

## Ethical Decision Making for Licensed SUD Counselors

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### Abstract

This qualitative study considered how six licensed substance use disorder (SUD) counselors in recovery from alcohol and/or drugs negotiate boundaries while adhering to Alcoholics Anonymous values and traditions. Themes that emerged included the use of both professional codes and 12-step values in ethical decision making, pride in recovery status, and a purposeful distance between themselves and their recovery program. Implications for counselors include the need to create healthy and safe boundaries while maintaining their own personal recovery and professional ethical standards.

*Keywords:* ethics, SUD counselor, dual relationships, substance use disorders counseling, boundaries, licensed mental health counselors

## Ethical Decision Making for Licensed SUD Counselors

There is an invisible divide between non-licensed and licensed substance use disorder (SUD) counselors in recovery due to ethical regulations for the licensed practitioner. The licensed SUD counselor in recovery who attends twelve step meetings faces a myriad of ethical issues. This study illustrates the never-changing 12-step values of Alcoholics Anonymous (AA), such as anonymity and unity, and the ever-changing ethical codes of the counseling profession regarding appropriate boundaries and professionalism. This study focused on boundary issues and ethical decision making processes. The term licensed *SUD counselor* describes the clinical licensed professional counselor working as a substance use disorder counselor who is in recovery and wears both the professional hat and the recovering person hat. “Two-Hatter” is an informal colloquial term that is commonly understood to refer to those with this dual status.

In this study, we use the term *licensed SUD counselor* to differentiate between the certified SUD counselor and the licensed professional SUD counselor. The distinction is important as it is very common for non-licensed professionals to work in the addictions field and most states have a special certification for substance abuse counselors.

### Boundary Issues

Counselors who are certified strictly as SUD counselors, not licensed mental health practitioners (LPCs, LCSWs, MFTs), follow a code of ethics specific to the addictions field (Association for Addictions Professionals, 2016). However, this study focused on professional counselors who are bound by a code of ethics for Masters level licenses such as the American

Counseling Association's [ACA] (2014) Codes or the codes of ethics specific to a different mental health profession (ie: social work, marriage and family). For licensed SUD counselors who are in recovery from drugs or alcohol and regularly attend 12-step meetings, boundary and ethical situations can become even more difficult to navigate.

When licensed SUD counselors attend 12-step meetings such as Alcoholics Anonymous (AA) or Narcotics Anonymous (NA) they may see current, future, or former clients. Similarly, when they are in their professional roles they may see clients who they know from meetings. The 12-step traditions of AA and other 12-step programs recognize the need for anonymity, nonprofessionalism, unity, and the responsibility of members to help others. Members of these programs may adopt values from the 12-step traditions which may conflict with the ACA Codes such as those prohibiting relationships with clients, former clients, and family members of clients. These troubles may be magnified if the practitioner lives, works, and attends meetings in a rural community.

Boundary experiences are complicated by many variables and the thought processes behind decision making are often contextual and value-laden (Doyle, 1997). Doyle (1997) stated that SUD counselors, in comparison to other mental health counselors, have greater opportunities to interact with clients outside of therapy sessions. Counselors' recovery status may be common knowledge in their work and recovery environments. Taleff (2009) stated that it is not wise to use ethical codes as the only or final authority because circumstances vary greatly for the recovering counselor. He explained that while ethical codes prohibit some behaviors, many variables need to be considered in complex situations, and there is a need to use moral codes as well.

### **Prior Research**

The problems of dual relationships and boundaries for counselors recovering from substance use disorders is not new (Doyle, 1997). Literature on the topic of the boundaries and ethical issues for licensed SUD counselors is scant, in part perhaps due to anonymity issues. Decades ago, barriers and difficulties facing SUD counselors were introduced to literature only briefly (Doukas & Cullen, 2011). Doukas and Cullen (2011) suggested that current literature is outdated and that further research needs to be conducted on this topic in the form of qualitative studies, that would allow this unique group of counselors to construct their own narratives.

