the whole notion of being a moral agent is contingent upon the ability to override instincts, biases, and social conditioning to make a better choice. The freedom to choose is thus a necessary condition of morality, and the bane of those who wish for universal moral progress.

Sartre's (1975) example is relevant here because it characterizes something important about the kinds of ethical decisions that addiction professionals face. Rarely does one deliberate over the ethicality of over-billing or asking a client out on a date—these wrongs are just obvious and warrant strict sanctions. But the question of how to educate addiction professionals such that they improve their ethical decision-making dispositions centers on issues where, as Reamer (2012) put it, "in the final analysis, reasonable, thoughtful, and principled practitioners may disagree" (para. 14).

According to Sartre (1975), these disagreements do not have an objective settlement procedure, even from an omniscient perspective. There is no superseding value, or character trait, or piece of knowledge that can determine a decision about whether, for example, it is best to disclose relevant personal information (like being a former "addict") in order to foster safe communication with a client, or withhold such information in order to avoid the risk of shifting the focus of attention from client to counselor. Yes, the counselor must make the choice in light of all the contextual knowledge she can muster, but ultimately, the decision is hers; and like Sartre's (1975) example, it is a choice between values that are on an ethical par—that is, neither is blatantly harmful to either party and both are professionally defensible. Therefore, the idea of

ethical improvement should be qualified. What we want is improvement in the degree to which practitioners engage critically with the expectations proposed in their COE, in discussion with their peers and supervisors about what is best, given the context and the values at play from a professional standpoint as well as a personal one. Conclusions of this sort of deliberation would be considered "authentic decisions", following Sartre (1975), when a reasoned and informed choice is made to value one thing over another in recognition of the truth that all such decisions are made from the inside and imposed on others.

Our moral situation is thus starkly opposed to the assumption that there is a genuine distinction between ethics and morals where morals are personal attitudes regarding right and wrong and ethics are externally imposed ideals. All values are both imposed and then chosen, chosen and thus imposed. But such decisions do not belong to the few—that handful of lawyers and experts, for example, that bring together the principles and specifics of the COE. Ethical decisions confront everyone, and no code—neither external nor internal—can definitively decide how those decisions ought to go.

Deliberate Practice and Vigorous Debate: The Path to Ethical "Progress"

Because there has not been any study in the U.S. from which to source ethics complaints lodged against addiction counselors, this area of study is overwhelmingly incomplete. Since there is no standardized set of data, no definitive ranking or even identification of the most common grievances, it is impossible to assign rank order to ethical transgressions (Knapp & VandeCreek, 2006). To date, the most recent and comprehensive study on ethics violations in the substance use disorder field comes from St. Germaine (1997) covering the years 1990 and 1991. National survey data was collected from 40 state drug and alcohol counselor certification boards in the United States representing 32,991 certified addiction counselors with a total sample of 372

ethics complaints gathered (a return rate of 74.5 percent). Of these complaints, 285 were subsequently investigated, 98 were dismissed, and 87 were left pending. The most common ethics complaints were: 1) dual relationships (sexual/social/friend/financial/business) with current and former clients (28.49%, n = 106); 2) incompetence in the counseling relationship/unable to practice with skills and safety due to alcohol or drug/mental/or other condition (12.37%, n = 46); 3) practicing without proper certification (9.95%, n = 37); and, 4) breach of confidentiality (8.33%, n = 31).

Van Hoose and Kottler (1985) claim "the majority of ethics violations result not from a willful disregard of professional codes, but rather from ignorance and poor judgment" (p. 10). While no known study to date verifies that claim, St. Germaine's (1997) research offers some evidential contribution to the noticeable dearth and obsolescence of addiction counseling literature. While St. Germaine (1997) recommends more ethics training, the nature of these ethics violations may say more about human foibles inherent to human nature. Further, introducing people to COEs doesn't necessarily change a counselor's personal ethical and moral standards. COEs don't guarantee safeguards or cultivate ethical responsibility; nor do they transmit depth of conviction, moral courage, or understanding of values and principles (Van Hoose & Kottler, 1985). If anything, St. Germaine's study calls into question the claim that the COE is a device based on the assumption or belief that the etiology of ethics breaches is a function of excusable ignorance of ethics codes (Van Hoose & Kottler, 1985). The more egregious violations stemming from fraud, exploitation of clients and carrying out sexual affairs with them, for example, appear more suggestive of willful disregard and poor judgment (as an outgrowth of moral character and personality of the staff member involved) than ignorance of the specific ethics code or incompetence per se. However, as White (2005) noted about the specific

