

Addiction Counseling Self-Efficacy of Mental Health Counselors-in-Training

by

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Abstract

The purpose of this study was to examine the level of mental health counselors-in-training self-efficacy in providing addiction counseling and the modalities of addiction related counseling education. In addition, the statistically significant differences between the level of self-efficacy and the modalities of addiction counseling education were investigated. The results indicated that participants had a moderate to high level of self-reported counseling self-efficacy on the Addiction Counselor Self-Efficacy Scale (ACSES). Ninety percent of the participants received some addiction or addiction related education through an addiction-specific course and/or integration throughout the mental health counseling curriculum. The results indicated that there was no statistically significant difference in the self-efficacy level by education modality. The findings of the study were discussed and implications for counselor educators and counseling programs were presented, as well as limitations of the study and recommendations for further research.

Acknowledgments

The Lord declares “For I know the plans I have for you, plans to prosper you and not to harm you, plans to give you hope and a future. Then you will call on me and come and pray to me, and I will listen to you. You will seek me and find me when you seek me with all your heart. I will be found by you” (Jeremiah 29:11-14). My LIFE verse! The past five years have been a journey filled with triumphs, challenges, joy, happiness, tears, sorrow, peace, and love! First, foremost, and most importantly I thank my Lord and savior for His grace that has been so generously bestowed onto my life. Back in 2009, I heard God’s whispers that His plan was greater than the one I was trying to create. I listened to Him and decided that I needed to back to school. My passion in life is teaching and my gift is counseling. His directions lead me to the Counseling Education and Supervision doctoral program at Auburn University. I owe ALL my success to His wisdom and guidance from the first day of graduate school to the final defense date! I am not sure what the next chapter in life entails, however, this journey has taught me that my life verse becomes reality every day I wake up and walk in faith!

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“Family isn't always blood. It's the people in your life who want you in theirs. It's the ones who accept you for who you are. The ones who would do anything to see you smile, and who love you no matter what.”

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“Don’t Quit”

When things go wrong, as they sometimes will;
when the road you’re trudging seems all up hill;
when the funds are low, and the debts are high;
and you want to smile, but you have to sigh;
when care is pressing you down a bit,
rest if you must, but don’t you quite.

Life is strange with its twists and turns,
as every one of us sometimes learns,
and many a failure turns about,
when he might of won had you stuck it out.
Don’t give up though the pace seems slow.
You may succeed with another blow.

Success if failure turned inside out;
the silver tint of the clouds of doubts,
and you never can tell how close you are;
it may be near when it seems so far.
So stick to the fight when you’re hardest hit.
It’s when things seem worse that you must not quit!

I look forward to crossing the stage soon as Dr. Carroll and being a proud Auburn University Alumni. The Auburn creed continues to remind me that “... I believe in work, hard work; ... I believe in a spirit that is not afraid; ... and I walk humbly with my God”

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CHAPTER I. INTRODUCTION

Addiction problems associated with substance abuse and process addictions continues to have a significant effect on the United States and creates a hefty toll on community resources (Crits-Christoph & Siqueland, 1996; Hagedorn, 2009; Lee, Craig, Fetherston, & Simpson, 2013). Alcohol, tobacco, illicit drugs, and related issues are extremely costly to our nation, exceeding \$700 billion annually in expenses related to crime, lost work productivity, and healthcare treatment (National Institute on Drug Abuse [NIDA], 2014). It has been estimated that process addictions (gambling, internet, and sex) have cost our society more than \$285 billion annually, which does not include additional costs potentially attributed to addictive eating, spending/shopping, or exercise (Hagedorn, 2009; Karim & Chaudhri, 2012). It is estimated that one in four individuals are affected by an addiction or addiction related issue (Hagedorn, Cullbreth, & Cashwell, 2012).

While pathological use of alcohol, and more recently, psychoactive substances have been accepted as addictive diseases, developing brain science has set the stage for inclusion of process addictions, including food, sex, shopping and gambling problems, in a broader definition of addiction as set forth by the American Society of Addiction Medicine ([ASAM], 2011). An addiction is a primary, chronic disease involving brain reward, motivation, memory and related circuitry; it can lead to relapse, progressive development, and the potential for fatality if not treated (ASAM, 2011). Trained

professional counselors have been a vital resource in confronting the growing addiction epidemic in today's society including the critical social problems of individuals who are facing addiction issues, the consequences as a result of their addiction, as well as those affected by the addicted person (Hagedorn, 2007; Hagedorn et al., 2012; Lee et al., 2013; Luborsky, McLellen, Diguier, Woody, & Seligman, 1997; Morgan & Toloczko, 1997; Najavits & Weiss, 1994; Project MATCH Research Group, 1998). Although specialists including psychologists, social workers, and psychiatrists have provided treatment to individuals with addiction or addiction-related issues for decades, the majority of clinical services in the field of addictions is provided by master level counselors (Fisher & Harrison, 2009; Hagedorn 2009; Hagedorn et al., 2012; Linton, 2012; Wendler, 2007; Whittinghill, Carroll, & Morgan, 2005).

The professional clinicians who practice in the field of addiction counseling has evolved over the years and it became imperative that addiction specific knowledge and skills were needed to effectively work with the growing diverse populations and wide range of associated secondary issues (Hagedorn et al., 2012; White, 1999, 2000, 2013; Miller, Scarborough, Clark, Leonard, & Keziah, 2010; Whittinghill, 2006; Whittingill et al., 2005). In an attempt to improve clinicians' addiction specific knowledge and skills base, *The Addiction Counseling Competencies: The Knowledge, Skills, and Attitudes of Professional Practice*, was published by the Substance Abuse and Mental Health Services Administration's (SAMSHA) Addiction Technology Transfer Center (ATTC) addiction treatment workforce (Center for Substance Abuse Treatment [CSAT], 2006). This set of proficiency guidelines included addiction counseling focus areas such as: client assessment and screening, treatment planning, referral, specific counseling skills, family

and community education, along with cultural competency (CSAT, 2006; “Field embrace,” 1998; Murdock, Wendler, & Nilsson, 2005; Wendler, 2007).

Counselor education preparation programs recognized that addictions and addiction related topics such as identification of addictive behaviors, strategies for prevention, intervention, and treatment, along with specific counseling skills were all important elements in the counseling program curriculum (Lawson & Lawson, 1990; McDermott, Tricker, & Farha, 1991; Morgan & Toloczko, 1997; Salyers, Ritchie, Luellen, & Roseman, 2005; Selin, & Svanum, 1981; Whittinghill, 2006; Whittinghill et al., 2005). The Council for Accreditation of Counseling and Related Programs (CACREP) made revisions to the standards in order to address the need for counselors-in-training who may work with clients with an addiction and addiction-related issue(s) to receive the education and clinical skills to become proficient clinicians (CACREP, 2009). The 2009 CACREP standards changes included: the addition of an addiction counseling degree program track, revisions to the core curriculum student learning outcomes (i.e. competencies) within all counseling programs, as well as the adoption of specific education standards on addiction and related counseling to the clinical mental health counseling program track.

As mental health counselors-in-training enter the field of counseling, self-efficacy is an important determinant of their ability to assume their roles as professionals with success and confidence (Johnson, Baker, Kopala, & Thompson, 1989; Larson & Daniels, 1998; Larson, Suzuki, Gillespie, Potenza, Betchel, & Touclouse, 1996; Lent, Hoffman, Hill, Treistman, Mount, & Singley, 2006; Melchert, Hays, Wilhanen, & Kolocek, 1996; Pajares, 2002; Wendler, 2007). Perceived self-efficacy refers to individuals’ beliefs in

their capabilities to organize and carry out courses of action to attain created goals. Perceived self-efficacy affects individuals' choice and commitment of goal setting, how much effort they expend and how long they will persist in the face of obstacles and aversive experiences (Bandura, 1977, 1982; Bandura & Adams 1977).

One common thread in research has been that the mental health counselor's-in-training addiction and related counseling knowledge and skill competency has increased when some method of formal education (i.e. coursework or experiential component) was received (Chandler, Balkin, & Perepiczka, 2011; Friedlander & Snyder, 1983; Johnson et al., 1989; Melchert et al., 1996; Munson, Zoerink, & Stadulis, 1986; Tang, Addison, LaSure-Bryan, Norman, O'Connell, & Stewart-Sicking, 2004). However, the majority of research previously conducted in the addiction counseling field has focused on identifying addiction counseling competences of professional addiction counselor specialists and/or licensed clinicians. Little empirical attention has been directed towards studying counselors' -in-training competencies in providing addiction and related counseling skills (Najavits & Weiss, 1994; Wendler, 2007).

Purpose of the Study

There is a scarcity of literature on the competencies in providing addiction counseling among mental health counselors-in-training. This study plans to expand on the research and information related to the mental health counselors-in-training self-efficacy in providing addiction counseling skills. Additionally, this study attempts to fill a gap in scholarly knowledge on the implementation of addiction and addiction-related education within the mental health counseling programs.

The purpose of this study was to identify the addiction counseling self-efficacy of mental health counselors-in-training. The researcher will also examine the education modalities mental health counselors-in-training are receiving or have received in addiction counseling. Specifically, the aim of this study was to examine the statistically significant differences in the self-reported self-efficacy levels and the received education modalities.

Research Questions

1. What are the levels of self-efficacy among mental health counselors-in-training?
2. What is the modality of education that mental health counselors-in-training receive in addiction counseling?
3. Is there a statistically significant difference in the overall self-reported counseling self-efficacy by modality of education received?
4. Is there a statistically significant difference in the factors of counseling self-efficacy by modality of education received?

Significance of the Study

The Bureau of Labor Statistics, U.S. Department of Labor, Occupational Outlook Handbook (2014) states that the employment of counselors working in the substance abuse and behavioral disorders, and mental health industry is projected to grow over 30 percent from 2012 to 2022, which is much faster than the average of all occupations. Due to the demand for qualified clinicians in the field of addiction counseling, there needs to be an increased research emphasis of the education and training skills of counselors-in-training (Hagedorn, 2007; Hagedorn et al., 2012; Lee et al., 2013; Libretto, Weil, Nemes, Copland Linder, & Johansson, 2004; Sias & Lambie, 2008; Whittinghill et al., 2005).

Specifically, it is imperative that counselors-in-training develop competencies in recognizing, assessing/screening, and treating addictive disorders through education and training during their master's degree programs (Chandler et al., 2011; Madson, Bethea, Daniels, & Necaise, 2008).

Additionally, there continues to be a shift to a formal degree requirement for employment with treatment centers, community agencies, private practice, and careers in government (The Bureau of Labor Statistics, 2014). Clinicians currently in the field of addiction counseling have credited the academic training of a masters counseling program with benefiting the development of their competency level (Carroll, 2000; Hagedorn et al., 2012; Lambie & Foster, 2006; Lawson & Lawson, 1990; Linton, 2012; Mustaine et al., 2003; Taleff & Martin, 1996). There has been nominal research on the implementation of addiction and addiction related counseling education in the mental health counseling programs (Lee et al., 2013). Until recently, the formal instruction of addiction and related counseling education and training skills have been criticized as being inadequate (Cellucci & Vik, 2001; da Silva, Cardoso, Pruett, Chan, & Tansey, 2006; Lee et al., 2013; McDermott, Tricker, & Farha, 1991; Morgan & Toloczko, 1997; Salyers et al., 2005; Whittinghill et al., 2005). Iarussi, Perjessy, and Reed (2013) recognized the need to research learning outcomes of independent course(s) versus the integration in clinical mental health masters' coursework in addiction counseling training.

This current study explored mental health counselors-in-training addiction counseling skills. Researchers have spent decades investigating self-efficacy, however, only recently have explored addiction counseling self-efficacy, specific research was needed to look at mental health counselors-in-training perceived addiction counseling

self-efficacy levels. The identification of the competency level and implementation of addiction counseling education from the viewpoint of the mental health counselors-in-training can assist counselor educators and program directors in facilitating modifications to coursework, experiential activities and/or mental health program curriculum.

Definition of Terms

Addiction: The short definition provided by American Society of Addiction Medicine (ASAM), (2011): Addiction is a primary, chronic disease of brain reward, motivation, memory and related circuitry. Dysfunction in these circuits leads to characteristic biological, psychological, social and spiritual manifestations. This is reflected in an individual pathologically pursuing reward and/or relief by substance use and other behaviors. The term addiction has evolved throughout the decades of research. Alcoholism, alcohol abuse, use, disorder as well as drug abuse, use, disorder are terms that have been used in previous research and literature. For the congruency of this study, the term “addiction” is used.

Behavioral / Process addictions: An addiction to a behavior or action, such as gambling, shopping, eating, or sexual activities (CACREP, 2009).

Counselor-in-training (CIT): a formalized word for a master level student which is intended to be prepared for the leadership and responsibility of being a counselor. Although each program may have its own special requirements or features, they all have elements in common as well as learning outcomes.

Modality of education: A modality of education describes the way that education is imparted to an individual.

Self-efficacy: Perceived self-efficacy is defined as people's beliefs about their capabilities to produce designated levels of performance that exercise influence over events that affect their lives. Self-efficacy beliefs determine how people feel, think, motivate themselves and behave. Such beliefs produce these diverse effects through four major processes. They include cognitive, motivational, affective and selection processes (Bandura 1977, 1978).

Chapter II. LITERATURE REVIEW

Introduction

The following review of literature began with a brief overview of addictions and the evolution of the addiction counseling field. The development of competencies in addiction counseling was reviewed along with relevant research on the certification, education, and training skills in the field of addiction counseling. Subsequently, addiction specific standards of The Council for Accreditation of Counseling and Related Programs (CACREP) were identified and the implementation of addiction and addiction-related counseling areas in mental health program curriculum was discussed. Next, self-efficacy theory was introduced and research in the area of self-efficacy and counseling skills was provided.

Addictions Overview

The abuse of alcohol, tobacco, and illicit drugs continues to be one of the nation's top health problems; causing more deaths, illnesses, and disabilities than most other preventable health conditions (American Academy of Family Physicians [AAFP], 2011). The increasing addiction problem is a dangerous trend in the United States. According to the Substance Abuse and Mental Health Services Administration's (SAMHSA) Drug Abuse Warning Network (DAWN) nearly 4.6 million hospital emergency department visits in 2009 was the result of alcohol or drug abuse (SAMSHA, 2010). Additionally,

approximately 53 percent of adults in the United States had reported that one or more of their close relatives had an addiction or addiction related problem (SAMSHA, 2013).

Current records from the 2013 National Survey on Drug Use and Health (NSDUH), an annual survey sponsored by SAMSHA, indicated 21.6 million individuals (8.2 percent of the population aged 12 or older) were classified with a substance dependence or substance use disorder (SUD) (SAMSHA, 2014). Additionally, 10.4 million individuals (5.6 percent of the population aged 12 or older) had a co-occurring SUD and mental health issue based on criteria specified in the *Diagnostic and statistical manual of mental disorders*, 4th edition, text rev. (DSM-IV-TR) (SAMSHA, 2014). The SAMSHA's NSDUH study showed that approximately 22.7 million individuals (8.6 percent of the population aged 12 or older) needed treatment for an alcohol use or illicit drug problem, however, only 2.5 million received treatment at a specialty facility (SAMHSA, 2014).

Researchers discussed of two types of addictions: substance addictions (e.g., alcoholism, drug abuse, and smoking); and behavioral or process addictions (e.g., gambling, spending, shopping, eating, and sexual activity) (Hagedorn, Cullbreth, & Cashwell, 2012).