Due to human complexity, it is impractical to assume one theory can cover all ethical aspects (Schildmann, Gordon, & Vollmann, 2010, p. 11). Pettifor (2001) reminded counselors that ethics were developed to distinguish between right and wrong, and that while enforced ethical codes are standards for practice, they are arguably culture-bound. Gerald Corey stated, "I don't see how we can separate ethics from our being and our own personal philosophy and value system" (American Counseling Association, 2010, 10:10), yet ethical code A.4.b states, "Counselors are aware of—and avoid imposing—their own values, attitudes, beliefs, and behaviors" (ACA, 2014, p. 5). Counselors, including those who are recovering and nonrecovering, counseling supervisors, consultants, and counselor educators will benefit from a greater understanding of the daily demands on these counselors in recovery (Hollander et al., 2006).

## **Methods**

The purpose of this study was to consider how licensed SUD counselors in recovery consider and negotiate boundaries in their professional work in the context of professional ethical guidelines and adherence to AA values and traditions. A phenomenological qualitative approach was used because this is an area that has not been extensively studied, is not well understood, and because this phenomenon is best understood through a social context which explores individual situations subjectively and experientially.

This phenomenological qualitative method resembled a collective case study in that it took into account six individual's experiences with hopes of finding commonalities among them. The goal was to discover the more universal characteristics of the phenomenon based on the common experiences and decision-making processes. The most important parts of their stories were used in analysis to find themes common to all participants. The primary question under examination is: What contexts, values, or situations have typically influenced or affected recovering professional SUD counselors' decision-making in dual relationships? The study was approved by the Argosy University IRB.

## **Participants**

Participants were six individuals who are licensed SUD counselors and who at the time of the study regularly attended 12-step meetings. The inclusion criteria were as follows: Participants must consider themselves members of a 12-step program (in recovery themselves), have been professional mental health practitioners working for at least 1 year (overlapping their recovery) in a substance use disorder treatment facility (inpatient or outpatient), and were willing to voluntarily share experiences with boundaries and ethical issues in recorded interviews. Participants signed informed consents which thoroughly explained participant rights and confidentiality.

## **Data Coding and Analysis**

The raw data in this study were the words and meanings derived from semi-structured in-depth interviews with participants. Among other questions, all participants were asked the following questions:

- How do you make boundary/ethical decisions on a daily basis?
- What are the perceived implications of the traditions in your professional life?

The interviews were transcribed and coded. Each participant's interview was then summarized based on codes. Next, themes were discovered within each interview, and the themes were then compared and contrasted with one another. Finally, the researcher made a summarizing description of the decision-making processes. This was the piece that tied together the underlying structure of the experiences (Creswell, 2006).

### Case Summaries

The ethical decision-making portions of the interviews have been summarized. The summaries illustrate some of the thought processes and values used in making decisions when juggling both AA values/traditions and upholding professional obligations. Pseudonyms have been used to protect both the confidentiality and anonymity of participants.

#### **Interviewee One: Debra**

Debra is a married Caucasian female from Tennessee who has been in the substance abuse field for 7 years. She is 54-years old, has 24 years of sobriety, and is a licensed marriage and family therapist (LMFT). At the time of the study she did not have an AA sponsor but did sponsor others in AA. She has been in her own personal counseling before and stated she feels satisfaction in working with the substance use disorder population.

Debra discussed that she decreased the number of meetings she attends because clients also attended the meetings. She stated that she felt less comfortable sharing personal issues where clients were present. Debra expressed the idea that AA is her basis or foundation for life, which guides her decisions in clinical, personal, and recovery situations. She stated that ethical decisions are value based. In response to the question regarding how she makes ethical decisions on a daily basis she responded, "I think sometimes it's intuitive . . . [and] some is learned from the ethical codes and consultation with peers or colleagues." She stated she also consults regularly with an individual who has also been in the recovery field for over 20 years. She admitted that she has "to be extra careful" in boundary issues in general.