violation of staff breaking professional barriers to sexual involvement with clients, relationship over-involvement or "boundary drift" (p. 547) may be a more useful heuristic construct to represent the preponderance of counselor–client sexual intimacy type cases. According to White (2005), warning signs indicative of early boundary drift include many often-successive steps such as resisting supervision, courtship behaviors, increased one-to-one session duration, resistance to referral, sexualizing content, and possessiveness of client. Thus, poorly defined boundaries between counselor/program staff and client can be conceptually understood as a process issue that can progressively culminate in sexual intimacies. As such, counselor self-monitoring and good supervision may obviate a good deal of cases of counselor–client enmeshment so that warning signs of boundary drift are swiftly flagged (White, 2005).

How then do we address the need to educate addiction professionals in the fine art of ethical thinking? Some decisions are more authentic, and more reasonable in light of contextual features of the situation and the values that must be weighed in relation to these. John Stuart Mill (1869) famously defended the principle of freedom of thought and expression on the grounds that the suppression of (nearly) any speech carried risks that far outweighed the "pain" of hearing offensive and/or false speech. His argument was that the suppressed speech could be true, false, or somewhere in between. If the suppressed speech is true, we suppress it at our peril as truth-seekers, and in so doing we presume our own infallibility. If the suppressed speech contains part of the truth, again we suppress it at our peril as truth-seekers (Mill, 1869). The interesting case is suppressed speech that is false, which provokes the question: should truth-seekers tolerate falsehoods?

Mill (1869) argued that false speech plays an important role in our appreciation of the truth. Unless truth is vigorously and openly contested, truth is held as mere dogma, losing its

vivacity and power. His idea was that persons in possession of some truth must also understand the grounds of that truth—the reasons and evidence it has in its favor. The ground of truth fades as it becomes common knowledge, until its truth is no longer appreciated as a philosophical achievement. Only by facing contestation—speech that calls into question its veracity—does a person hold onto the grounds of truth that are needed to quell critics and build knowledge on the basis of that truth.

Mill's (1896) argument assists our approach to codes of ethics and ethics training in its relation to Sartre's (1978) assessment of our moral situation—that ethical decision-making at best occurs in a realm of uncertainty and fallibility. Like the sorts of political statements that Mill (1869) was interested in, moral conclusions are philosophical conclusions: they cannot be proved like theorems of logic or mathematics; they must be argued for on the basis of reasons and evidence, principles and facts. And reasonable people can and do come to different conclusions.

We should therefore teach ethical decision-making from this perspective: the vivacity and power of any ethical "truth" (value-choice may be a better word) depends on understanding its ground, which upholds its place and worth only in light of its rivals. Instruction therefore might look more like structured debate than lectures on codes and exercises in application. For, if anything can be gleaned from the literature on the failure of students and counselors to improve through ethics training, it is that perhaps the very notion of a "correct answer" is a mistake (Taleff, 2010). Nevertheless, the process whereby authentic decisions are made must be cultivated in professionals at every level, and not merely during education and credentialing. At the professional level, there is perhaps no better way to hone these skills than what Reamer (2012) calls "deliberate practice" (following use of the term by Ericsson, Krampe, and Tesch-

Römer, 1993). Deliberate practice is distinct from the kind of practice that predicts progress simply from logging time. As Reamer (2012) stated:

> the distinguishing factor [of deliberate practice] is the practitioner deliberately, purposefully, and mindfully seeking out new challenges to enhance his or her expertise in ways that require sharp concentration and real effort. Those who become true experts do not practice casually. Instead, they practice with strong determination and an awareness that they are trying to improve their skills (para. 11).