Recently, revisions were made to expand the evolving identification of addictions in the *Diagnostic and statistical manual of mental disorders*, 5th ed. (DSM-5) (American Psychiatric Association [APA], 2013). The *DSM-5's* revised chapter of "Substance-Related and Addictive Disorders" included essential changes to the disorders grouped there, as well as changes to the criteria of certain conditions. Specifically, there was the addition of a new category "behavioral addictions" where gambling disorder was

recognized as similar in nature to substance-related disorders in the clinical expression, brain origin, comorbidity, physiology, and treatment (APA, 2013). The definition of addiction from The American Society of Addiction Medicine (ASAM) (2011) was in alignment with revised chapter on Substance-Related and Addictive Disorders of the DSM-5. ASAM adopted a comprehensive definition of the term addiction to encompass the current research and the acknowledgement that addiction was not solely related to problematic substance abuse (ASAM, 2011). In ASAM's public policy statement, the term addiction has both a short and long definition. The short definition of the term addiction is defined by ASAM (2011) as:

“Addiction is a primary, chronic disease of brain reward, motivation, memory and related circuitry. Dysfunction in these circuits leads to characteristic biological, psychological, social and spiritual manifestations. This is reflected in an individual pathologically pursuing reward and/or relief by substance use and other behaviors.

Addiction is characterized by inability to consistently abstain, impairment in behavioral control, craving, diminished recognition of significant problems with one's behaviors and interpersonal relationships, and a dysfunctional emotional response. Like other chronic diseases, addiction often involves cycles of relapse and remission. Without treatment or engagement in recovery activities, addiction is progressive and can result in disability or premature death.”

The long definition of addiction includes neurobiology, genetics and other factors that influence the diagnosis of the term, characteristics, as well as risk and relapse

discussion, behavioral manifestation, cognitive and emotional changes and aspects of treatment (ASAM, 2011).

Development of the Addiction Counseling Field

The origin of today's counselors, who work in the addiction field, came straight from what was referred to as the paraprofessional movement of the early 1900s (Hagedorn et al., 2012; White, 1999, 2000b, 2004). The paraprofessional's personal recovery and desire to help others was often the primary credential to work within the addiction counseling workplace (White, 1998, 2004). Paraprofessionals embraced the comprehensive, multidimensional (body, mind, and spirit) approach known as the Disease Concept of Treatment, or the Minnesota Model. This treatment philosophy relied largely on the firsthand lived experience of the paraprofessional with no emphasis on formal education or training in addiction counseling (Banken & McGovern, 1992; Fisher & Harrison, 2009; Hagedorn et al., 2012; Libretto, Weil, Nemes, Copeland Liner, & Johansson, 2004; Sias & Lambie, 2008; White, 1999, 2000a, 2000b; Whittinghill, 2006; Yalisove, 1998, 2005). This disease concept included the elements of: medical detoxification, analysis of the causes of addiction, verbal and written commitment of sobriety, the practice of recovery storytelling (self-disclosure), reciprocal recovery support, counseling (new skills that were integrated from the fields of psychiatry, psychology, and social work), and development of community resources (Banken & McGovern, 1992; Mustaine, West, & Wyrick, 2003; Rieckman, Farentinos, Tillotson, Kocarnik, & McCarty, 2011; White, 1998, 1999, 2000a, 2000b, 2003, 2004).

During the development of the counseling profession, individuals were expected to be all knowing and treat a wide variety of individuals' problems or issues

(Edmundson, Gallon, & Porter, 2008; Vacc & Loesch, 2000; Whittinghill, Carroll, & Morgan, 2005). Over time, counselors found it extremely difficult, if not impossible, to be clinically effective with all populations and the increased associated problems. As a result, professional counseling specializations were established for the treatment of problems associated with specific client populations. One such specialization included the distinction of mental health and addictions as separate fields that share common assessment, diagnosis, and treatment (Hagedorn et al., 2012; Kerwin, Walker-Smith, & Kirby, 2006; Mustaine et al., 2003; Sias & Lambie, 2008; Whittinghill, 2006; Whittinghill et al., 2005). The field of addiction counseling saw advancements with federal funds dedicated to build mental health and addiction treatment centers and committed resources to train individuals in providing clinical services (Banken & McGovern, 1992; Mustaine et al., 2003; West & Hamm, 2012; White, 2000a, 2003). The development of counseling associations and organizations along with certification and licensing boards were established at both the state and national level to address the professional counseling specialties (Banken & McGovern, 1992; Cannon & Cooper, 2010; Hagedorn et al., 2012; Lawson & Lawson, 1990; Miller, Scarborough, Clark, Leonard, & Keziah, 2010; Morgen, Miller, & Stretch, 2012; Mustaine et al., 2003; Page & Bailey, 1995; West & Hamm, 2012; Yalisove, 1998, 2005).

Initial research looked at addiction specific educational and clinical skill areas that were believed to be vital in providing counseling to the addiction population (Buckalew & Daly 1986; Crits-Christoph, Baranackie, Kurcais, Beck, Carroll, Perry, Luborsky, McLellan, Woody, Thompson, Gallagher, & Zitrin, 1991; Dove, 1999; Lawson & Lawson, 1990; Morgan & Toloczko, 1997). Buckalew and Daly (1986)

discussed the need for knowledge of essential counseling program components including: (a) a foundation for understanding drug action, (b) nature and effects of specific drugs (c) the ability to incorporate a counseling orientation to deal with social and personal issues surrounding drug use, (d) coping skills, (e) and available community resources.

Additionally, addiction education and the development of proficiencies such as decision-making and coping skills needed be covered in the counseling program education (Buckalew and Daly, 1986). Research also revealed that definitions of addiction terms, knowledge of theories and research, psychopharmacology and medical effects, ethics and legal issues, and referral options were deemed necessary for the competency of clinicians who worked in the addiction field (Lawson & Lawson, 1990). As the addiction field has grown and evolved, the extent of education and clinical training in addiction counseling varied among professionals (Banken & McGovern, 1992; Center for Substance Abuse Treatment[CSAT], 2006; “Field Embraces,” 1998; Morgen et al., 2012). These early researchers gave way to the formation of a set of competencies specific to the field of addiction counseling.

Addiction Counseling Competencies

State certification boards emerged along with national licensing organizations, attempting to regulate and standardize the addiction educational training standards. The U.S. government established SAMSHA, who created the CSAT to support requirements of effective addiction treatment and recovery services (Banken & McGovern, 1992; CSAT, 2006; “Field Embraces,” 1998). In 1993, CSAT developed the Addiction Technology Transfer Center (ATTC) Program to foster improvements in the preparation of addiction treatment professionals (CSAT, 2006). ATTC established the National

Curriculum Committee (the Committee) comprised of representatives from CSAT, International Certification and Reciprocity Consortium (IC&RC), the National Association of Alcoholism and Drug Abuse Counselors (NAADAC), the APA, the National Association of State Alcohol & Drug Abuse Directors (NASADAD), the International Coalition of Addiction Studies Educators (INCASE) and the American Academy of Health Care Providers in the Addictive Disorders. The Committee evaluated existing curricula, priorities for future curricula development, delineation the competencies of the knowledge, skills, and attitudes of the original Addiction Counselor Competencies (CSAT, 2006).

In 1998, after multiple revisions and continued research the Addiction Counseling Competencies was published and included competency standards specific to the knowledge, skills, and attitudes of professional practice (CSAT, 2006). The document was divided into two broad categories: (a) transdisciplinary foundations, and (b) practice dimensions. The transdisciplinary foundations included four universal competencies that incorporate the prerequisite knowledge and attitudes needed to develop professional treatment skills: (a) understanding addiction, (b) treatment knowledge, (c) application to practice, and (d) professional readiness. The practice dimensions included distinct competencies needed to provide effective addiction counseling treatment: (a) clinical evaluation; (b) treatment planning; (c) referral; (d) service coordination; (e) counseling; (f) client, family, and community education; (g) documentation; and (h) professional and ethical responsibilities (CSAT, 2006). These Addiction Counseling Competencies created a foundation in unifying addiction educational and clinical content areas for clinicians who work in the field of addictions.

Addiction Counseling Credentialing, Education, and Training

During this time of counseling certification, licensing, and competency development and growth, master's degree level clinicians began to entering the addiction field of counseling. These individuals were qualified to practice addiction counseling based on their education rather than their recovery status, as the basis for legitimately providing treatment (Goodwin, 2006; Hosie, West, & Mackey, 1990). What evolved was a blending of three distinct yet different groups of clinicians in the addiction field: minimally-educated paraprofessionals (with recovery as their entry point into the treatment community), master's degree level counselors (without recovery status as their primary entry point), and a hybrid of the two: master's degree level recovering counselors (Cullbreth, 2000; Lawson & Lawson, 1990).

State certification and licensing boards continued to vary in the requirements needed to meet minimal levels of competencies and standards of counselors in the addiction field (Morgen et al., 2012; Hagedorn et al., 2012; Miller et al., 2010; Mustaine et al., 2003; Sias, Lambie, & Foster, 2006). However, rationale existed for certification and licensing boards to increase the clinician's credentials to require graduate level education and skill competency to provide counseling to individuals afflicted with addiction or addiction related issues (Banken & McGovern, 1992; Hagedorn et al., 2012; Mulvey, Hubbard, & Hayashi, 2003; Mustaine et al., 2003; West & Hamm, 2012; White, 2000a, 2003). The master degree level counselors were considered more productive than paraprofessionals. Paraprofessionals often only had on-the-job training and frequently lacked the essential knowledge and complex clinical skills required to address associated

psychological needs beyond addiction issues (Carroll, 2000; Goodwin, 2006; Sias et al., 2006; Taleff & Martin, 1996).

A study of both professional school and community counselor educators was conducted that looked at the perceptions of how counselors-in-training approached assessing, intervening and providing services when addiction problems arose (Carroll, 2000). Carroll (2000) suggested that useful skills such as how to (a) screen, assess, and diagnose, (b) counsel and educate clients, (c) determine appropriate levels of professional treatment and referral, and (d) use self-help groups were important and needed to be incorporated into counseling education programs.

As curriculum content in providing addiction counseling changed, updates to previous research was warranted to reassess the current adequacy of addiction education. There was a need to understand what kind of information about addiction education counselors-in-training at the masters and doctoral level received, their impressions of their abilities to treat these problems, and their thoughts about addictions training within counseling graduate programs (Madson, Bethea, Daniel, & Necaise, 2008). Madson and his colleagues (2008) collected and analyzed specific topics that were covered in substance counseling course(s). These topics were then combined into four general categories: (a) addictions and diagnostic information, (b) treatment, (c) related problems, and (d) specific populations. There were huge inconsistencies on the coverage of these particular topics. Only 72 percent received information about legal substances, 65 percent received information on illicit substances, 43 percent received information on prescription medication, only 30 percent received information on inhalants and 64 percent received information on polysubstance abuse. Additionally, only 29 percent of

participants believed they developed competencies to address coexisting psychiatric conditions as part of their training. Madson and his colleagues (2008) discussed that a well-integrated curriculum would comprise of (a) thorough assessment of addiction disorders, (b) identify appropriate treatment level of the client's needs, and (c) development of treatment plans that include evidence-based addiction treatment. Finally, there was discussion of the need for counselors-in-training to have training on cultural diversity among various populations to maximize the treatment outcomes (Madson et al., 2008).

Research has concluded that clinicians who work with addiction or addiction related individuals needed to have education and training skills in addictions in order to be competent professionals (Buckalew & Daly, 1986; Carroll, 2000; Kerwin et al., 2006; Madson et al., 2008; Page & Bailey, 1995; Scott, 2000). Whittinghill et al. (2005) suggested that addictions standards were necessary to guide the delivery of addiction courses and if standards were not developed or revised, educational deficiencies would continue to persist. The research findings supported CACREP standard revisions in order to assess or measure the competency of the counselors-in-training (Adams, 2005; Bobby & Kandor, 1992; Sweeny, 1992).

CACREP Standards

Accreditation, credentialing, and professional advocacy are major activities of the counseling field, which required deliberate, painstaking, and persistent efforts (Adams, 2005; Cannon & Cooper, 2010; Sweeny, 1992). CACREP was created in 1981 and has operated as the primary accreditation body for the counseling profession (Adams, 2005). CACREP has developed and revised education standards to more fully address and

enhance the role and mission of the various counseling training specialties (Adams, 2005; Cannon & Cooper, 2010; Schmidt, 1999; Sweeny, 1992).

A full review of the CACREP standards occurs on a seven-year cycle. The periodic revisions of the CACREP seek to reflect the current training needs of counselors and ensures continued relevancy of the standards in the preparation of today's and tomorrow's counseling professionals (Bobby & Urofsky, 2008). There have been several revisions of the CACREP standards; however, the 2001 changes marked a transition point in defining core curriculum and program areas (CACREP, 2001). The 2001 CACREP standards included eight different options of master's level counseling program areas (Career Counseling; College Counseling; Community Counseling; Gerontological Counseling; Marital, Couple, and Family Counseling/Therapy; Mental Health Counseling; School Counseling; Student Affairs) (CACREP, 2001). All counselors-in-training enrolled in CACREP programs were to have specific education and demonstrate knowledge in eight common core areas (Professional Identity, Social and Cultural Diversity, Human Growth and Development, Career Development, Helping Relationships, Group Work, Assessment, and Research and Program Evaluation). Each of the core areas required curricular components that all counseling programs were to teach to counselors-in-training, regardless of their counseling specialty area (CACREP, 2001; Lee, 2011).

Upon the examination of the 2001 standards, several researchers (Lee, Craig, Fetherson, & Simpson, 2013; Salyers, Ritchie, Lullen, & Roseman, 2005) noted that in the Human Growth and Development core area of the standards, it indicated all students must have knowledge of "human behavior including an understanding of development

crises, disability, exceptional behavior, addictive behavior, psychopathology, and situational and environmental factors that affect both normal and abnormal behavior” (CACREP, 2001, Standard K. 3. C). However, there was no mention of substance abuse or addictive behavior in the Community or Career Counseling program area standards (CACREP, 2001; Lee et al., 2013; Salyers et al., 2005).

CACREP accreditation standards for counseling programs underwent revisions again in the mid-2000s. The 2009 CACREP standards were a culmination of a multiyear process that incorporated significant revisions and changes to professional identity issues, core curriculum requirements and student learning outcomes (Bobby & Urofsky, 2008; Whittingill, 2006). Notable changes from the 2001 to 2009 standards demonstrated an increase in the need for acknowledgement of addictions and addictive behaviors instruction, not only for those who counsel addicted clients, but for all counselors-in-training regardless of their program area of specialization (Bobby & Urofsky, 2008; Hagedorn, 2007; Hagedorn et al., 2012; Iarussi, Perjessy, & Reed, 2013; Lee et al., 2013; Miller et al., 2010; Morgan & Tolczko, 1997; Salyers et al., 2005; Whittinghill et al., 2005). The 2009 CACREP core curriculum standards required all counselors-in-training to know the “theories and etiology of addictions and addictive behaviors, including strategies for prevention, intervention and treatment” (CACREP, 2009). In addition to having all counselors-in-training gain knowledge about addiction and addictive behaviors, a specialty program option “Addiction Counseling,” was created and had a separate set of competencies for counselors who wish to work specifically with the addictions population. Another addition was in the 2009 CACREP standards glossary, which now provided a definition for process addictions: “Process addictions are

considered addictions to behaviors or activities, such as gambling, sex, eating, and shopping” (CACREP, 2009).

Finally, there were significant changes to the 2009 CACREP standards that placed an increased emphasis on addictions and addictive behaviors within the curricula of Clinical Mental Health Counseling (CMHC) programs. CMHC program replaced two existing CACREP program options, Community Counseling and Mental Health Counseling. A counselor-in-training who wished to complete the CMHC program was expected to have competency in several areas of addiction knowledge and skills. The 2009 CACREP standards called for CMHC programs to demonstrate evidence that counselors-in-training learning occurred in four of the six domains of the program competences (see table 1).