#### **Interviewee Two: Brad**

Brad is a 62-year-old married Caucasian male with 28 years of recovery. He lives in Illinois and has provided SUD treatment as a licensed clinical social worker (LCSW) for over 30 years. At the time of the study, he stated that he did not have an AA sponsor because his previous sponsor relapsed; therefore, he was not at the time sponsoring others. He has received his own personal counseling since his recovery began and stated that for the most part he is quite satisfied counseling in the SUD field.

Brad stated, "Sometimes what is shared at a 12 step meeting comes back that should have stayed at a 12 step meeting. I feel I have to be somewhat guarded in what I share about me personally and also about clients." He admits having gotten into boundary and ethical trouble in the past.

Brad stated that he often makes decisions based on just "doing the next right thing." He added that insight into what to do often just comes to him intuitively: "doing in your heart what you know is right more on a soulful level than on an academic level." He added that he has learned a lot from past experiences.

In the beginning of the interview he stated he kept the professional code of ethics first, yet he also stated that some decisions are based on 12-step values. In regard to professional and 12-step values he stated, "It gets cloudy sometimes. It gets a little foggy, you know. It's not always real clear." He stated that in order to make ethical decisions he uses others in recovery

and consultation. He noted that he has experienced significant boundary issues in the past and pointed out that some agencies do not make allowances for intent (good intentions). He stated that he has to protect clients' confidentiality and anonymity if they go to meetings, so he uses both the program and the code of ethics as guides. He uses his faith and spirituality in most decisions. He stated that the 12-step traditions that affect ethical boundary decisions are primarily anonymity and the spiritual foundation and these are the most influential in his own decision making. In respect to the guiding principle from his professional codes that helps with the majority of his ethical decision making, Brad cited autonomy.

### **Interviewee Three: David**

David is a married, 62-year-old Caucasian male from Illinois. He has been in recovery for 18 years and has been working in the substance abuse field for 29 years. At the time of the study, he stated he is fairly satisfied working with substance abuse clientele. David is a LCSW and stated he has received his own counseling.

David stated that some of his boundary experiences include getting a client that he has seen around the program, suggesting a client try a 12-step program, and finding out that his sponsor sponsors his clients. He reported that he self discloses his recovery status with practically everyone.

When asked about what influenced his decision-making in dual relationships, he replied, "Having been in therapy myself with somebody that was in a 12-step program early on helped that a lot, to sort that out." David noted that his ethical decisions are based on values and that those values include the values of the program, his spiritual/personal beliefs, and professional codes. He reported having his own personal counselor and consulting with other professionals for decision-making. David expressed that confidentiality is at the top of the list of his ethical considerations.

David stated that experience has helped him to be more aware of how to set healthy boundaries. He said that ultimately, he is aware that he has made good ethical decisions when he can lay his head down at night and go to sleep. When asked what it took to be able to sleep at night, he replied "working a good program." When asked what a good program was, he replied, "talking to people . . . because there aren't always clear absolute delineations between these things [regarding ethical decisions]." He also added that self-care activities, such as his active spiritual life, meditation, and exercise help him to sleep at night, meaning these activities help give him a clear conscience regarding this ethical decision making.

### **Interviewee Four: Charles**

Charles is an unmarried 68-year-old Caucasian male in Florida. He is a LCSW. He has been in the SUD field approximately 15 years and has been clean and sober for 21 years. He has a sponsor and is a sponsor of two people in NA. At the time of the study he was receiving his own personal counseling and stated he was usually satisfied in the field of SUDs but not with the profession as a whole.

Among the boundary issues that Charles discussed as a SUD counselor in a 12-step recovery program were issues that arose in the form of transference and countertransference. He

also stated that financial issues presented a boundary issue at times. For example, he stated that sometimes he purposefully does not discuss certain things that could cause a situation to be construed as a dual relationship when entering into financial/business agreements. He said he pushes some limits and explained that the social worker codes say that he is to avoid having outside contact with clients or families of clients, which can often prove a difficult task.