Adding specifics to what deliberate practice requires, Reamer (2012) suggests professionals take a serious look at potential ethical dilemmas or difficult cases that might arise in their practices, especially those identified as presenting conflicting duties and values, and consider options and consequences for all who are party to a decision. Consulting with other professionals conversant in routine outcome monitoring and well-versed in deliberate practice from varying perspectives bends "deliberate practice" toward ethical humility and authenticity in improving future performance (Goldberg et al., 2016). Professionals in this way are continuously preparing for ethical decision-making by increasing their awareness of the relevant variables that play a role in the process of making the decision and the responsibility that comes from choosing as one does (Rousmaniere, 2016).

Conclusion

While codes of ethics have clear benefits, they aren't without limitations. COEs run the risk of dogmatizing what's right and wrong and in so doing wall off contestation or the thinking process that makes it possible to deal with difficult ethics situations. Further, ethical truths can "lose their vivacity" in the panoply of ethics codes faced by professionals—rendering accusations of "that's unethical!" moot. With so many ethics codes governing how professionals

comport, claims against counselors as "unethical" shut down discussion and can seem arbitrarily enforced. Here, Mill's (1869) argument shows the risks of reducing truth to mere dogma and bears relevancy in terms of the potential of COEs to supplant debate. On an anecdotal level, counselors may feel bridled by the litany of codes given to unrealistic expectations or seemingly lofty quixotic ideas that are out of touch with the reality of the addiction treatment industry or the context in which counselors practice. For example, some ethics workshops may entreat professionals to file a misconduct report or to speak out if they see something unethical, thereby putting themselves in harm's way. Yet these workshop facilitators are unscrupulously mute on how counselors can pragmatically protect themselves against the reality of institutional reprisal (e.g., being fired, subjected to bullying supervision, or put on an "employee development" or "personal improvement" plan). Furthermore, counselors can become emotively disengaged from ethics codes, resulting in ethical reasoning not becoming "habituated" in practice, especially when traditional ethics education based on philosophical principles is unlikely to transfer seamlessly to workplace practice (Hoyk & Hersey, 2008).

There can be an unspoken tension between obedience to ethics codes that are below the normal level of consciousness— automatic behavior that follows the duty to "do the right thing" as informed by personal values, morals, beliefs, etc., and blind obedience that requires the counselor to suppress his or her own conscience regarding a counselor's primary duty of care, despite evidence that things are wrong (Heffernan, 2011). Thus, instead of a fixed code of ethics, a "learning base" whereby principles are vaguely proposed and counselors are given the task of deciding what they mean, is necessary to assist students in becoming more effective counselors (Smythe, 2015). The kind of ethics training that counselors presently receive simply assumes that the COE represents moral and ethical truths that are adequate to the job, and all that is

required is application. This is wrong-headed; instead, new counselors should be trained in dialogue structured around the patent truth that moral problems are often difficult, and ethical dilemmas require answers that can and should be debated (Taleff, 2010). Thus, in preparation for the contingencies of real practice in addiction treatment and counseling, it is first suggested that our ethics education curriculum quickly moves beyond introduction to the basic standards given in the COE and application of those standards to a curriculum with room for and encouragement of vigorous debate of every aspect of ethical decision-making. This is similar to what Kultgen (1988) envisioned as ethics education for counselors and students in which they are:

> exposed to no-holds-barred debates on the ethical dilemmas of professional practice…Students should not only witness debates, but be required to enter into them. An informed, practiced, and critical grasp of alternative moral and social perspectives should become as integral an element of professional education as technical skill (p. 368).

One potentially useful method of delivering content for ethics competency development would engage students in building a code of ethics from the ground up and debating the merits of its basis and application against an interesting array of possible ethical dilemmas.

Second, as a concrete mode of lifelong learning, frequent and structured "deliberate practice" is useful, with the caveat that there is no one timeless answer to how any scenario might be dealt with "ethically". Perhaps deliberate practice could be written into the COE as an open-ended commitment to bettering oneself as an addiction professional, where "bettering oneself" is acknowledged to be something much more demanding than compliance with stated principles.