Table 1
The CMHC Addiction-Related Competencies in the 2009 CACREP Standards

Domain	Standard	Competency
Foundations	A.6	Recognizes the potential for substance abuse disorders to mimic and coexist with a variety of medical and psychological disorders
Counseling, Prevention, and Intervention (Knowledge)	C.4	Know the disease concept and etiology of addiction and co-occurring disorders
Counseling, Prevention, and Intervention (Skills and Practices)	D.8	Provides appropriate counseling strategies when working with clients with addiction and co-occurring disorders
Assessment (Knowledge)	G.4	Identifies standards screening and assessment instruments for substance use disorders and process addiction
Assessment (Skills and Practices)	H.3	Screen for addiction, aggression, and danger to self and/or others, as well as co-occurring mental disorders
Assessment (Knowledge)	H.4	Applies the assessment of a client’s stage of dependency, change, or recovery to determine the appropriate treatment modality and placement criteria within the continuum of care
Diagnosis (Knowledge)	K.3	Knows the impact of co-occurring substance use disorders on medical and psychological disorders

Currently, CACREP standards are undergoing the next revision process. The draft # 2 of the 2016 CACREP standards continues to identify the importance of addictions and addictive issues education (CACREP, 2014). The addiction-related standard of “theories and etiology of addictions and addictive behaviors” has stayed in the Human Growth and Development core curriculum for all counselors-in-training program areas (CACREP, 2014). Several revisions occurred in CMHC program standards that are corresponding with changes in the ASAM addiction definition and the DSM-5 revised chapter “Substance-Related and Addictive Disorders.” In the CMHC programs, the Foundations domain has revised the wording of the addiction standard to read

“neurological and medical foundations and etiology of addiction and co-occurring disorders (CACREP, 2014). Additionally, in the CMHC Contextual Dimensions domain; “potential substance use disorders to mimic and/or co-occur with a variety of neurological, medical and psychological disorders” standard was included (CACREP, 2014).

Curriculum Implementation of Addiction Counseling Education

Although research has investigated the general counseling education and training skills, very little data existed on the curricula and the outcomes of efficacy for preparing counselors-in-training to assess and treat addiction clients (Selin & Svanum, 1981; Lubin, Brady, Woodward, & Thomas, 1986; McDermott, Tricker, & Farha, 1991). McDermott et al. (1991) investigated the effect of specific addiction counseling training for counselors-in-training. The research discussed that there is a lack of academic preparation of addiction counseling with the counselors-in-training, which “is attested to by the paucity of models for the training of counselors to work with these problems” (p. 87). The results showed that the training session specifically designed for the addiction population significantly increased the objective knowledge base of the counselors-in-training. The implications of their research suggested that counseling training programs should include at least one semester long course on addiction related issues. This additional course would allow for the training of more effective addiction counselors (McDermott et al., 1991).

The results of a study conducted with community and school counselors-in-training showed how counselors’-in-training perceptions of addictions topics was influenced when they have received as little as three semester hours of instruction in

addiction counseling (Carroll, 2000). Counselors-in-training who received at least three or more semester hours of instruction in addiction counseling were more likely to treat clients with an addiction or co-occurring issue than counselors-in-training who received less than three hours of instruction. Specifically, counselors-in-training who did not receive formal education were more likely to refer a client with an addiction or co-occurring disorder (Carroll, 2000).

First in a series of research studies, Morgan and Toloczko (1997) examined courses and curricula that existed in CACAREP counselor training programs across the United States to assess addiction and addiction-related education. The results were compiled from the program representatives or liaisons of 70 CACAREP programs that had master's level counseling programs, which was approximately an 81 percent response rate. Overall, Morgan and Toloczko (1997) found varying results on the number of courses and the extent that addiction content was implemented into counseling curricula. Ninety seven percent of the respondents indicated that addiction-related education and training was needed. Only 30 percent of programs had a course specific in addiction and addiction-related issues; however, only one program had a required course. Seventy-seven percent of the programs offered an elective course(s) that focus on addiction and addiction-related problems. Of the respondents, 73 percent stated that other required course(s) within the curriculum cover some of the general issues of addictions. Eighty seven percent of the participants reported that field placement or the experiential component (practicum, internship) were the course(s) that dealt primarily with addiction issues.

Whittinghill's et al. (2005) study confirmed some elements from the previous study of implementing of addictions education by Morgan and Toloczko (1997). The researchers examined the perceived need for CACREP-accredited counselor education programs to formalize curriculum standards for addictions counseling course(s). Participants were professors or liaisons from CACREP accredited counselor education programs. The percentage of programs that offered addiction course(s) and those programs that have required course(s) remained similar to Morgan and Toloczko's (1997) research. Interestingly, the offer of an elective addictions course dropped from 77 percent to 50 percent. It was noted that more than half of those surveyed, 56.6 percent, indicated that the establishment of addictions in the curricula was "important" (23.3%), "very important" (14.4%), or "extremely important" (18.9%).

In a replication research of Morgan and Toloczko's (1997) and Whittinghill's et al. (2005) research studies, CACREP accredited programs were surveyed to investigate how addictions education was included in the education curricula of counseling programs (Salyer et al., 2005). Specifically, the researchers investigated the extent to which counselors-in-training were exposed to clients presenting with addictions issues. The results of the research showed that the majority of respondents (84.5%) reported that addictions education was offered as a part of the counseling program, a slight increase from Morgan and Toloczko's (1997), and Whittinghill's et al. (2005) studies.

Additionally, 52.2 percent of the respondents in Salyer et al.'s (2005) study reported that addictions education was offered as a separate course for their counselors-in-training and 32.7 percent of the participants reported that addictions topics were offered both as a separate course and as a component of other courses. When asked to

identify the course(s) that included addictions education as part of the counseling curriculum, more than 25 different courses were listed. The most frequently listed courses were: (a) practicum, (b) internship, (c) assessment/diagnosis, and (d) introduction to community counseling. Seventy one percent of respondents indicated that between 11 percent and 50 percent of the clients seen by their practicum students in community or mental health programs presented with addictions issues. Eighteen percent reported that more than half of the clients seen by practicum counselors-in-training presented with addictions issues and 64 percent of respondents reported that between 11 percent and 50 percent of their internship students worked in addictions facilities. One of the most significant finding was that 63.7 percent of the respondents rated the importance of including addictions counseling education as part of counseling curriculum education as an eight or higher on a Likert scale of 1-10 (Sayler et al., 2005). Finally, Salyer and her colleagues (2005) discussed three different ways to address the addiction education and skills deficiency issues which included creating a specialty addiction program, establishing new core curricular standards addressing addiction education standards, and/or infusion of addiction issues and education into each of the current eight common core standards.

Madson's et al. (2008) research focused on education of addiction and addiction related issues that counseling professionals received during their graduate level counseling programs. Results showed that the implementation of addiction education varied. Only 34 percent of the participants reported that a specific course in addiction education was a part of the counseling curriculum. Fifty two percent indicated that addiction education and training was integrated throughout the curriculum. Fifty eight

percent indicated that counselors-in-training may not be well-trained to address addictions problems.

Most Recently, Lee et al. (2013) provided an in-depth review of previous literature that discussed the need of incorporating addiction counseling education and training to counselor education programs. With the changes that were made to the 2009 CACREP standards, counselor educators were urged to make changes in the curriculum to ensure that the addiction-related standards were met for all counselors-in-training. Essentially, three methods of implementing the addiction-related competencies into the CMHC program curriculum were discussed: (a) infusion, (b) stand-alone course, and (c) a combination (Lee et al., 2013). The infusion method involved faculty incorporating relevant addiction standards into existing curricula required of all counselors-in-training. In other words, rather than creating new course(s), faculty may decide to revise current course(s) to reflect the new standards. For counselor educators who choose the infusion method, Webber and Mascari (2009) provided guidelines to assist with infusing standards that would ensure that the addiction counseling education and standards were met. The next option discussed was the stand-alone course option. Faculty could create a new course(s) to meet the addiction counseling accreditation standards. The counseling program faculty could also partner with another university department(s) that may already offer an addiction or addiction related course(s). These partnerships would require counselor education faculty to communicate the relevant CACREP standards that were expected to be met through that stand-alone course(s) (Lee et al., 2013). The third option mentioned was a combination of a stand-alone course and integration of the addiction counseling standards throughout the curriculum. Program faculty opting to

utilize this method were likely to create at least one stand-alone addiction course, while also integrating some standards into existing course(s) (Lee et al., 2013). Finally, Lee et al. (2013) stressed that regardless of the method(s) implementation clinical mental health counselor education programs choose, the new addiction counseling standards recognized the need for all counselors-in-training to gain more addiction-related knowledge and skills.

Iarussi et al. (2013) recently completed a research project exploring how the CACREP addiction-specific standards were being integrated into Clinical Mental Health Counseling (CMHC) programs. The researchers surveyed program coordinators of CMHC programs to identify how the standards specific to addictions were being fulfilled by identifying the type of course(s), number of courses, and whether the course(s) were required or elective. Of the addiction-related standards, 86 percent of program coordinators reported standards A.6 and C.4 to be the highest satisfied rates of meeting these standards. Standards A.6 states “recognizes the potential for substance abuse disorders to mimic and coexist with a variety of medical and psychological disorders” and standard C.4 “knows the disease concept and etiology of addiction and co-occurring disorders.” Standard H.3 “screens for addiction, aggression, and danger to self and/or others, as well as co-occurring mental disorders” was satisfied the least with 76.7 percent of the respondents reported meeting this standard. The study found a wide range of courses were used to satisfy the CACREP standards specific to addictions. Those courses include content specific (i.e., having wording of substance abuse, addiction or related word in the course title), diagnosis/psychopathology, appraisal/assessment, and practicum/internship. Overall, 72.1 percent of respondents did report that each of the

seven addiction-specific standards were being met in their CMHC programs (Iarussi et al., 2013).

Counselors-in-training need to develop confidence and competence in providing effective addiction counseling services. Effective counselors are expected to have the capability to adapt multiple counseling skills such as attending, responding, probing, interpreting, and reflecting feelings continuously in order to manage the fluctuating and varying circumstances within a counseling session (Easton, Martin, & Wilson, 2008; Larson & Daniels, 1998; Lent, Hill, & Hoffman, 2003; Lent, Hoffman, Hill, Treistman, Mount & Singley, 2006).

Self – Efficacy

Self-Efficacy Theory

Self-efficacy beliefs have been broadly applied to the understanding of human motivation, behavior and skill performance. The foundation for self-efficacy belief is Bandura's Social Cognitive Theory (SCT), which advanced the view of human functioning as the product of interactions of behavioral, environmental, and personal influences (Bandura, 1977, 1978, 1986, 1997; Pajares, 2002). Bandura's notion of this human functioning created the conception of reciprocal determinism. This view asserts that personal form (cognitive, affect, and biological events), along with behavior and environmental influences creates interactions that result in a triadic reciprocity (Bandura, 1977; 1978; 1986; Pajares, 1996; 2002). At the core of SCT is Bandura's self-efficacy beliefs, which are individual's beliefs of their capabilities to organize and carry out specific courses of action required to attain specific types of performances (Bandura, 1977, 1982, 1986). According to SCT, individuals engage in their own development and

exercise control over their thoughts, motivations and actions. “What people think, believe and feel affect how they behave” (Bandura, 1986, p. 25). Social cognitive theorists believe individuals control their own learning and behaviors and in return set their own goals and standards.

Sources of Self-Efficacy

People’s beliefs about their personal efficacy constitutes a major aspect of their self-knowledge. Self-efficacy beliefs are shaped from four principal sources of information: (a) enactive mastery experiences or performance accomplishments; (b) vicarious experience or modeling; (c) verbal persuasion; and (d) physiological states and/or emotional arousal. Any given stimulus, depending on its form, may function through one or more of these sources of efficacy information (Bandura, 1977, 1982; 1997; Bandura & Adams, 1977; Pajares, 2002). Individuals’ sense of self-efficacy is the result of the cognitive processing from these sources of information (Bandura, 1977).

The first source, enactive mastery experience or performance accomplishment, is described as the most influencing source of efficacy information because it serves as an indicator of capability and provides the most accurate evidence of whether one can forge whatever it takes to succeed (Bandura, 1977, 1982; 1986; Bandura & Adams, 1977). Individuals act on their efficacy beliefs and evaluate their self-appraisal adequacy from their performance achievement. This source of information dictates that if individuals succeed at performing a task, their sense of efficacy generally increases; whereas performance failure of a task lowers their sense of efficacy (Bandura, 1997). As personal efficacy increases, individuals become less discouraged by setbacks and failures. The confidence to persevere helps develop their capabilities to use better control over events

(Bandura, 1995, 1997). Bandura (1997) further contends that “performance attainments on many tasks are determined more by how hard one works at them than by inherent capacity” (p. 104). To become efficacious, counselors-in-training need multiple mastery experiences. These experiences enhance counseling self-efficacy, which leads to increased confidence (Daniels & Larson, 2001).

A second source of information is acquired through vicarious experiences. People do not rely on enactive mastery experiences as the sole source of information about their capabilities (Bandura, 1977, 1982; 1986; Bandura & Adams, 1977). Effective assessments are partly influenced vicariously by observing another individual modeling the behavior (Bandura, 1986). Modeling serves as an effective tool for promoting a sense of personal efficacy. Vicarious experiences alter efficacy beliefs through transmission of competencies and the comparison of the accomplishments of others. When self-competence is gauged largely in relation to the performance of others, social comparison operates as primary factor in the self-appraisal of capabilities (Bandura, 1977). This source of information is especially influential when the individuals succeed at some task after overcoming initial difficulties (Bandura, 1997).

Verbal persuasion, the third source of learning information, serves as a further means of strengthening people’s beliefs that occurs when individuals are convinced of their capability of performing a task (Bandura, 1977, 1982; 1986; Bandura & Adams, 1977). It is easier to sustain a sense of efficacy, especially when struggling with difficulties, if others express confidence in one’s proficiencies. People who are persuaded verbally that they possess the capabilities to master given tasks are more likely to put forth greater effort than if they harbor self-doubts and dwell on personal deficiencies

when difficulties arise (Bandura, 1977). Verbal persuasion alone may be limited in its power to create enduring increases in perceived efficacy, but it can bolster self-change if the positive appraisal is within realistic bounds (Bandura, 1977, 1997).

The fourth source of information that shape self-efficacy beliefs includes individuals' perceptions of their physiological state while performing a task (Bandura, 1977, 1982, 1986; Bandura & Adams, 1977). People rely partly on their state of physiological arousal in judging their anxiety and vulnerability to stress (Bandura, 1977). Because high arousal usually debilitates performance, individuals are more likely to expect success when they are not beset by aversive arousal than if they are tense and agitated (Bandura, 1977, 1997). Individuals who are emotionally aroused (e.g., experiencing anxiety) during the performance of a task may interpret the arousal as debilitating or challenging. How the arousal is cognitively processed influences self-efficacy beliefs in either negative or positive ways (Bandura, 1977, 1986, 1995, 1997).

Counselor Self-Efficacy

Self-efficacy is both a personal and a social construct because individuals function individually as well as communally (Bandura, 1982; Pajares, 2002). Perceived efficacy is thought to influence: (a) choices of attempting and committing to an activity or set goal, (b) the amount of effort and persistence that is expended, (c) perseverance in the face of challenging situations, and (d) resilience to adversity (Bandura, 1977, 1982). Counseling self-efficacy (CSE) has been defined as a counselor's beliefs or judgments about her or his capabilities to effectively counsel a client in the near future or perform specific role related behaviors (Larson & Daniels, 1998). Counseling-efficacy beliefs are essential in understanding how individuals feel, think, behave, and self-motivate. CSE

has been positively correlated to a counselor's training level and experience (Johnson, Baker, Kopala, Kiselica, & Thompson, 1989; Larson, Suzuki, Gillespie, Potenza, Betchel, & Toulouse, 1992; Melchert, Hays, Wiljanen & Kolocek, 1996).

Counselors-in-Training Self-Efficacy Research

Multiple studies have applied self-efficacy theory and beliefs to the examination of the professional development of counselors-in-training including areas of clinical and/or community counseling, school counseling, and career counseling (Friedlander, & Snyder, 1983; Johnson et al., 1989; Melchert et al., 1996; Munson, Zoerink, & Stadulis, 1986; Tang, Addison, LaSure-Bryant, Norman, O'Connell, & Stewart-Sicking, 2004). Sippes, Sugden and Faiver (1988) examined the relationship among self-efficacy, training level and counselor response types (e.g., minimal responses, information gathering, probing statements, restatements, reflection, self-disclosure, interpretation, and confrontation). The authors found an inverse relationship between counselor self-efficacy and counselor response types where counselors-in-training expressed greater levels of confidence in making reflective statements and probing questions (lower response types) than in making interpretations (higher response types).