Charles stated he uses professional codes, personal morals, and the principles and values of the program to guide decision-making and admitted that sometimes the right thing to do was not all that clear. He stated that he thinks he does a good job of leaving work at work. He stated that he makes decisions based on whether his actions will keep him up at night. His experiences have taught him to better recognize red flags and to maintain boundaries. Experience has also taught him that boundary issues often have negative effects; therefore, he has learned to set and reset firm boundaries with clients. He talks to others in recovery about his own personal issues as well as some boundary issues: "Fortunately I was taught early on that you have to have boundaries for your own sanity." However, he also pointed out, "I have to weigh each instance separately."

Charles went on to state that his personal code of ethics includes some of the values from the program, such as unity and using a higher power, to make decisions. The most important code for Charles was nonmaleficence. "The most important thing is that I don't do anything that's going to harm somebody, but what if I'm doing something that's beneficial? How far do I want to put my neck out to do something beneficial?"

#### **Interviewee Five: Dan**

Dan is a 61-year-old single Caucasian male in Illinois. He has applied for his license as a professional counselor (LPC) having fairly recently completed a master's in counseling program. At the time of the study, he had been working in the substance use disorder field in a clinical capacity as an employee and intern, following his professional code of ethics for approximately 15 months. At the time of the study he had been in recovery for 26 years. He stated that he has a sponsor and only nominally sponsors others. He stated that he has been receiving his own personal counseling since being in the substance abuse field. He noted that he is very satisfied with his profession as a substance abuse counselor.

Dan stated that he believed it was important to first decipher the following information to best set up healthy boundaries in counseling: "Who is the client? Who is the counselor? How much does each know about the other, and how appropriate is such knowledge to the therapeutic relationship?" Recently, Dan began attending different meetings because current clients were attending his regular meetings:

I used to be a pretty regular attender of the 10:30 am meetings at this club. I really slowed down on going to those 10:30 am meetings because of that very principle. I didn't want me to be all the time in the same space. Maybe it would be a stumbling block for them. I don't think it would be much of a stumbling block to me. But this morning two [clients] happened to be at the same meeting I was at. It didn't make any difference in the way I commented but I also did not walk up to them after the meeting because everybody in that meeting, I believe, understood that these guys were clients at the [agency]. Some of them may have known that I'm a counselor there but we didn't

make a big splash over it. . . . Also at least two of my clients have known a lot of the same people I know.

Dan stated that some of the values he uses in ethical decision making are related to personal and family history but added that not everybody has those same values and/or history and that does not mean that his values are better or worse than others. He said he places a high value on his recovery and recovery in general. He tends to base ethical decisions on morals and personal values, which include the 12-step program's traditions and values, as well as his own spirituality.

### **Interviewee Six: Carolyn**

Carolyn is a 63-year-old single Caucasian female with 34 years of recovery. At the time of the study, she was living in Missouri and had been working with the substance abuse population for 30 years. Carolyn has a sponsor and sponsors others minimally. She stated that she has received her own personal counseling.

Carolyn reports that clients occasionally ask her to be their sponsor to which she politely declines and explains why. Overall, however, she reported not having experienced a lot of boundary issues because of her dual status. She did explain that sometimes boundaries are blurry, and oftentimes clients have tried to ask her clinical questions at meetings. At times she has allowed this if they take her to the side and ask quietly. She explained, "What happens in Vegas stays in Vegas." She stated she occasionally pushes the boundaries slightly in order to help clients.