But the salient point here is this: just as improving one's skill at the piano cannot be summarized and conveyed by any set of instructions, neither can improving one's skill at ethical

reasoning be reduced to a set of principles and the instructions for applying them. Ethical competency does not come solely from grappling with issues in the abstract, but also from decisions made in context, where features of the actual situation may well pull one in different and equally valued directions. Ethics competency is more than acculturation into a set of principles befitting the profession—it demands factual knowledge from personal case experience and research, engagement with peers representing the scope of possible "truths", and a lifetime of practice. And still in all, the "right" choice is nothing more than the one authentically chosen.

In closing, it's worth noting that

> there are numerous instances where ethics breaches are not made by bad people, but by good people who have historical patterns of integrity and competence but where systemic issues compromise the ability to act ethically, the extrusion of individual staff for ethics breaches constitutes a process of scapegoating that individualizes what is in essence an agency environmental problem (Van Hoose & Kottler, 1985, p. 6).

Thus, ethics codes may only be as good as the culture of the agency and the behavior of others in the organization (e.g., Enron, Wells Fargo), which serve as the "ethical yardstick" by which a counselor adapts to "the ecology of ethics across the web of interactions and systems that make up the practice environment" (Strom-Gottfried, 2007, pp. 18-19; citing Cohen, 2002, p. 9).

In turn, it is virtually a given that there is a pre-existing gap between what the agency publicly airs as its ethical commitments (mission statement, goals, objectives, values, ideas, etc.) and actual practices and performance (White, 1997). The virtues and values established by the COE may be diametrically opposed to the pressures and expectations of the practice environment when "doing the right thing" requires the counselor to possess the moral courage to put his or her neck on the line and risk termination or career suicide (Murray, 2010; Reamer, 2013). Because of this tension, there is a real need for state regulatory authorities, and agencies themselves, to conduct ethics inquiries and to catalog undocumented grievances and formal complaints. This

should require proactive listening to individual staff member reports, systemic collection of information on informal policies, evaluation of de facto treatment protocols and practices, and the uncovering and investigation of "hidden ethics reports" (Weston, 2001, p. 308). Also entailed would be tracking of any informal socio-cultural subsystems that exist and efforts to understand the underlying top-down (management) and horizontal (peer) pressures that beset employees (Bazerman & Tenbrunsel, 2011). On the basis of such ethics inquiries and inventories, agencies would be rated on their ability to create, encourage, and engage ethical commitment.

Ethics is as much a personal–professional issue as an organizational systems issue, but programs tend to define ethics as an individual issue rather than an institutional one (White, 1993). Codes of ethics may guide the conduct of a counselor but contribute little to the development of promoting high standards or a strong organizational culture through which all members share values related to standards of professional practice, such as exceeding minimal ethical standards of comportment and striving for the ideal human character, duties, and behaviors (White, 1993). Thus, state regulatory authorities must admonish agencies to establish internal mechanisms for addressing ethical issues, instead of passively relying on the COE and/or thinking of it solely as an instrument applicable to a select number of staff (i.e., certified counselors) and thus as merely a reflection of personal–professional ethics (Weston, 2001). Agencies should ask themselves: what tools or methods does the everyday addiction treatment program employ to promote ethical values and behavior? Similarly, what sort of feedback mechanisms are structured into programs for crucial quality ethics checks at a systems level that apply to all staff and can address ethics violations as a systemic issue (see White, 1993; Reamer, 2000, 2013)?

Accreditors, auditors, and state regulatory authorities must devise an ethics rating system for each program and its organizational values and ingrained standards (transcending individual staff) somewhat similar to agencies providing credit ratings for companies and organizations issuing debt, and their debt instruments, so that external stakeholders and the public can judge creditworthiness (Bazerman & Tenbrunsel, 2011). The desired output would be an ethics report card fostering the development of ethical standards and ethical sensitivities that say to all staff members, clients, families, stakeholders, and the broader community: "This is who we are. These are the standards of practice by which you can judge us. If we fail to meet these standards, we expect and ask that you bring this discrepancy to our attention" (White, 1993, p. 22).

In sum, this paper has reimagined how COEs might be modified and ethics training reformatted, as well as indicating the value of frequent, deliberate practice for ethics discourse and professional peer groups. These modifications will assist professionals in the area of treatment and counseling. Future papers on professional codes of ethics should look at the literature related to cognitive developmental theories, which speak to growth from rigid thinking toward cognitive complexity and holistic thinking. From an educational standpoint, cognitive developmental theory and moral development are useful conceptual frameworks for structuring ethics workshops and classes. Study of how agencies foster ethical behavior in relation to decision-making theories and ethics competency development in general will also be instructive and is worthy of future exploration.