In addition, Daniels and Larson (2001) examined the effect of performance feedback on counseling self-efficacy and anxiety. Research indicated that high levels of anxiety had deleterious impacts on counselors-in-training. Results of this study indicated that feedback from supervisors predicted counselor self-efficacy, where positive feedback increased counselor self-efficacy and negative feedback decreased self-efficacy.

Counselors-in-training who lacked confidence may need special consideration, because in

order to become an efficacious counselor-in-training, multiple mastery experiences are necessary to enhance counseling self-efficacy (Daniels & Larson, 2001).

Friedlander & Snyder (1983) examined counselor trainees' self-efficacy beliefs in the supervision environment. Counselors-in-training rated the level of confidence they had in performing various aspects of counselor training, including academic coursework, assessment and individual counseling, group and family interventions, and case management. The factors that influence the self-efficacy of counselors-in-training revealed that counseling self-efficacy was highly correlated to clinical and academic experiences.

Johnson et al. (1989) examined the self-efficacy levels of basic counseling skills in counselors-in-training and found that counseling self-efficacy increased during master's level practicum/internship counseling course(s). Having exposure to counseling skills and training confirmed that counselor's-in-training self-efficacy could move from an inaccurate assessment of skills to more accurate perception of self-efficacy. Additionally, the research indicated that counselors-in-training who were in later stages of their counseling programs exhibited greater self-efficacy. Melchert et al. (1996) tested models of counselor development in relation to the counseling self-efficacy of counselors-in-training. The findings included counselors'-in-training clinical experience and training contributed to higher perceived self-efficacy on counselor's-in-training knowledge and skills competencies related to the practice of individual and group counseling skills.

Lent et al. (2003) conceptualized counseling self-efficacy in three broad sub domains: (a) performing basic helping skills, (b) managing session tasks, and (c)

negotiating challenge situations and presenting issues. Lent et al. (2006) later examined client aspects of counselor's self-efficacy beliefs in novice counselors. Both general and specific self-efficacy beliefs changed over the course of the practicum/internship experience(s). Counselors-in-training with higher levels of self-efficacy were found to appear more composed during sessions, generate more supportive counseling responses, and persisted longer and expended more exertion when hindrances to the counseling process occurred (Lent et al., 2006).

The influence of factors such as prior work experience, number of courses taken, and number of internship hours were also examined in relation to counselor self-efficacy (Tang et al., 2004). Tang et al. (2004) measured the self-efficacy of counselors-in-training from both CACREP and Non-CACREP universities. The results did reveal that counselors-in-training who had the most clinical work experience, course work during their master's degree program, and logged internship hours had an increase in overall-self-efficacy levels.

Addiction Counseling Self-Efficacy Research

Research has looked at the clients' perspective of self-efficacy in relation to addictions and counseling skills (Bandura, 1999; Klutckowski & Troth, 1995; Whittinghill, Whittinghill & Loesch, 2000). A vast amount of research attention has been given to counselors and counselors-in-training self-efficacy beliefs in various counseling specialties. Clinicians and counselors-in-training addiction counseling self-efficacy beliefs have had minimal research investigation (Wendler, 2007). Adams and Gallon (1997) surveyed 776 addiction counselors from treatment centers in 17 states to rate their perceived proficiency (but not self-efficacy per se) when working with clients who had

addiction issues. The survey looked at the differences in self-efficacy of beginning counselors and the supervisors of the novice counselors. The beginning counselors rated themselves as more proficient than the scores from the beginning counselors' supervisors.

The findings mirrored the study of Sipps et al. (1988) in which beginning counselors overestimated the confidence evaluations due to a lack of experience in the skills for which they were assessing. Chappel and Veach (1987) investigated second-year medical students' attitude towards addiction treatment through pretests and posttests. Their research showed that there was a positive attitude change that was achieved as a result of the completion of an addictions course. The addictions course included lectures, reading assignments, and an experiential component (Chappel & Veach, 1987). Amodeo and Fassler (2000) assessed master's level social workers' perceived competency for working with clients with addiction and found similar results. Social workers were asked to rate their personal sense of competency in (a) assessing, (b) intervening, and (c) diagnosing the client. Social workers who had completed a 9-month addiction treatment training course had rated themselves as significantly more competent in providing intervention strategies across all diagnostic categories and providing intervention strategies for addiction diagnoses as those who did not complete addiction specific training (Amodeo & Fassler, 2000).

Similar research has investigated social worker's self-efficacy in providing addiction related counseling skills through the development and validation of the Substance Abuse Self-Efficacy Scale (SATSES) (Krantz, 2003; Krantz & O'Hare, 2006; Krantz, 2011). The sample population was limited to experienced social workers and results indicated a high self-efficacy level among the measurements variables of:

assessment and treatment, individual and group counseling, case management, and ethics (Krantz, 2003; Krantz & O'Hare, 2006; Krantz, 2011).

Chandler, Balkin, and Perepiczka (2011) investigated the perceived self-efficacy of licensed counselors in providing addiction services. The nationwide, quantitative study investigated the relationship between their perceived self-efficacy and the number of addiction course(s) taken and the number of combined practicum and internship clocked hours completed in their graduate program, along with the percentage of clients with substance abuse as a primary diagnosis. The results from the Chandler et al. (2011) study indicated that professional counselors have a “high” perceived self-efficacy and 82 percent of the participants did receive addiction information in an elective course. Additionally, one study investigated counselors’ -in-training beliefs regarding addictions and their attitudes and perceptions regarding addiction treatment (Chasek, Jorgensen, & Maxson, 2012). Their results included that non-stereotypical attitudes and treatment intervention attitudes could influence counselors’ -in-training treatment optimism. Chasek et al. (2012) concluded that when individuals have non-stereotypical viewpoints along with accurate information on addictions and treatment methods, there can be a more optimistic view for effective treatment of addiction and addiction related issues.

In 2005, Murdock, Wendler, and Nilsson investigated counselors’ perceived addiction counseling self-efficacy through the development and validation of the Addiction Counseling Self-Efficacy Scale (ACSES). The initial aim of the ACSES instrument was to “aid in the exploring the process and outcome of addiction counseling, relationships between self-efficacy and the interest in addiction counseling, persistence despite obstacles such as client relapse and recidivism, and general workforce

development” (Murdock et al., 2005). Two studies were conducted and the population was aimed specifically at clinicians who worked in the addiction field. Over 50 percent of the participants in both studies had over eight years of counseling in the addictions field and most had a graduate degree. The findings offered preliminary support for the viability and effectiveness of a measure to perceived self-efficacy of counselors to provide addiction specific counseling.

A third study was conducted to revalidate the ACSES scale (Wendler, 2007). The sample population in one of the test-retest investigations included counselors-in-training in a masters level counseling program along with beginning counselors in the addiction field (Wendler, 2007). No specific research outcomes addressed the counselor’s-in-training or beginning counselors’ self-efficacy levels. The finding did indicate that the ACSES instrument is a viable measurement of perceived self-efficacy in providing addiction counseling (Wendler, 2007). Wendler’s (2007) study was the first known research that included counselors-in-training in the investigation of the self-efficacy levels in providing addiction counseling.

Summary

The field of addiction counseling has evolved and clinicians who work with addicted individuals are expected to have competencies in an array of addiction specific education areas that are essential in providing the necessary counseling skills. Recent research has placed an importance on the implementation of addiction and addiction related education in the mental health counseling curricula.

This dissertation was an exploratory research of mental health counselors-in-training self-efficacy level in providing addiction counseling skills. The addiction and

addiction related education implementation in the mental health or related counseling programs was also examined. Additionally, the significant difference of the self-reported self-efficacy level of mental health counselors-in-training and the modalities of education was investigated.

CHAPTER III. RESEARCH METHODS

Introduction

The purpose of this study was to identify the self-reported addiction counseling self-efficacy of mental health counselors-in-training and the education modalities received. Specifically, the aim of this research was to examine the significant differences in the self-efficacy levels as measured by the Addiction Counselor Self-Efficacy Scale (ACSES) and the modalities of addiction and addiction related education mental health counselors-in-training received. Reviewed in this chapter are the research design and research questions, description of the participants, instrumentation, data collection, and the method for data analysis.

Research Design

A non-experimental cross-sectional survey research design was adopted for this study. A non-experimental cross-sectional survey design describes current existing characteristics and independent variables that are non-manipulatable (Johnson, 2001). Cross-sectional studies are descriptive and are used to provide data and make inferences about a population of interest at one point in time (Hall, 2008). Strengths of a cross-section study are the relative quickness and ease to gather the intended research information. Data on all variables is collected at one time. Additionally, most cross-sectional studies are descriptive and can provide a foundation for further exploration in longitudinal studies or experimental studies (Barratt & Kirwan, 2009). Weaknesses of a cross-sectional study are the inability to measure incidences or evolution of behavior.

Additionally, there is susceptible bias due to potential low response rate (Barratt & Kirwan, 2009; Hall, 2008).

Research Questions

A non-experimental cross-sectional survey design was utilized to answer the following research questions:

1. What are the levels of self-efficacy among mental health counselors-in-training?
2. What is the modality of education that mental health counselors-in-training receive in addiction counseling?
3. Is there a statistically significant difference in the overall self-reported counseling self-efficacy by modality of education received?
4. Is there a statistically significant difference in the factors of counseling self-efficacy by modality of education received?

Participants

The participants in this study included counselors-in-training who are currently working on a master's degree in a mental health or related counseling program. Additionally, recent graduates from a mental health or related counseling program within the past nine months were also included in the population sample. All participants were identified as 19 years of age or older. An initial 206 participant surveys were collected, however, only 120 participants met all research criteria and were included in the data analyses.

Participation in this study was voluntary. The first page of the survey was the information letter (see Appendix D). Access to the survey was granted when the

participant electronically indicated they met the qualifications to participate in the study and were willing to complete the survey. Electronic indication of consent was obtained when the potential participant clicked the “next” button on the consent page. Participants were given the opportunity to withdraw from the study at any time by simply exiting from the website and closing the web browser. Once the participant’s answers were submitted, withdrawal of their responses was not available, as all data is anonymous.

Instrumentation

A demographic questionnaire (see Appendix F) and Addiction Counseling Self-Efficacy Scale (ACSES) (see Appendix E) were used in this study. The demographic questionnaire was designed by the researcher after reviewing questions from research studies discussed in the review of literature. Several questions were taken from the ACSES measurement demographic questionnaire used in their previous research studies. The components of the questionnaire included: gender, age, ethnicity, master’s degree program area title, and participant’s master’s degree program accreditation status, progress in the master’s program, regional location, and modality of education in addiction or addiction related counseling. Additionally, participants were asked to answer an open-ended question to share any additional information that would be helpful to know to serve individuals with an addiction(s) or addiction related issue(s).

Addiction Counseling Self-Efficacy Scale (ACSES)

The Addiction Counseling Self-Efficacy Scale (ACSES) is a self-report instrument developed by Murdock, Wendler, and Nilsson (2005) to measure the self-efficacy levels across addiction counseling skill areas. The development of the ACSES items originated from the Substance Abuse and Mental Services Administration

(SAMHSA)'s Center for Substance Abuse Treatment (CSAT) Addiction Counseling Competencies (1998), as well as previous counseling self-efficacy theory and research. A panel of five experts in the addiction counseling field reviewed the preliminary 92 proposed scale items to determine the applicability to measure the competency of the self-efficacy addiction counseling skill areas and provide initial content validity. Two hundred and fifty-seven professionally trained addiction counselors were recruited from the Addiction Technology Transfer Centers (ATTC) sponsored continuing education workshops in Midwest and Southern regions of the United States and participated in the first preliminary study. Findings from the study provided evidence to the feasibility and usefulness of the self-efficacy scale for counselors based on the CSAT's (1998) competencies. Modifications that were made to the scale after the preliminary analyses resulted in a revised 67 self-efficacy item scale.

In efforts to increase the score variability, the second study sought out a wider sample range in terms of the participant's professional experiences including novice to advanced counselors. The data of 440 participants were collected from counselors in three states. A principal components factor analysis with a varimax rotation was conducted on the 67 self-efficacy items. Items that had communalities below .50 or that did not have loading of at least .50 on any scale were dropped individually from the data set. The solution had five rather than six factors and accounted 65% of the variance in the 32 retained items. The resulting factors scores demonstrated strong internal consistency: Specific Addiction Counseling Skills, $\alpha=.92$; Assessment, Treatment Planning, and Referral Skills, $\alpha=.90$; Co-Occurring Disorders, $\alpha=.89$; Group Counseling Skills, $\alpha=.87$; Basic Counseling Skills, $\alpha=.87$; total ACSES, $\alpha=.89$.

The Addiction Counselor Self-Efficacy Scale (ACSES) underwent a third research study to provide additional support for the validity and reliability of the self-report instrument designed to measure addiction counseling self-efficacy beliefs (Wendler, 2007). Overall, the data analysis results support the psychometric properties of the ACSES. ACSES scores evidenced strong test-retest stability and internal consistency reliability. A confirmatory factor analysis compared ACSES scores with participant criteria and the scale was found to be sensitive to counselor's level of expertise, supporting criterion validity. ACSES scores were compared with survey instruments to assess convergent, discriminant, and criterion validity (Wendler, 2007). Bivariate correlations demonstrated moderate relationships between the ACSES and a measure of general counseling self-efficacy (Counseling Self-Estimate Inventory [COSE]), which supported convergent validity; and a weak relationships with a measure of health-related anxiety (Multidimensional Health Questionnaire [MHQ]), which supported discriminant validity. Three of the four antecedent sources of self-efficacy information (Bandura, 1986) significantly predicted ACSES scores, further supporting criterion validity.

The current ACSES measurement is composed of 31 statements and consists of five individual scale variables. The ACSES five individual variables include: (a) Specific Addiction Treatment Skills, which measures counseling skills specific to addiction treatment, such as assessing clients' readiness to change addictive behaviors or identify triggers for relapse; (b) Assessment and Treatment Planning Skills, which evaluates skills in assessment and collaborating with the client to determine treatment needs; (c) Co-occurring Disorders Skills, which include items that assesses self-efficacy for working with clients with various co-occurring mental health disorders; (d) Group Counseling

Skills, which refers to aspects of the group counseling process; and (e) Basic Counseling Skills, which includes counselors' skills at establishing a strong therapeutic relationship with clients (Wendler, 2007). The responses to each statement are based on a 6 point Likert scale: 1= no confidence to 6= absolute confidence. The higher scores indicate a greater degree of self-efficacy. The participants are required to select only one response for each of the statements. One example statement is "assess a client's previous experience with self-help groups like AA, NA, CA, etc." Permission was granted by the intellectual property owner to use the ACSES instrument in this current research study (Appendix I).

Data Collection Procedures

Upon approval from the Auburn University Institution Review Board (see Appendix A), collection of data for the current research study spanned over a six week period. Emails were sent to multiple listservs that were counseling related requesting distribution of the research participation invitation. The email included an email flyer (Appendix B) requesting participation of individuals who qualified for the study along with a request for listserv' members to distribute the received email to individuals they believed may have qualified for the survey. The email flyer included the purpose of the research, participation requirements, confidentiality and anonymous nature of the research, how the data would be used, the link to the online survey, and IRB approval information. In addition, using a snowball sampling technique, a professional contact email flyer (Appendix C) was sent to the researcher's professional contacts to further solicit participants who may have been eligible for participation. In the professional contact email flyer the recipients were requested to distribute the email flyer to

individuals who may meet the participation criteria. The link included in both email flyers was accessed by participants who believed they met the research criteria.