Carolyn stated she uses the codes and the program to make ethical decisions. She puts an emphasis on maintaining anonymity and confidentiality. Ethical and boundary decisions tend to come intuitively to her due to her many years of experience, yet she states that she uses the program values and traditions as well as the professional codes as guides. She said she stays constantly vigilant of boundaries yet puts her recovering self and her program first. She stated that AA is her foundation for life. In meetings she is quiet about her profession and some people in the meetings have no idea she is a substance use disorder counselor. She acknowledged that she is very open with clients about her recovery status and thought this helped her relate to clients better; she stated that she is more quickly able to gain their trust because of it.

Carolyn stated that she sets boundaries often with clients. She uses her spirituality to guide her decisions in many aspects of her life, including her professional life. She said she understands that some clients are more resistant to the idea of 12-step programs, have different spiritual beliefs, and that the program is not for everybody. She stated that she talks with someone in a supervisory role or a colleague if she finds herself struggling with a boundary issue.

### **Themes**

The research question was: "What contexts, values, or situations have typically influenced or affected recovering professional SUD counselors' decision-making in dual relationships?" The main theme that emerged from this question was that these recovering practitioners used both their professional codes and their 12-step values to influence decisions. While there is no quantitative data to prove mathematical equality, interviewees typically

explained their ethical decision making both in terms of their professional responsibilities, as well as their obligations to the program and its members. As an example of this theme, Carolyn explained, “Of course we have ethical guidelines professionally, and then we have guidelines set forth by the support groups in terms of anonymity and respecting people’s confidentiality at meetings; so there’s basically confidentiality going both ways.” Charles demonstrated the use of his own personal/recovery ethics and their relation to the professional codes by stating, “Well, I guess I feel like I am blurring some lines, but I also have a code of ethics that I live by and it may not coincide with the NSWs...”.

Another theme that emerged was that these counselors tend to put literal and figurative distance between themselves and their recovery program. In a literal sense, they tend to change meetings and fellowship less with the members, rather they tend to keep a small group of trusted recovery supports. In a figurative sense, they tend to share less personal information in AA meetings and feel they must always be cognizant of what they say and who they say it to. Evidence of this theme can be found in statements such as Brad’s acknowledgement that “sometimes what is shared at a 12-step meeting comes back that should have stayed at a 12-step meeting. I feel I have to be somewhat guarded in what I share about me personally and also about clients.” Charles stated, “Fortunately, I was taught early on that you have to have boundaries for your own sanity” and Carolyn said, “When I go to the meetings, however, I am not a counselor in any way shape or form. I’ve got my AA hat on then.” David chose new meetings to attend to avoid clients.

Another major theme was that these practitioners each expressed a sense of pride in their dual status as well as seem to place great value on their recovery status and recovery in general. Examples of this include Brad’s statement about value on recovery because it is such a large part of his personal identity, Charles’ statement that NA is the basis of his life, Dan reporting that he is very grateful to AA because he “owes it all” to the program, Carolyn’s statement that first and foremost she is a recovering person, and David’s assertion that he would not have his professional life without the 12-step program.

In summary, these professionals reported a blurring, or ambiguity, of ethical boundaries and roles and gave a variety of examples. The commonality between these examples was that these practitioners abided by their codes of ethics, which sometimes coincided with or overlapped the 12-step values and traditions, and sometimes those codes were somewhat in conflict, or at least became unclear in comparison to, their 12-step values. The blurring of boundaries and roles seems to cause a distance between licensed SUD counselors and their recovery program.

## **Discussion**

Due to professional responsibilities, these 12-step members who counsel in the substance use disorder field and follow a professional code of ethics feel they must continually monitor boundaries in both their clinical roles and their--12-step fellowship activities. This seems to affect their ability to help others in recovery according to AA’s responsibility statement: “I am responsible. When anyone, anywhere, reaches out for help, I want the hand of AA always to be there. And for that: I am responsible” (Alcoholics Anonymous World Services, 2018f, What is

the history behind AA's Responsibility Statement? para 1.). Also, all participants attempt to incorporate the 12-step values and traditions into their lives and personalities, which appeared to affect how they make their personal and professional decisions, including boundary and ethical decisions.