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Table: *Code of Ethics*

Pros/Strengths/ Maximums	Cons/Limitations/ Minimums
Attempts to ensure…clinicians are not detrimental to the profession…[and] will demonstrate sensible regard for social mores and expectations of community; [gives] grounds for safeguarding professional freedom and integrity" (Strom-Gottfried, 2007, p. 10).	Professionals may consign themselves to rigidly adhere to COE in rote mechanical manner as a perceived ethical responsibility; COEs are the "lowest common denominators in the norms of persons of ordinary conscientiousness with a wide spectrum of prejudices" (Kultgen, 1988, p. 225).
Offers a social, political, cultural, moral, legal, ethical, and professional starting place (in progress) for calibrating thinking about gray areas of addiction ethics (Zur, 2005).	May be accepted as unquestioned (moral) truth and codes which are repeated enough are liable to "becoming the dumbed-down professional standard" (Zur, 2005, p. 268); and consequently, propagating moral myths about unethical behavior Fostering the potential for moral grandstanding and the attendant increase in self-righteousness from upholding the COE, bespeaking to the virtuous character of the professional (Pope, Sonne, & Greene, 2006).
Ambiguity of codes helps provisions gain wide acceptance. Over-specific codes of unethical conduct might infer that not listed as ethical.	Can be read in the abstract and take on fuzzy generalities in wording and seeming contradictions in wording; general and vague terms may not be taken as intended.
Offers a structured code with a set of guidelines for what is important; enables accountability and a mechanism for holding personally and professionally responsible conduct.	Tends to idealize "values of independence, privacy, and isolation over. . . values of interconnectedness, mutuality, and interdependence …and give mere lip service to cultural diversity" (Zur, 2005, pp. 264-265).
Serves as a reminder of what should and shouldn't be; …aid[s] what ought to be done in terms of clarifying responsibility to client, society and profession" (Strom-Gottfried, 2007, p. 10).	Overly focused on counselor at expense of practice environment and agency culture.
Emblematic of a vision, value, and mission statement.	Codes apt to be misinterpreted, e.g., confusion between clinical and legal decision-making may overlap in ethical decision-making.
Provides bearing for action and thinking.	Codes may impose ethical dogma (e.g., mandate no discrimination as opposed to unfair discrimination), intimating the end, not the beginning, of ethical consideration of an ethical response to a situation (Pope et al., 2006, p. 16).
Intended to slow down thinking and allow practitioners to reason differently around the issue at hand.	COE seems to promote idea that "learning ethical standards, principles, and guidelines, along with examples of how they have been applied translates into ethical practice" (Pope et al., 2006, p. 16).
Does not solely propose ironclad rules that must be followed to the letter.	Tendency to overly focus on risk management and obedience to law, this obscures relevance and application of humanistic considerations; subordinating client interest or priority of humane intervention (Lazarus, 1994; Zur, 2005, 2017).