The electronic survey was created in Qualtrics, an online survey software used to develop surveys, collect data, and to transpose into an analysis program. The use of online surveys has grown in popularity in the field of counselor education because of the advantages of reduced response time, lower cost, ease of data entry, flexibility and control of format, and overall advances in technology (Granello & Wheaton, 2004). The collection of data on the Internet has several important benefits which include; (a) it allows access to much larger, more diverse sample; (b) the data collection can be completed online, coded, and saved data files, and can greatly save time for the researcher; (c) there is a greater potential inclusion of difficult-to-access samples through specialized web sites; (d) the data can be collected at any time day or night; (e) there is increased access to cross-cultural samples that may reside in other countries where actual travel may be prohibited (Heppner & Heppner, 2004; Heppner, Kivlighan, & Wampold, 2008).

The participants completed the survey that included an information letter containing qualifications for the current research, the survey measurement, the demographic questionnaire and open-ended question. At the completion of the online survey questions, the participants were directed to a page thanking them for their participation along with acknowledgement of the \$1.00 donation to Gratitude House (Appendix G). Additionally, there was a conclusion page (Appendix H), which included a recap of the purpose of the research study, discussion of concerns, and contact information for any inquires or questions for the researcher.

Recommendation by Bourque and Fielder (2003), and Dillman, Smyth, and Christian (2009) was the use of incentives. In an effort to complete quality research with a satisfactory response rate, potential participants were informed on the email flyer and information letter that a \$1.00 contribution will go to “Gratitude House,” a non-profit addiction treatment center that offers comprehensive long-term residential, day treatment and outpatient services to women with substance abuse and co-occurring mental health issues. Gratitude House has specialty programs for pregnant women, “Mothers and Infants in Treatment Together” and women with HIV/Aids (Gratitude House: Here There is Hope, 2014).

Data Analysis

Data analysis for this quantitative study consisted of descriptive statistics, reliability testing, data screening along with the parametric tests of a one way analysis of variance (ANOVA) and a multivariate analysis of variance (MANOVA). To establish reliability the researcher looked at the internal consistency by measuring the Cronbach’s alpha for the total score and each of the five ACSES variables score. Data screening included the transformation of the total ACSES and five variable scores. An ANOVA examined the statistically significant difference in the overall self-reported counseling self-efficacy by modality of education received. A MANOVA examined the statistically significant difference in the factors of counseling self-efficacy by modality of education received. One open-ended question was analyzed by merging the participant’s responses into Microsoft excel and used a note card system to code frequency of concepts and themes that emerged from the participants who opted to respond (Allport, 1942).

Summary

This chapter has discussed the methods that were used to conduct this study as well as the research questions that guided the design of the study. This study was designed to identify the self-efficacy level of mental health counselors-in-training and the education modalities received. Additionally, this study examined the statistically significant difference in the self-reported addiction counseling self-efficacy level and the modalities of addiction and addiction related counseling education mental health counselors-in-training are receiving or have received in the master's degree program.

Counselors-in-training in a mental health or related counseling master program and recent graduates within the past nine months were the population sample used for the current study. The Addiction Counseling Self-Efficacy Scale (ACSES) was used to measure the mental health counselors-in-training self-efficacy level in providing addiction counseling. Questions regarding the participants' demographics along with an open-ended question were also included in the survey. Data was collected by emailing listservs' and researchers' professional contacts requesting participation along with a request to forward to individuals who may have qualified for the survey participation.

Data collected was analyzed using descriptive statistics along with parametric tests of an ANOVA and MANOVA. The current study was intended to expand on the knowledge of mental health counselors-in-training self-efficacy levels and their modalities of addiction and addiction related counseling. Findings from the posed research questions are presented in Chapter IV.

CHAPTER IV. RESULTS

The purpose of this study was to explicate the self-efficacy levels of mental health counselors-in-training in providing addiction counseling. Additionally, exploration of the statistically significant differences in the modality of addiction and addiction related education received by the mental health counselors-in-training was reviewed. The following chapter presents the results of the data analyses conducted from this investigation of research. Specifically, the chapter included the identification of the participant's demographic information, descriptive statistics for the measurement used, as well as the outcomes of the statistical analyses that were presented for each of the four research questions. Finally, data from the open-ended question was examined and the discussion of the content analysis presented.

The research questions are as follows:

1. What are the levels of self-efficacy among mental health counselors-in-training?
2. What is the modality of education that mental health counselors-in-training receive in addiction counseling?
3. Is there a statistically significant difference in the overall self-reported counseling self-efficacy by modality of education received?
4. Is there a statistically significant difference in the variables of counseling self-efficacy by modality of education received?

Participant Demographics

A total of 206 participant surveys were downloaded after the online Qualtrics link was closed. Multiple reviews of the collected data were conducted to screen and exclude any participants that did not meet all of the criteria of the research study. Data from the initial 206 surveys was visually inspected to identify participants who terminated the study prior to answering questions necessary for data analyses. Of the 206 participants, a total of 40 participant surveys were eliminated based on non-completion. An additional 22 participant surveys were eliminated due to non-mental health or related majors, and 24 participants surveys were dismissed due to stating their progress in their master's program was not at the practicum, internship, or recent graduate status. It is unknown how many potential qualified individuals received the link to the survey; therefore an overall response rate could not be calculated. One hundred and twenty participants' surveys met all the criteria for data analysis and were used for this research.

Demographic data collected included gender, age, and ethnicity. Additionally, participants' master's degree program area title, accreditation status, program's regional location, and progress in their counseling education were collected to further identify the mental health counselors-in-training. Participants identified themselves as female, 107 (89.2%), male, 13 (10.8%), and no one opted to self-identify, 0 (0.0%). The reported ages of the participants ranged from 22 to 60 with an average age of 34.5 ($SD = 11.80$). One participant elected not to state their age. The participants in the overall sample identified their ethnicity as Asian ($n = 2, 1.7%$), Black/African American ($n = 15, 12.5%$), Hispanic/Latino(a) ($n = 3, 2.5%$), American Indian ($n = 1, .8%$), White/Caucasian ($n = 94, 78.3%$). Four participants (3.3%) identified their ethnicity as Biracial/Multiracial,

which included the one response of “Black white” ($n = 1, .8\%$), one response of “Hispanic, White” ($n = 1, .8\%$), one response of “Native American/asian/white/hispanic” ($n = 1, .8\%$), and one participant (.8%) did not provide additional information. Table 2 contains descriptive statistics on the demographic questions.

Table 2
Descriptive Statistics of Study Participants

Descriptor	Variable	<i>n</i>	<i>f</i>
Gender ($N=120$)	Female	107	89.2%
	Male	13	10.8%
	Self-Identify	0	0.0%
Ethnicity ($N=120$)	Asian	2	1.7%
	Black/African American	15	12.5%
	Hispanic/Latino(a)	3	2.5%
	American Indian	1	.8%
	White/Caucasian	94	78.3%
	Biracial/Multiracial	4	3.3%
	Non-Identified	1	.8%

Descriptive information presented in table 3 provides information on the participants’ master’s education. The majority of participant, 60.8% ($n = 73$) identified their master’s degree program area title as Clinical Mental Health Counseling, followed by 18.3% ($n = 22$) as Mental Health Counseling, then 8.3% ($n = 10$) as Community Counseling. A total of 12.5% ($n = 15$) identified their degree program area title as “other, specify.” The following were degree area titles identified by the researcher as being

closely related to the mental health program area title set criteria of the research study: Counseling Psychology ($n = 5$, 4.1%), Mental Health Counseling and Behavioral Medicine ($n = 3$, 2.5%), Community Agency Counseling ($n = 2$, 1.7%), Agency Counseling ($n = 1$, .8%), Clinical Counseling ($n = 1$, .8%), General Counseling ($n = 1$, .8%), Clinical Mental Health Counseling & School Counseling ($n = 1$, .8%), and Pastoral Counseling ($n = 1$, .8%). Additionally, participants reported their master's program accreditation as CACREP ($n = 96$, 80%), Non-CACREP ($n = 19$, 15.8%), and I do not know ($n = 5$, 4.2%).

Table 3
Descriptive Statistics of Master's Degree Program

Descriptor	Variable	<i>n</i>	<i>f</i>
<hr/>			
Master's Degree Program			
Area Title (<i>N</i> =120)	Clinical Mental Health Counseling	73	60.8%
	Mental Health Counseling	22	18.3%
	Community Counseling	10	8.3%
	Counseling Psychology	5	4.1%
	Mental Health Counseling and Behavioral Medicine	3	2.5%
	Community Agency Counseling	2	1.7%
	Agency Counseling	1	.8%
	Clinical Counseling	1	.8%
	General Counseling	1	.8%
	Clinical Mental Health & School Counseling	1	.8%
	Pastoral Counseling	1	.8%
<hr/>			
Master's Program Accreditation (<i>N</i> =120)	CACREP	96	80.0%
	NON-CACREP	19	15.8%
	I don't know	5	4.2%
<hr/>			

The regional location of the participant's master degree program was asked to be identified and is reflected in Table 4. There was one oversight that was brought to light

during the data collection phase. The abbreviation of New Mexico (NM) was not listed in the Western region option. The initials (MN), Minnesota, were listed in both the Midwestern region, as well as, the Western region. It was unknown how this error affected the response rate for this demographic question. The reported descriptive statistics were based on information collected. The majority participants, 52.5%, stated that their master's program was located in the Southern Region (AL, AR, FL, GA, KY, Latin America, LA, MD, MS, NC, SC, TN, TX, VA, WV) ($n = 63$). Participants in the Midwestern Region (IL, IN, IA, KS, MI, MN, MO, NE, ND, OH, OK, SD, WY) represented 20.8% ($n = 25$). Participants in the North Atlantic Region (CT, DE, District of Columbia, Europe, ME, MA, NH, NJ, NY, PA, Puerto Rico, RI, VT, Virgin Islands) represented 20.0% ($n = 24$), and the Western Region (AK, AZ, CA, CO, HI, ID, MT, NV, MN, OR, Philippines, UT, WA, WY) represented 4.2% ($n = 5$) of the participants' master's program regional location. Three participants chose to not answer the question.

Table 4
Descriptive Statistics of Regional Location of Master's Program

Descriptor	Variable	n	f
Master's Program Regional Location ($N=120$)	Southern Region	63	52.5%
	Midwest Region	25	20.8%
	North Atlantic Region	24	20.0%
	Western Region	5	4.2%
	Non-Identified	3	1.7%

Reliability Statistics

The participants reported their self-efficacy level using the Addiction Counseling Self-Efficacy Scale (ACSES). The reliability of the ACSES was examined to ensure incorporation in analyses of the posed research questions. Overall, the ACSES had good reliability using the Cronbach's coefficient alpha ($\alpha > .9$). The five variables of the ACSES had coefficient alphas between .83 and .92. Table 5 provides an overview of the reliability of each variable and the corresponding reliability from the original measure.

Table 5
Reliability of ACSES Variables with Current Participants

Scale	Cronbach's α
Specific Addiction Treatment Skills (Aadx; $n = 8$)	.910 (.89)
Assessment and Treatment Planning Skills (Asplanref; $n = 5$)	.830 (.84)
Co-Occurring Disorders Skills (COD; $n = 6$)	.922 (.88)
Group Counseling Skills (Group; $n = 6$)	.915 (.91)
Basic Counseling Skills (Micro; $n = 6$)	.874 (.87)
Total Addiction Counseling Self-Efficacy Scale (ACSES); $n = 31$)	.962 (.95)

Note. The n values provided are the number of questions in each scale. The Cronbach's alphas reported in parenthesis are from the original measure.

Data Screening

Data collected was inspected and screened for normality. Skewness and kurtosis statistics, along with histograms, were used to examine normality of the distribution with the absolute value of three considered to be normal. Results indicated

that all variables met normal distribution based on the skewness and kurtosis coefficients. Skewness values ranged from -0.616 to -1.025. Kurtosis values ranged from 0.315 to 2.195. Table 6 presents the skewness and kurtosis results. Additionally, histograms were used to visually examine the variables normality of distribution.

Table 6
Skewness and Kurtosis Coefficients

Variable	<i>n</i> Statistic	Skewness		Kurtosis	
		Statistic	Std. Error	Statistic	Std. Error
Adtx	31	-0.744	.221	2.195	.438
Asplanref	31	-1.025	.221	-0.744	.438
COD	31	-0.616	.221	-0.616	.438
Group	31	-0.702	.221	-0.702	.438
Micro	31	-0.913	.211	-0.913	.438

The total ACSES variable histogram was approximately normal as illustrated in

Figure 1.

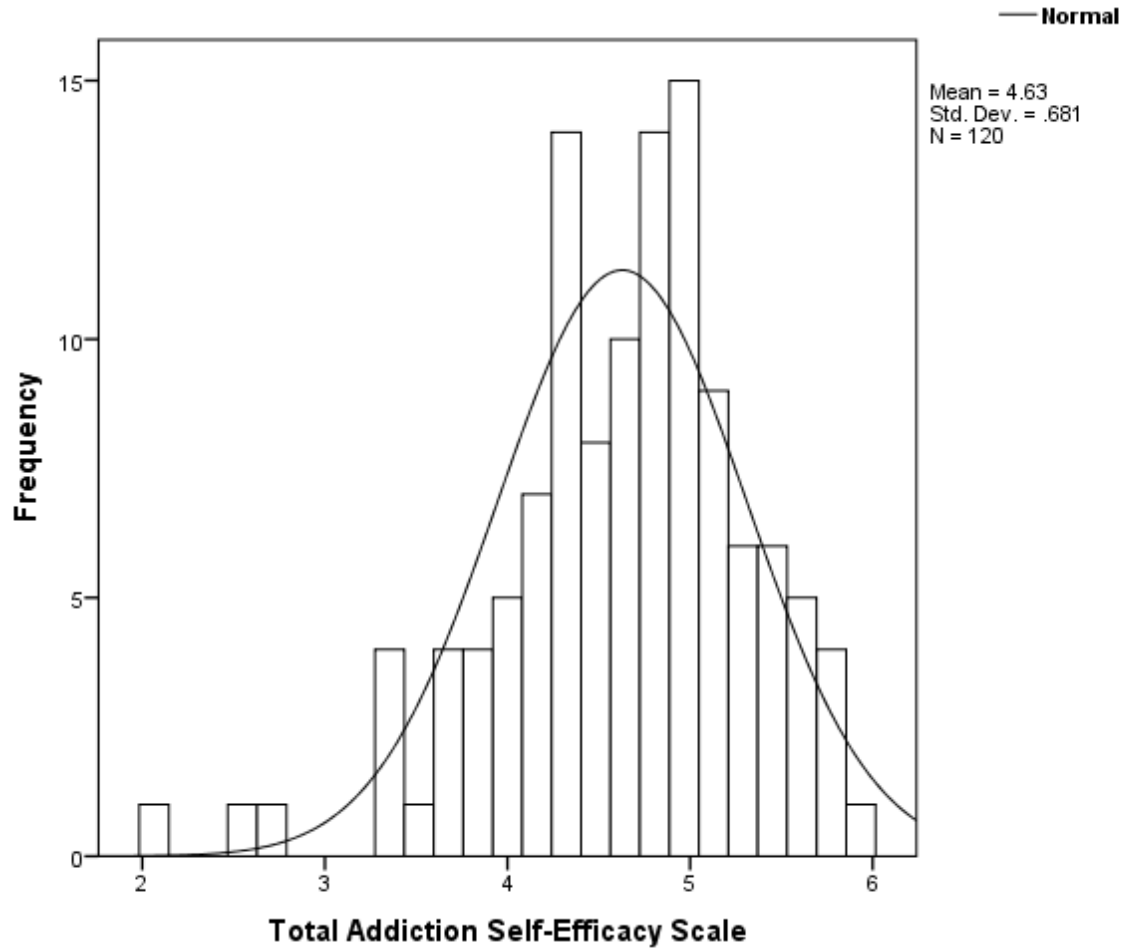


Figure 1. Histogram from Total Addiction Self-Efficacy Scale

The Specific Addiction Treatment Skills variable histogram was approximately normal as illustrated in Figure 2.