The findings of this study support that licensed SUD counselors in recovery tend to base their decisions, not only on the codes of their professions, but also on the traditions and values of their 12-step programs. The influence of their 12-step programs on their ethical decisions makes sense given that AA members share cultural commonalities, which include aspects of their value and belief systems. The participants in this study tended to express a sense of pride in their dual status and tend to place a high value on their recovery status and recovery in general.

Maintaining clinical distance amidst a tight-knit recovery community appeared to offer unique challenges to these professional clinicians. Clinicians must draw from their vast knowledge and value repertoire to resolve ethical dilemmas. This is in keeping with what Tjeltveit (1999) stated, "Psychotherapists have, in fact, always answered ethical questions—by drawing upon consensus, training, experts, experience, intuition, rational, arguments, science, and so forth" (p. 6). As a result of this study, these researchers believe it may not be feasible to separate the practitioner's clinical mind from their daily lives and decisions if boundary issues are ever-present.

Regarding AA's tradition 11 on the need for anonymity at the public level (Alcoholics Anonymous World Services [AAWS], 1952), participants in this study all stated that they were open about their recovery to clients in most cases but that protecting the anonymity of their clients' involvement in 12-step programs was of utmost importance. Clinicians expressed the belief that self-disclosure helped their clients trust them more readily; they also appeared to perceive their dual status as an asset that could help the client, and also because many stated that people were aware of their recovery status anyway in light of both client and clinician belonging to the same AA community. Some may have also thought it necessary to self-disclose in order to proactively set boundaries with clients. For example, by self-disclosing, they could inform clients of boundary expectations should they see each other in a meeting.

Tradition eight pertains to the need to avoid professionalizing AA (AAWS, 1952). Most of the participants in this study stated that they worked in 12-step facilitation agencies, but they reportedly did not use more than appropriate amounts of 12-step concepts in counseling, as they used other clinical theories and strategies while remembering not to "push" the 12-step program inappropriately.

Interviewees unanimously expressed that sometimes the expectations get confusing and boundaries get blurred when managing both 12-step involvement and professional expectations. Ultimately these researchers agree with Berton (2013) who stated, "Ethics are not timeless" (p. 233). Berton was referring to the need for ethics to change with and adapt to the times.

Limitations of the study included a small sample size which may result in only loosely representing the perception and experiences of others. The study did not account for causal

factors, such as other subcultural differences or levels of training, as causes for boundary issues. Also, the researcher's assumptions might have affected the study. Assumptions included:

1. Boundary issues tend to have more negative than positive results
2. There is a lack of guidance for and understanding of licensed SUD counselors
3. Many ethical violations are overlooked by colleagues and continue to occur

### **Implications on Counselors**

For those supporting the recovering clinician, it may be advantageous to be aware of the contextual experiences faced by this population. These researchers believe that licensed SUD counselors represent a much larger, invisible, population working in the field, which may be difficult to find because they may not always openly discuss their dual status with other colleagues or supervisors. They may remain hidden due to fear of being stigmatized by having an addiction (Hill & Leeming, 2014). The interviewees in this study discussed that they often talked with people in the program regarding personal issues, which included some professional issues. Certainly, they did not reveal client information, as confidentiality was of utmost importance, similarly or equally important as anonymity of 12-step members. It appears that these clinicians talked more with people in the program than they spoke to consultants or professional colleagues. Regular consultation was mentioned by only one interviewee who stated that her consultant was also in recovery.

Other clinicians may not be aware of the personal and professional difficulties their colleagues face when they own this dual status. Supportive awareness in the office for those in recovery would be helpful and could eliminate uncomfortable situations in which unaware staff members attempt to probe the dual-status clinician about meeting attendance or discussions in attempts to find out more about clients. Juggling both the professional codes and the traditions and values of a 12-step program continually can be a heavy burden to carry, as was learned in this study.