Table: *Continued*

Pros/Strengths/ Maximums*	Cons/Limitations/ Minimums*
Provides insight to recognize and acknowledge ethical issues with standards that can be extrapolated to different practice situations	Practitioners may not be well versed in the COE; it may make little noticeable difference in the real world of treatment and clinical rounds.
Signifies a balanced perspective, with no absolute right or wrong, but just better or worse solutions.	Proclivities harbored by staff to under no obligation follow COE (e.g., program director, managers, administrators, board members), thus lacks teeth and bite.
Establishes transparency of practice and an ethical floor by standardizing a set of common values, expectations, and minimum standards.	Can be treated as window dressing: e.g., simply posted on a wall with most significant items in code obscured due to length of verbiage (Unger, 1982).
Expresses a compendium of ideals and aspirational goals to elevate practice standards.	Codes can lose meaning and value as practitioners whittle down the COE to the most relevant parts and pieces in a self-stylized and pared-down version: as many aspects of the COE may be viewed as superfluous, and extraneously at odds with personal moral code (Parsons, 2001).
Reminder of what should be important statements to emulate and values to imbue professional identity.	Ethical integrity diminished when COE fails to distinguish between tattle telling, ethical reporting of unethical conduct, and whistle-blowing.
Help when no clear-cut right or wrong answer comes to mind or without guidance (Guy, 1990).	Often crudely applied (e.g., as all-things-considered or absolute finally say) with legal reasons typically used as reference point for why action is right or wrong and used to trump ethical codes.
Reminder of the important principles and values as benchmarks for ethical maturity and professional identity.	COE can be enshrined as “sacred document” over-moralizing ethics with "promiscuous use of “unethical” causing ethical blurring and watering down the concept of ethical integrity.
Typically cover the highest ideas of professional conduct for self-evaluation and professional boundaries.	Agency policy and employee job duties supersede COE; not used for decision-making, reprimanding, or planning best course of action.
Ethical codes “establish norms for proper behavior and methods to arrive at those behaviors” (Roberts, 2016, p. 286).	Codes using negative phrasing and compulsion—“shall” and “shall not”—stress consequences without affirmative rationale or proof of claim.
Helps to neutralize personal morals/ethics/values—i.e., practitioner emotional baggage carried by clinicians (from running amok).	COEs also seem to discount organizational influences faced by practitioner and ignore the fact that some agency’s do not want or value ethical leadership.
Without COEs, practitioners “have no basis for making judgments and no way of knowing whether we have behaved properly or improperly” (Van Hoose & Kottler, 1985, p. 170).	There is no prescription for ethical enforcement at the organizational level (fostering breach of ethics).

Table: *Continued*

Pros/Strengths/ Maximums*	Cons/Limitations/ Minimums*
"Protects professionals from government interference and legislative regulations; …internal bickering about matters clearly delineated within the code and…unfounded complaints and egregious claims against professionals" (Van Hoose & Kottler, 1985, p. 11).	Ethics codes may be taught imperfectly and become learned dogma—unclear, difficult to objectify, and with no standardized consensus of what it means to be an ethical counselor (Forrest, 2010).
Makes explicit the virtues and ideal ethical and moral standards of a "good counselor" (Weston, 2001). A check and balance on the practitioner's personal values/ethics/morals.	Principles from the code are bound to conflict with basic values and ideas harbored by clinicians in disagreement with ethical standards of the organization (Weston, 2001). Creates moral vs. ethical pressure undermining the good intent of the COE.
Spells out a number of morally unacceptable and unequivocally forbidden behaviors (Guy, 1990).	Expectations and values expressed by COE may be out of touch with the realities of the practice environment "on the ground", extant literature, and scientific research.
Acts as a check and balance against practitioners' own personal values, ethics, and morals to contemplate professional ethics (Fisher, 2016).	Professional codes may fail to recognize or acknowledge that "patient and professional are always in a personal relationship (a relationship between persons)" (Greenspan, 1993, p. 199).
Establishes an ethical floor by standardizing a set of common values, expectations, and minimum standards (Fisher, 2016).	Acceptance of professional codes may effectively demonstrate confusion with the principles of a COE being morally sound (Pryzwansky & Wendt, 1999).
In practical application, solutions for thorny ethical issues yield to professional discretion.	"Codes may not align with state laws or regulations regarding reporting requirements" (Corey et al., 2015, p. 7).
Helps orientate thinking towards values and responsibilities rooted in the identity of the profession.	Codes inhere ethnocultural bias fused to culture-specific notions of professionalism (Lefley, 2002).
General provisions guard against loopholes for misconduct (Unger, 1982).	Neglects personal moral ideas (which can "evoke higher aspirations than the minimum responsivities incumbent on all professionals") and moral relevance of the professional's personal moral life, resources, and obligations to professional responsibilities (Martin, 2000, p. 149).
Standardizes certain clinical behavior with common language and professional agreement on ethical decision-making.	"COEs are written from the perspective of a particular professional group, and does not take into account the needs of other stakeholders such as individual consumer or workers. In fact, most mental health workers are not even connected to an organization such as the APA so for most people such a relativist account doesn't even matter" (Cutler, 2002, p. xi).