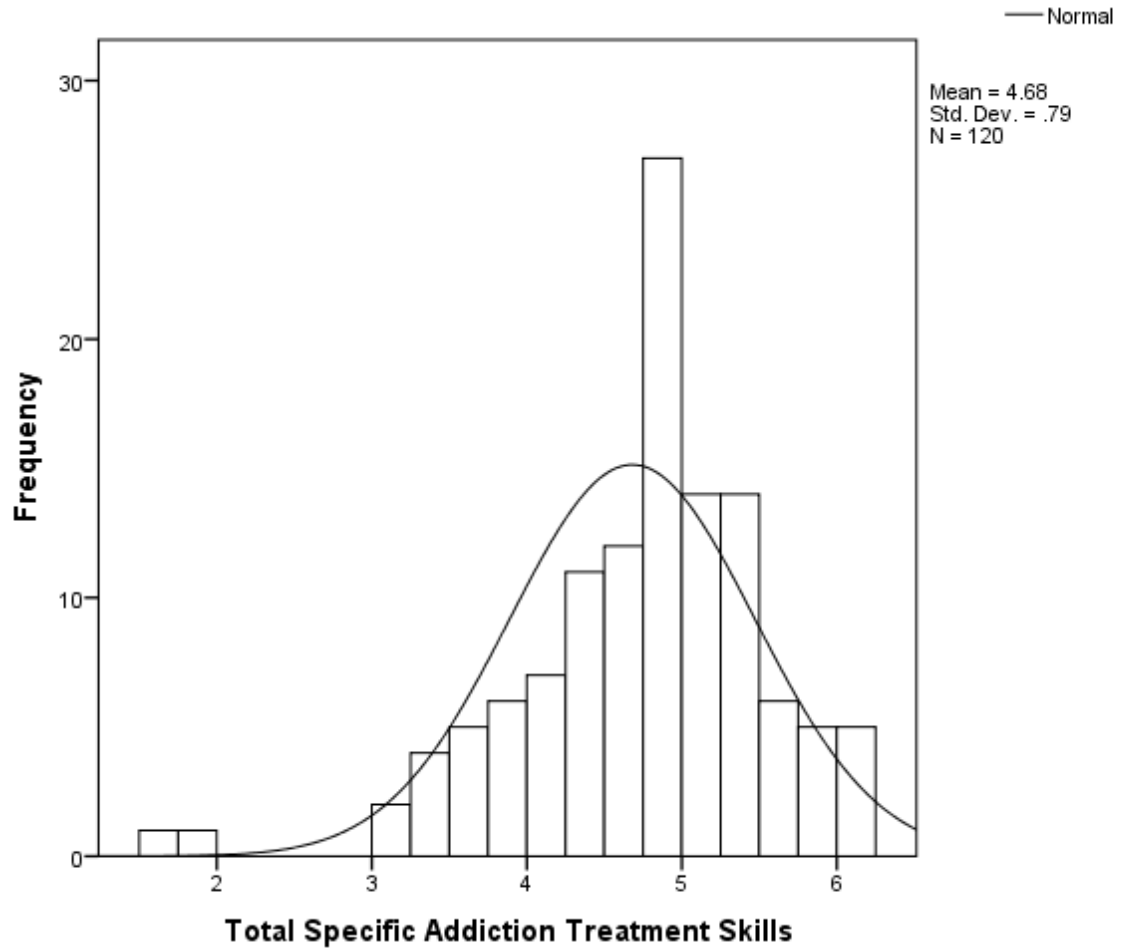


Figure 2. Histogram for Total Specific Addiction Treatment Skills

The Assessment and Treatment Planning Skills variable histogram was approximately normal as illustrated in Figure 3.

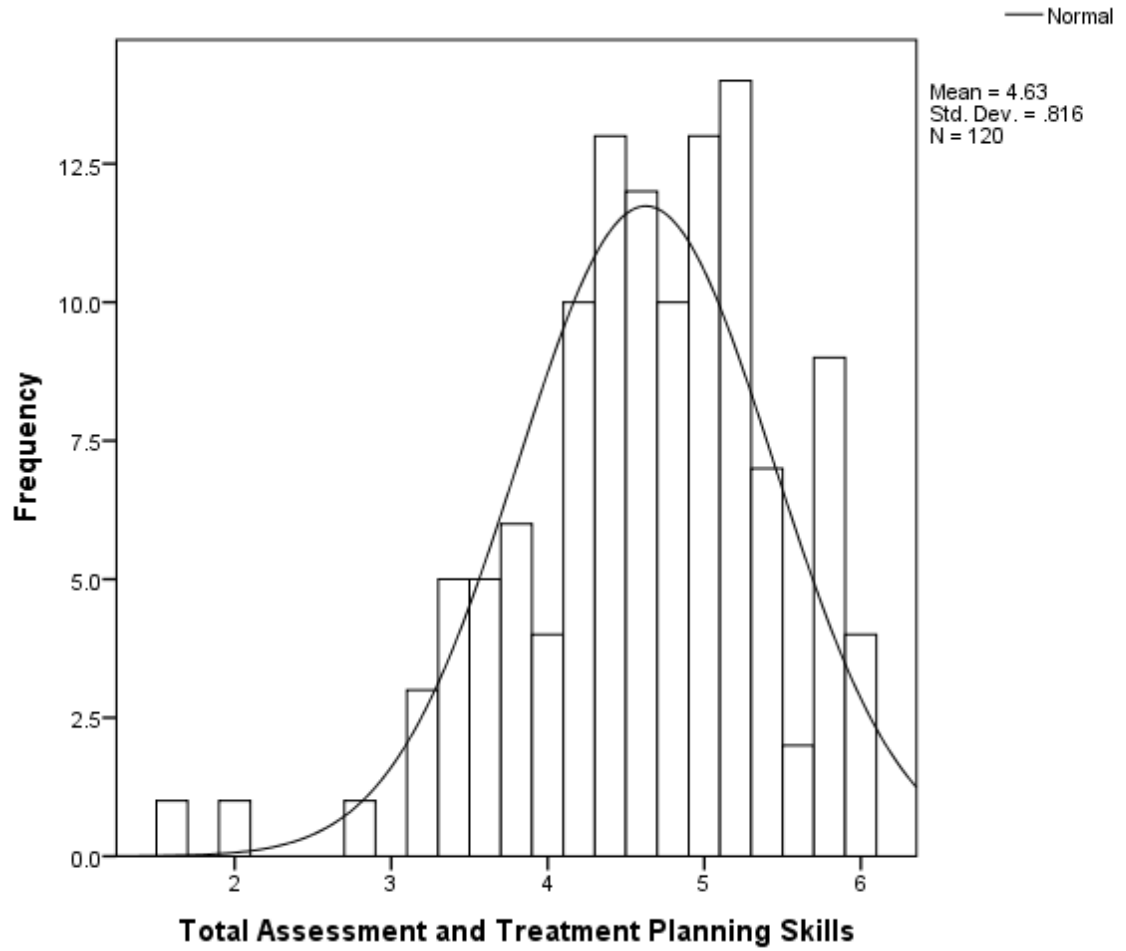


Figure 3. Histogram of Total Assessment and Treatment Planning Skills

The Co-Occurring Disorders Skills variable histogram was approximately normal as illustrated in Figure 4.

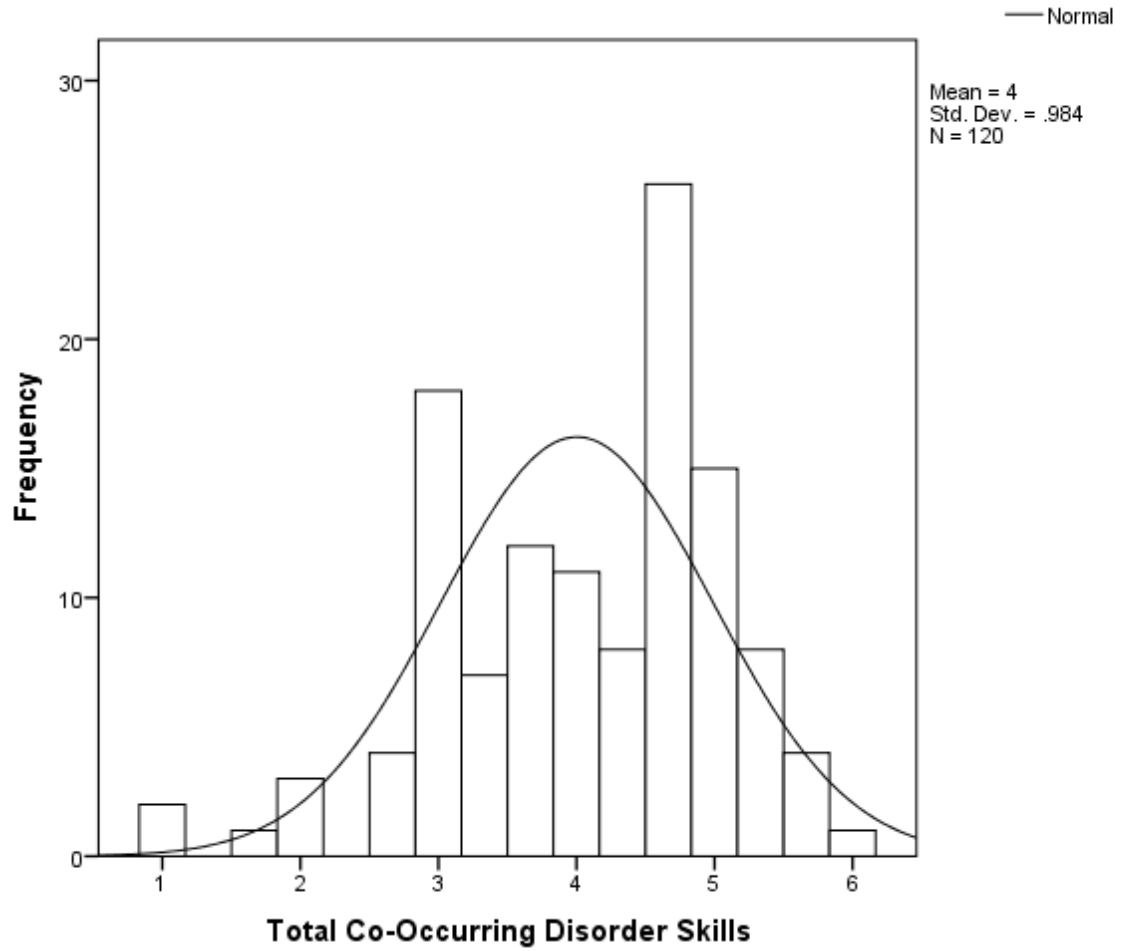


Figure 4. Histogram of Total Co-Occurring Disorder Skills

The Group Counseling Skills variable histogram was approximately normal as illustrated in Figure 5.

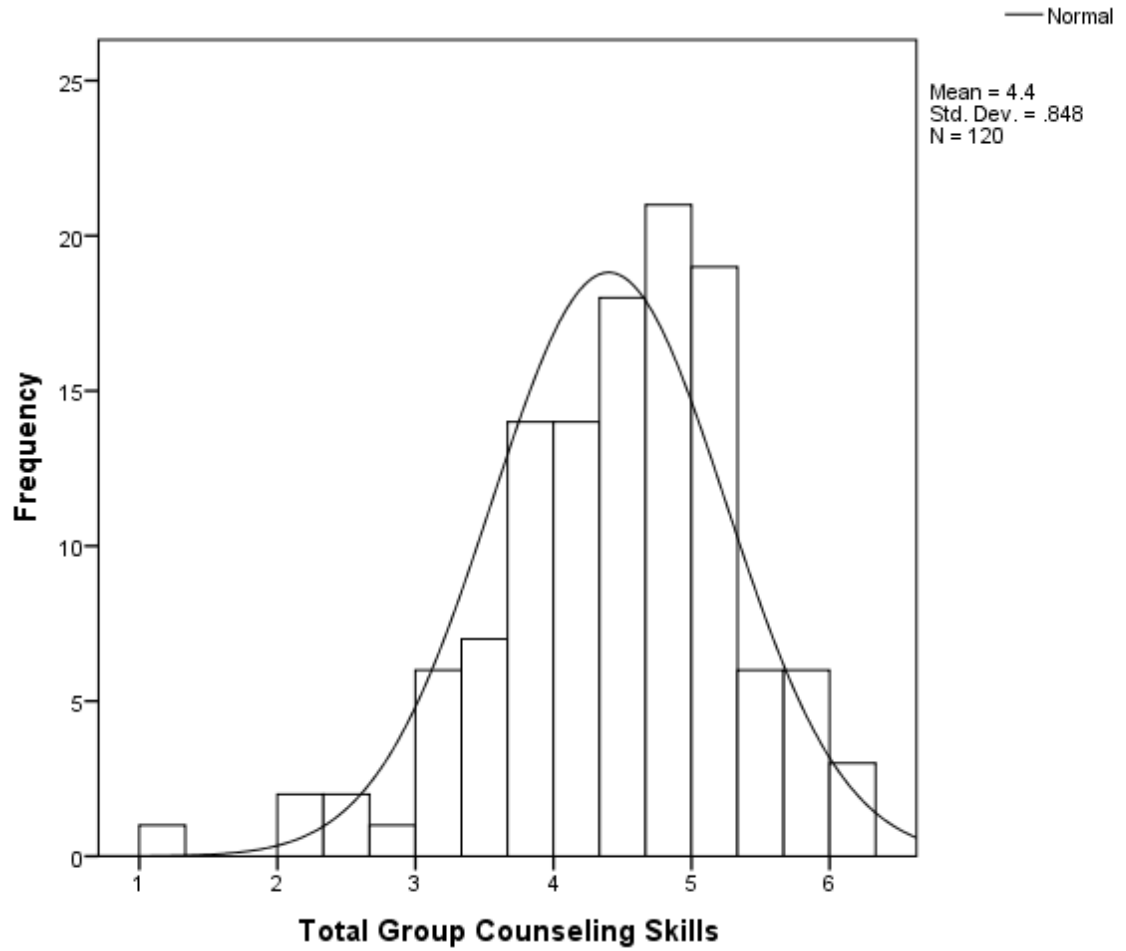


Figure 5. Histogram of Total Group Counseling Skills

The Basic Counseling Skills variable histogram has a strong negatively skewed curve as illustrated in Figure 6.