Doyle, in 1997, posited that there was a need for greater guidance for counselors in recovery. He suggested implementing substance abuse counselor training on issues of boundaries, adding ethical codes specific to the recovering counselor, and the need for future research in this area. Doyle (1997) referred to the certified substance abuse counselor and its profession; however, there is a need to address the special ethical considerations for substance use disorder counselors who are licensed mental health practitioners as well, and possibly more so. The findings of this study support Doyle's assertions.

Lastly, and possibly most importantly, clinicians in recovery may need to know that they are not alone; the information gathered in this study can be used in their personal and professional lives to help them create healthier and safer boundaries while still allowing themselves to be who they are as individuals and maintaining their own personal recovery and professional ethical standards.

Oftentimes boundary issues are discussed in vague terms. This population would do well to be proactive and to consider specific instances to avoid and plan for. Learning vicariously and considering potential pitfalls may be the solution to deter a quality clinician from leaving the

profession and/or relapsing. Supervisors and consultants would do well to ask the following question of recovering consultees or supervisees: If it is true that this dual status may cause you to grow distant from your recovery program, can you now, and will you be able to in the future, afford that distance? In other words, humans go through seasons, and it may be important for all involved to be aware of what might happen if the recovery distance becomes too great a chasm that a professional neglects his or her own recovery needs. The question must also be raised, if a relapse appears likely, is it sometimes necessary for the practitioner to change fields or specialties? Supervisors would do well to be knowledgeable about the values, beliefs, and special needs of their employees/supervisees and encourage them to maintain self-care activities, such as using 12-step supports and going to a personal counselor as appropriate in order to maintain their own wellbeing and ethical behavior. This area of recovering clinicians may be one area that needs more research to better illuminate the precarious personal and professional boundary dilemmas some clinicians may face because of their profession and their recovery status.

### **Recommendations for Future Research**

All interviewees stated that they were very highly concerned with protecting the confidentiality of clients due to their professional ethics, protecting the anonymity of 12-step attendees, not wanting to impose on clients' personal space, and protecting their professional selves. These have been mentioned in no order of importance, as order of importance has not been quantitatively analyzed; however, quantitative research would be helpful to discover the order of importance of these concerns, which may better illustrate core values which lead to ethical decisions for professional licensed SUD counselors in recovery.

Also, a quantitative study might yield interesting results in regard to identifying specific personality characteristics that lead to better formation of healthy boundaries, issues that appear to be most problematic, and other concepts related to this dual status such as proven solutions to boundary and ethical concerns for this population. For example, a quantitative study might be able to decipher whether marital status or personal counseling for the practitioner have any direct effects on the practitioner's comfort level regarding their dual status and ability to set clear boundaries.

### **Conclusion**

These licensed clinicians in 12-step programs who are working in the SUD field attempt to uphold their professional codes of ethics and their 12-step values and traditions while feeling a need to protect others (clients and others in 12-step meetings) as well as themselves (their recoveries and their professions). They reported that their professional and recovery roles overlapped and that boundaries between their clinical clients and their 12-step counterparts could become blurry at times. The recovering licensed SUD counselors in this study expressed their need to be continually aware of boundary issues both in their profession and personal/recovery lives and there is a distance between them and their recovery program due, at least in part, because of their dual status. This finding should not imply a general positive or negative connotation, but an overall finding of this research. Individuals will certainly have their own experiences with recovery distance which they may interpret as positive, negative, neutral, or

changing. According to this study's findings, these boundary issues are often resolved by weighing both ethical codes and 12-step traditions and values.

There is a need to better understand this special population of professional mental health clinicians in the field of substance use disorders who are also in recovery and consider themselves members of a 12-step program. Little research has been done to understand their strengths, difficulties, and special circumstances. Even the existing small amount of research tends to include certified drug and alcohol counselors who are not licensed mental health practitioners. These authors suggest that future research focus on licensed mental health practitioners working in the field of substance use disorders.

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