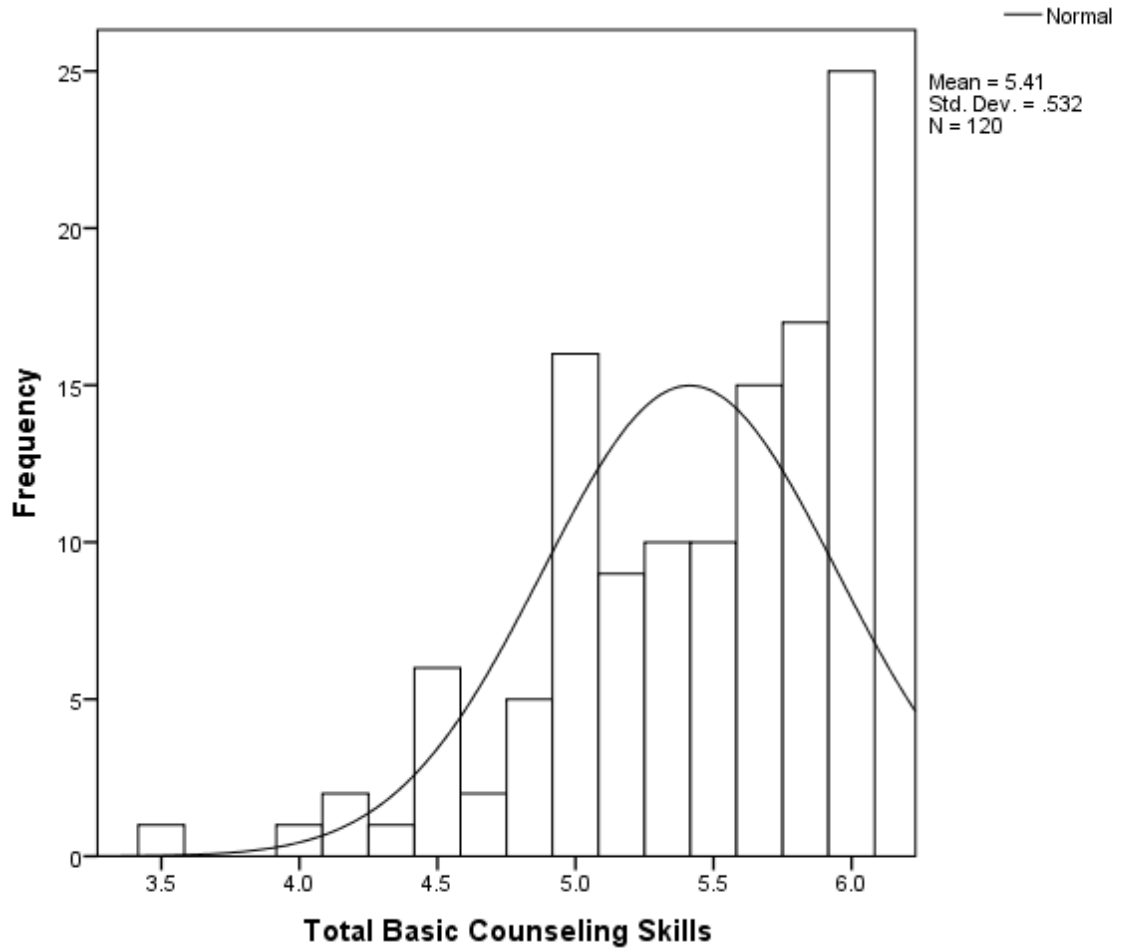


Figure 6. Histogram of Basic Counseling Skills

After the review of the Basic Counseling Skills variable histogram's negatively skewness, it was determined that variable transformations were to be performed in attempt to correct the negative skewness. The transformation of the variable(s) could have had an impact on the normality assumption when performing the parametric analyses in research question three and four. Reverse score transformations of reflect and inverse (inverse), reflect and logarithm (log), and reflect and square root (sqrt) were performed initially on the Basic Counseling Skills variable. All five variables were

transformed once it was identified that there was slight correction with the transformation. Table 7 represents the transformation results statistics of the all five variables.

Table 7
Transformations of ACSES Variables

Variable	<u>Skewness</u>			<u>Kurtosis</u>		
	Inverse	Log	Sqrt	Inverse	Log	Sqrt
Actx	1.256	-0.197	0.390	1.716	0.311	0.715
Asplanref	1.187	-.0300	0.197	1.123	-0.076	0.137
COD	1.435	-0.270	0.185	3.642	0.019	-0.180
Group	1.585	-0.459	0.115	2.976	0.502	0.415
Micro	0.098	0.322	0.591	-1.253	-0.867	-0.345

Preliminary analyses of the transformed variables were used and there was no significant change in the results of the parametric output. Therefore, the original variable scores were used in the proceeding analyses.

Research Question Results

Research Question 1: What are the levels of self-efficacy among mental health counselors-in-training? The Addiction Counseling Self-Efficacy Scale (ACSES) was utilized to assess the level of self-efficacy among mental health counselors-in-training. The ACSES consisted of five variables that measure the self-efficacy of different skills related to addiction counseling. The five variables are: (a) Specific Addiction Treatment Skills (Actx), (b) Assessment and Treatment Planning Skills (Asplanref), (c) Co-occurring Disorders Skills (COD), (d) Group Counseling Skills (Group), and (e) Basic

Counseling Skills (Micro). The following Likert scale was used: 1 = no confidence to 6 = absolute confidence. The higher scores indicate a greater degree of self-efficacy.

Overall, the data indicated that mental health counselors-in-training had some confidence in their ability to perform various tasks related to addiction counseling (ACSES, $M = 4.63$, $SD = .681$). Participants felt most confident with the items listed in the Micro variable ($M = 5.41$, $SD = .532$). The items listed in the COD variable ($M = 4.00$, $SD .984$) were indicative of participants least confident skills related to addiction counseling. Table 8 provides the confidence levels of the five variables of the ACSES.

Table 8
Descriptive Statistics for ACSES Variables

Variable	N	Minimum	Maximum	Mean	SD
Adtx	120	2.0	6.0	4.68	.79
Asplanref	120	2.0	6.0	4.63	.82
COD	120	1.0	6.0	4.00	.98
Group	120	1.0	6.0	4.40	.85
Micro	120	4.0	6.0	5.41	.53
Total ACSES	120	2.0	6.0	4.63	.68

Research Question 2: What is the modality of education that mental health counselors-in-training receive in addiction counseling? A singular question was asked to the participants to gather information on the modalities of education. The question read “I am receiving or have received addiction or addiction-related counseling education in my master’s degree program through.” The response choices were: “An addiction-specific course only,” “Integration throughout my curriculum with no addiction-specific course,”

“A combination of an addiction-specific course and integration throughout my curriculum,” and “No formal education from master’s degree program.” The participants were only given one choice option when answering the question. Table 9 represents the breakdown of the participants’ addiction or addiction-related education modality responses.

The majority of the participants identified their addiction or addiction-related education as a content specific course ($n = 44, 36.7\%$), or a combination of a content specific course as well as integration throughout their master’s degree program ($n = 46, 38.3\%$). Only 18 participants (15.0%) have or had addiction or addiction-related education integration within their curriculum with no content specific course. An additional 12 participants (10%) have not received any formal education from their master’s program on addiction or addiction related education.

Table 9
Descriptive Statistics of Participant’s Education Modalities

I am receiving or have received addiction or addiction-related counseling education in my master’s degree program through:	<i>n</i>	<i>f</i>
An addiction-specific course only	44	36.7%
Integration throughout my curriculum with no addiction-specific course	18	15.0%
A combination of an addiction-specific course and integration throughout my curriculum	46	38.3%
No formal education from master’s degree program	12	10.0%

Research Question 3: Is there a statistically significant difference in the overall self-reported counseling self-efficacy by modality of education received? This question explored the difference between the total ACSES score of mental health counselors-in-training self-reported counseling self-efficacy and the modality of education they receive. A one-way subjects Analysis of variance (ANOVA) was conducted to compare the differences of the Total ACSES score on mental health counselors-in-training's education modalities received in an addiction specific course only, integration throughout my curriculum with no addiction-specific course, a combination of an addiction-specific course and integration throughout my curriculum, and no formal education from master's degree program. There was no significant difference of the Total ACSES score on the four options of received addiction or addiction-related counseling education in the participants master's degree program at the $p < .05$ level for the four education modalities [$F(3,116) = 1.42, p = 0.24$].

Research Question 4. Is there a statistically significant difference in the five variables of counseling self-efficacy by modality of education received? A one-way between-groups multivariate analysis of variance (MANOVA) was performed to investigate the mental health counselors-in-training's education modalities received among the ACSES five variables.

There was no significant difference of the four options of received addiction or addiction-related counseling education in the participants master's degree program on each of the five variables of counseling self-efficacy, Wilks' $\lambda = .634, F(15, 309.584) = .839, p = .634, \text{partial eta squared} = .036$. Table 10 reports the non-significant findings of the

MANOVA analysis on the mental health counselors-in-training modalities of education received among the five ACSES variables.

Table 10.

Comparison of the Five ACSES Variables by Education Modalities

ACSES Variable	<i>F</i>	<i>p</i>	Partial Eta Squared
Actx	1.043	.376	.026
Asplanref	.470	.704	.012
COD	1.849	.142	.046
Group	1.790	.142	.044
Micro	.601	.615	.015

Data from the open-ended question did illuminate additional information that was supportive of addiction specific clinical skills and addiction or related education of mental health counselors-in-training. Specifically, the findings from the open-ended question provided support from the quantitative measure and results. Forty participants elected to answer the question “What additional information would be helpful to know to serve individuals with addiction(s) or addicted related issues(s)? Please describe.” Since the majority of the participants’ responses had multiple topics in their comment, each topic was identified separately.

A general content analysis with open-coding analysis was conducted using a highlight and note card system to identify the main concepts and subsequent categories in the participants’ responses based on the emerged concepts (Allport, 1942; Philipp, 2000). The researcher visually scanned the responses and found two distinct concepts that were directly related to the two main points of interest for this current study: addiction

counseling skills and addiction counseling education. Each individual topic was placed on a notecard and then placed into either a clinical or education concepts. The topics were then reviewed for frequency in participation response and major categories were then identified within the clinical skills and counseling education concepts. Although the researcher used an open-coding analysis, the variables that were analyzed in the quantitative measure were used as a guide and ultimately were the set criteria for the identification of the categories. The frequencies of participants' responses were calculated from the emerged categories.

Participants indicated that there was a need for additional education and training in addiction counseling. One participant stated "I feel I need more experience in working with individuals with addiction(s)." Another participant shared "More experience and interactions with addicted clients." Additionally, participants reported that experience with group counseling skills and counseling techniques such as motivational interviewing and self-talk were deemed important in the development and/or improvement of clinical skills.

Participants expressed a need for learning specific knowledge and information related to addiction specific education as well as the client specific addiction population were needed. One participant expressed a need to know "whether the client has a belief in anything as "higher power" or discounts the 12-step model entirely, whether the client has family supports, etc." Nine participants mentioned the importance of family history, dynamics, and relationships as an area of improvement. Additionally, topics of drugs identification, drug effects on the brain and the biopsychosocial process were areas that counselors-in-training believe would be important to receive additional information.

Finally, co-occurring disorder counseling education and skills was reported to be needed, which would be congruent to the lowest self-efficacy score reported earlier. One participant stated “In our clinical mental health track, only one addictions course is required. I believe that in order to treat clients with an addiction, there should be more coursework specific to this type of counseling, as well as course specific to co-occurring mental health and addiction disorders.” The results of the open-ended question based on the two concept findings are presented in table 11 and 12.

Table 11
Clinical Skills Response Concept

Category	Frequencies	Subcategories:
Basic Counseling Skills	11	Experience and interactions with addiction populations Techniques with addiction population Being present, active listening skills, patience, persistence, instilling hope, client relatability/connection, Working with challenging clients
Group Counseling Skills	3	Creating/working with addicted clients in group counseling setting
Addiction Specific Treatment Skills	7	Ability to identify triggers Create Support / Recovery system Discuss self-help support networks, literature, AA/NA Ways to obtain additional training in addictions
Assessment and Treatment Planning Skills	7	Biopsychosocial / Diagnostic assessment Identifying the addiction history/pattern Treatment planning / setting goals for recovery
Co-Occurring Disorder Skills	4	Co-occurring techniques/competencies
Areas of Counseling Other	9	Motivational Interviewing practice, training, competency Readiness of Change Model Integrating the family into the counseling session Competency in Talk Therapy

Table 12
Education Related Response Concept

Category	Frequencies	Subcategories:
General education	6	Addiction coursework Literature on the subject/ self-help books Increase integration throughout the curriculum
Addiction specific education	12	Development of addiction Recovery Programs/treatment centers AA/NA, 12 step model Identifying and understanding triggers and their origin Support network, types of support, and referral system Community, disability, vocational services Sober living / lifestyle
Addiction population	10	Learning about past history of addict, number of times addict has sought help, legal history, financial status Effects childhood had on addict Addictive behaviors of the addict (i.e. manipulation) Maintaining sobriety Current relationship dynamics Cultural diversity, differences Feelings associated with treatment
Co-Occurring Disorders	4	Co-occurring / co-morbid techniques/competencies
Family	9	Intergenerational patterns of use/abuse of substances Family history Family dynamics Family support Knowledge of support for family, children, friends of the addict
Drugs/Medications	5	Knowledge of drugs/OTC Information of substance use Side effects, withdrawal, and replacement Decipher drug tests
Biological	3	Biological process Biological and physiological effects Drug effect on the brain
Types of Counseling	5	Motivational Interviewing Talk Therapy Trauma Work Change Model

Summary

The purpose of this study was to explore the mental health counselors' -in-training self-efficacy in providing addiction counseling. Additionally, the study examined the modalities of addiction and addiction related counseling education. Descriptive statistics were reported on the demographic statistics of the participants, the Addiction Counselor Self-Efficacy Scale (ACSES), and modality of education received. Results indicated that there was no significant difference on total ACSES score by education modalities. Additionally, there was no significant difference among the reported modalities of education for each of the five variables of the ACSES. The open-ended question produced several themes within the clinical skills and education classifications.

CHAPTER V. DISCUSSION

Introduction

The purpose of this research was to investigate mental health counselor's-in-training addiction counseling self-efficacy and addiction related education modalities currently receiving or received in their master's degree program. Specifically, this study examined the self-reported counseling self-efficacy scores and the statistically significant differences in modalities of counseling education of mental health counselors-in-training. This dissertation was a quantitative study that captured descriptive and inferential data on mental health counselors-in-training, their addiction counseling self-efficacy levels, and modalities in addiction or addiction related education received. For this study, participants completed an online survey that included descriptive questions and a self-efficacy measurement. Included in this chapter was a discussion of findings, conclusions, and limitations of the research study. Additionally, implications and recommendations for future research were presented.

Discussion of Findings

The first research question examined the mental health counselors'-in-training levels of self-efficacy in providing addiction and addiction related counseling using the Addiction Counseling Self-Efficacy Scale (ACSES). The five variables measured by the ACSES instrument are: (a) Specific Addiction Treatment Skills, (b) Assessment and Treatment Planning Skills, (c) Co-occurring Disorders Skills, (d) Group Counseling Skills, and (e) Basic Counseling Skills. The findings from this measure suggested that

mental health counselors-in-training have “moderate confidence” in their ability to perform various aspects of addiction and addiction related counseling skills.

In this study, overall, mental health counselors-in-training had some confidence in their ability to perform various tasks related to addiction counseling (ACSES, $M = 4.63$, $SD = .681$). The Basic Counseling Skills variable had the highest average score, while the lowest average score was the Co-Occurring Disorders Skills variable. These findings were parallel to the previous research results using the ACSES scale (Murdock, Wendler, & Nilsson, 2005; Wendler, 2007). Given that basic counseling skills were an established component of the majority of mental health counseling programs, this finding was congruous with what one would expect. Additionally, the open-ended question provided insight for the need to identify the education and training skills implementation of co-occurring counseling skills. Several participants specifically acknowledged “co-occurring disorders” or “co-morbid” counseling skills as an area for increased knowledge and/or experience that would benefit in their confidence and competency level in providing addiction and addiction related counseling.

The second research question collected descriptive data on the modalities of education that mental health counselors-in-training are receiving or have received in addiction counseling. The four education modality choices used in this study were: (a) an addiction-specific course only, (b) integration throughout the curriculum with no addiction-specific course, (c) combination of an addiction-specific course and integration throughout curriculum and (d) no formal education from master’s degree program. A large majority of mental health counselors-in-training reported receiving addiction and/or addiction related education in their master’s degree program. Ninety percent of the total

research participants reported that they received addiction and addiction related education through an addiction-specific course and/or integration throughout curriculum.

The wording of the education options was formulated from previous research regarding information on addiction counseling and the methods of incorporation into the master's degree program (Carroll, 2000; Iarussi, Perjessy, & Reed, 2013; Lee, Craig, Fetherson, & Simpson, 2013; Madson, Betha, Daniel, & Necaie, 2008; McDermott, Tricker, & Farha, 1991; Morgan & Toloczko, 1997; Whittinghill. 2006; Whittinghill, Carroll, & Morgan, 2005). The additional option of "no formal education from master's degree program" was added to the possible answer choices due to previous research outcomes specifying the lack of addiction specific education within master's counseling programs (Morgan & Toloczko, 1997; Whittinghill. 2006).

Research question three explored whether there was a statistically significant difference by the four options of education modalities described in research question two in the mental health counselors' -in-training overall self-reported level of self-efficacy measured by the ACSES instrument. A one-way subjects Analysis of variance (ANOVA) revealed no statistically significant difference in the self-efficacy level based on the modality of education. Prior to the analysis, transformations of the five ACSES variables were attempted to account for the negative skewness. Transformed total ACSES scores were created from the transformations of the five variables of the ACSES measurement. A preliminary analysis was conducted to investigate if the transformed total ACSES variable and the ACSES five variables would produce a difference in significance from the original total ACSES score and five variables. Previous research (Murdock et al., 2005; Wendler, 2007) and this dissertation were ultimately ineffective at enhancing the

normality of the distribution of the five variables and total ACSES score. The researcher made the decision to use the original total ACSES variables and five ACSES variables in order to provide congruency with past studies.

The final research question examined whether there was a statistically significant difference by the modality of education received in each of the ACSES measurement's five counseling self-efficacy variables. A one-way between-group multivariate analysis of variance (MANOVA) was performed to investigate the education modalities received among the ACSES five variables. The results found no significant differences.

However, in the analysis of the open-ended question, participants did share the need of additional information on various addiction counseling education and skill components that would be beneficial when working with clients who present with an addictive behavior or diagnosis. An open-ended question was asked to describe additional information that could be useful to know to serve individuals with addiction(s) or addicted related issues(s). Responses to the open-ended question added depth to this study's overall research on addiction education and counseling skills. Two main concepts emerged that corresponded to the investigation of the competency of addiction counseling training and the addiction counseling education. Results of this study showed that the basic counseling skills education appears to be an area of strength in mental health or related counseling program curriculum. Additionally, the skills of co-occurring disorders counseling appears to be an area where attention may be needed in the education and/or training among the curriculum of mental health or related counseling programs.

Conclusions

Overall, the results of this study have created a foundational compilation of descriptive and inferential data on mental health counselors-in-training self-efficacy in providing addiction counseling skills and its connection to the modality of training on addiction counseling subject area. Although there was abundant research on counselors-in-training self-efficacy, minimal research has been conducted in the area of addiction specific education and clinical skill competencies. Research such as this dissertation holds an important place in the addictions counseling education's past and future (Iarussi et al., 2013, Lee et al., 2013, Wendler, 2007) and promoted a compulsory use in addiction counseling research, education and training. This research study appeared to be the first in the investigation of identifying education modalities and the possible difference to addiction counseling self-efficacy of mental health counselors-in-training. Potential next steps as a result of the research study on addiction counseling self-efficacy and modalities of addiction education with mental health counselors-in-trainings were identified. Finally, prior to discussing proposed implications and future research directions, the major limitations of the study were addressed.

Limitations

There were several limitations for this research study. The first limitation was that the study utilized a self-report method to measure self-efficacy levels. The Addiction Counseling Self-Efficacy Scale (ACSES) allowed mental health counselors-in-training to provide responses based on their assessment of the proficiencies and aptitudes to perform certain addiction counseling skills. The levels of self-efficacy among mental health

counselors-in-training do not refer to the actual practice or experience, but only to the participants' confidence in their abilities to perform the tasks and skills related to the practice of addiction counseling. Participants may have underestimated or exaggerated their confidence level in their knowledge and ability to perform the specific clinical skills areas. This may have reduced or exacerbated the results. A related concern was the moderately high levels of self-efficacy among the mental health counselors-in-training sample. The participants would have had limited occasions to develop the skills and competencies of addiction specific counseling while in their master's program and training. The self-reported level of addiction counseling self-efficacy may be an unrealistic perception of their actual competency. Participants' perceptions of their own abilities may have been presented in a more favorable manner due to this study's focus on individuals who are already in their experiential component of the master's degree program.

A second limitation to this research study involved the recruitment method of participants. The use of online member directories, such as listservs, was a convenient data collection method. Although all of the listservs were counseling in nature, several of the listservs do not have any limitations on the individuals who can be added to the listserv. Individuals who received emails from the listserv may not be counselor educators, clinicians, counselors-in-training or appropriate recipients of the survey initiation. The researcher also used professional contacts to disseminate the request for participation to individuals who may meet the participant requirements. Both recruitment methods involved the recipient of the email to: (a) choose to participate in the research, (b) disperse the research request to potential individuals who may qualify, or (c) choose

not to participate in the data collection process. Due to the voluntary nature of the participants of this study, it was unknown whether the demographic information of the individuals who participated accurately represented mental health counselors-in-training.

A final limitation involved the potential threat to internal and external validity. The two internal validity concerns were the selection bias, which was due to the volunteer nature of the participants, and response bias due to the sole use of a self-report measure. The threat to external validity comes from the small sample size of mental health counselors-in-training. Although 166 participants completed the survey, only 120 individuals met the criteria for the research study. This sample only reflects a fraction of the current mental health counselors-in-training that were in their experiential component of their master's program and individuals who graduated within the past nine months of the data collection period. Although responses of this study had representation in all region locations, results cannot be inclusive to all mental health counseling programs. The results of this study were also primarily homogeneous in terms of gender and ethnicity identity.

Implications

The results of this study provided a foundation for understanding the self-efficacy levels of mental health counselors-in-training in providing addiction and addiction related counseling. Specifically, this study demonstrated that overall, mental health counselors-in-training display moderate confidence in providing addition and addition related counseling. Particularly they reported high confidence in utilizing Basic Counseling Skills while showing concerns in demonstrating Co-Occurring Disorders Skills. There are several implications from the results of this study.

Implications for Mental Health Counselors-in-Training

Research results may be useful in helping both mental health counselors-in-training and recent graduates to foster professional growth. This study may encourage the facilitation of self-reflection on their knowledge and skills of addiction and addiction related counseling in five domains of the Addiction Counseling Self-Efficacy Scale (ACSES). Academically and professionally, information gathered from this study could assist in assessing areas of strength and shine light on areas in need for further education or training in addiction and addiction related education.

Implications for Counselor Educators

Counselor educators may benefit from a review of content specific topics relating to addictions in the course(s) materials and overall curriculum provided in the master's degree program. Given that 90 percent of participants received some form of addition and addition related counseling education, counselor educators should continue to address addition related contents within the mental health or related counseling program curriculum. While the participants showed a high level of confidence in the Basic Counseling Skills , the participants displayed moderate confidence in the remaining four areas: (a) Specific Addiction Treatment Skills, (b) Assessment and Treatment Planning Skills, (d) Group Counseling Skills, and (d) Co-occurring Disorders Skills. In order to further advance self-efficiency among the counselors-in-training, counselor educators need to encompass the all four areas when addressing addition and addition related contents in coursework.

Specifically, outcomes from the open-ended question could warrant possible infusion of several key education and clinical skill topics into the existing curriculum. Co-Occurring Disorders had the lowest self-efficacy score and participants stated that both co-occurring/co-morbid knowledge and clinical skills was information that could be beneficial in increasing their competency in providing addiction counseling. Additionally, Group Counseling Skills had the second lowest self-efficacy score and the topics of group counseling were mentioned in several of the participants' responses. Finally, participants shared that an increase in experiential activities in addiction counseling was a needed improvement in order to serve those who have an addiction or related issue.

Implications for Mental Health Counseling Program Directors

This study could also benefit mental health counseling program directors in the planning, development, and evaluation of their current mental health counseling programs. The use of results indicated that although mental health counselors-in-training have a moderate level of addiction counseling self-efficacy, there were topics that emerged from the open-ended question that could be addressed specific to the education and experiential components of addiction and addiction related counseling. This examination could continue to foster the overall mental health counselors-in-training self-efficacy in providing counseling to the addiction or addiction related population. Specifically, clinical coordinators of mental health counseling programs are responsible for the practicum and internship facility placements. This study could provide additional support for supervision during the experiential component of the mental health mater's program. Additionally, collaboration of the practicum and internship site supervisors in

addiction counseling may help provide more opportunities for students' exposure to experience working with clients with addiction issues.

Recommendations for Future Research

As the number of individuals affected by the disease of addiction continues to increase, there is a growing need for competent counselors to provide clinical services to these individuals. This research focused on the mental-health counselors-in-training and recent graduate's belief in their abilities to perform clinical skills related to addiction and addiction related counseling. Future research on counselors-in-training self-efficacy in addiction counseling and education modalities should take into account the methods, analyses, findings, and limitations of this study. Further analyses of the current data collected from this study could yield possible significant outcomes that were not found based on the design and research questions posed for the purpose of this study.

Expanding the survey to include supplemental information on education that one may receive outside of their master's program curriculum could provide additional information that may have influenced the mental health counselor's-in-training addiction counseling self-efficacy levels. The curriculum and information/topics that are presented to mental health counselors-in-training may be dependent on state licensing education requirements, which vary state to state. Gathering information such as; (a) whether the addiction counseling education was a required or elective course of the master's degree program, (b) time/hours spent on addiction counseling education and clinical practice or training, (c) alternative forms of education, such as professional development seminar(s), educational or poster session(s) at a conference, (d) personal experience or (e) current or

past work experience(s) may provide a more comprehensive picture of how mental health counselors-in-training self-efficacy levels differ among education modalities.

The study of self-efficacy has individuals share their beliefs about their competencies in providing skills and tasks (Bandura, 1982). The ACSES scale could be used as a research tool and/or pre- and post-test measurement in conjunction with other assessments of counseling self-efficacy during the practicum and/or internship progress of the master's degree program and/or during the pre-licensure clinical experience period. Direct observation of addiction counseling specific skills of trainees during their master's degree program or pre-licensure training would provide a comparison to the self-reported level of competency of addiction counseling skills.

Future research should include a deeper examination of the perceptions of mental health counselor's-in-training in terms of the relationship between confidence and competencies in counseling skills and the modality of addiction education. Research involving the use of a mixed-methods or qualitative research design could expand upon the results of the singular open-ended question. Allowing mental health counselors-in-training to provide their own discussion on addiction counseling confidence and education may illuminate complementary information that would be expanding the understanding the relationship between counselor-in-training confidence and education received in addiction counseling.

Summary

The purpose of this research was to examine the self-reported counseling self-efficacy levels and modality of education acquired. Mental health counselors-in-training and recent graduates were studied and analyses were completed on the addiction

counseling self-efficacy levels and the differences in modalities of addiction education currently receiving or have received during their master's degree program. This dissertation found that there were moderately confidence in providing addiction counseling among mental health counselors-in-training and there was no statically significant difference in self-efficacy based on education modality that they received. Prior to this study, no known research has specifically addressed the mental health counselors-in-training self-efficacy in providing addiction counseling skills. This research provides a platform for continued exploration in the implementation of addiction and addiction related counseling education and research in relation to the mental health program curricula.

References

- Adams, S. A. (2005). Does CACREP accreditation make a difference? A look at NCE results and answers. *Journal of Professional Counseling: Practice, Theory, & Research, 33*(2), 60-76.
- Adams, R. J., & Gallon, S. L. (1997). *Entry-level addiction counselor competency survey: National results*. Portland, OR: Northwest Regional Education Laboratory.
- Allport, G. W. (1942). *The use of personal documents in psychological science* (Bulletin No. 49). New: Social Science Research Council.
- American Academy of Family Physicians. (2011). *Nation's top public health issues reflect AAFP initiatives*. Retrieved from <http://www.aafp.org/news/inside-aafp/20110125yrinrev-publichealth.html>
- American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders*. (5th Ed.). Arlington, VA: American Psychiatric Publishing.
- American Society of Addiction Medicine. (2011). *Public policy statement: Definition of addiction*. Retrieved from <http://www.asam.org/for-the-public/definition-of-addiction>
- Amodeo, M., & Fassler, I. (2000). Social workers and substance-abusing clients: Caseload composition and competency self-ratings. *American Journal of Drug & Alcohol Abuse, 26*(4), 629-641.
- Bandura, A. (1977). Self-efficacy: Toward a unifying theory of behavioral change. *Psychological Review, 84*(2), 191-215.
- Bandura, A. (1978). The self-system in reciprocal determination. *American Psychologist, 33*, 1101-1114.

33, 344-358.

Bandura, A. (1982). Self-efficacy mechanism in human agency. *American Psychologist*, 37(2), 122-147.

Bandura, A. (1986). *Social foundations of thought and action: A social cognitive theory*. Englewood Cliffs, NJ: Prentice-Hall.

Bandura, A. (1995). *Self-efficacy in changing societies*. New York, NY: Cambridge University Press.

Bandura, A. (1997). *Self-efficacy: The exercise of control*. New York, NY: Freeman.

Bandura, A. (1999). A sociocognitive analysis of substance abuse: An agentic perspective. *Psychological Science*, 10(3), 214-217.

Bandura, A. & Adams, N. E. (1977). Analysis of self-efficacy theory of behavioral change. *Cognitive Therapy and Research*, 1(4), 287-310.

Barratt, H., & Kirwan, M. (2009). Cross-sectional studies: Design, application, strengths and weaknesses of cross-sectional studies. *Health Knowledge*. Retrieved from <http://www.healthknowledge.org.uk/public-health-textbook/research-methods/1a-epidemiology/cs-as-is/cross-sectional-studies>

Banken, J. & McGovern, T. (1992). Alcoholism and drug abuse counseling: State of the art consideration. *Alcoholism Treatment Quarterly*, 9(2), 29-53.

Bobby, C. L. & Kandor, J. R. (1992). Assessment of selected CACREP standards by accredited and non-accredited programs. *Journal of Counseling and Development*, 70(6), 677-684.

Bobby, C. L. & Urofsky, R. I. (2008). CACREP adopts new standards. *Counseling Today*, 51(2), 59-60.

- Buckalew, L. W., & Daly, J. (1986). Drug education and counseling programs: Content, strategy, and responsibility. *Journal of Alcohol and Drug Education, 31*, 29-35.
- Bureau of Labor Statistics, U.S. Department of Labor, Occupational Outlook Handbook. (2014). *Substance Abuse and Behavioral Disorder Counselors*. Retrieved from <http://www.bls.gov/ooh/community-and-social-service/substance-abuse-and-behavioral-disorder-counselors.htm>
- Canon, E., & Cooper, J. (2010). Clinical mental health counseling: A national survey of counselor educators. *Journal of Mental Health Counseling, 32*(3), 236-246.
- Carroll, J. J. (2000). Counseling students' conceptions of substance dependence and related initial interventions. *Journal of Addictions & Offender Counseling, 20*(2), 84-93.
- Cellucci, T. & Vik, P. (2001). Training for substance abuse treatment among psychologists in a rural state. *Professional Psychology: Research and Practice, 32*(3), 248-252.
- Center for Substance Abuse Treatment. (2006). *Addiction Counseling Competencies: Knowledge, Skills, and Attitudes of Professional Practice*. Technical Assistance Publication (TAP) Series 21. HHS Publication No. (SMA) 08-4171. Rockville, MD: Substance Abuse and Mental Health Services Administration.
- Chandler, N., Balkin, R. S., & Perepiczka, M. (2011). Perceived self-efficacy of licensed counselors to provide substance abuse counseling. *Journal of Addictions & Offender Counseling, 32*(1-2) 29-42.
- Chappel, J. N. & Veach. T. L. (1987). Effect of a course on students' attitudes towards substance abuse and its treatment. *Journal of Medical Education, 62*, 394-400.
- Chasek, C. L., Jorgensen, M., & Maxson, T. (2012). Assessing counseling students'

- attitudes regarding substance abuse and treatment. *Journal of Addictions & Offender Counseling*, 33(2), 107-114.
- Council for Accreditation of Counseling and Related Education Programs. (2001). *CACREP accreditation standards and procedures manual*. Retrieved from <http://www.cacrep.org/wp-content/uploads/2013/12/2009-Standards.pdf>
- Council for Accreditation of Counseling and Related Education Programs. (2009). *CACREP accreditation standards and procedures manual*. Retrieved from <http://www.cacrep.org/wp-content/uploads/2013/12/2009-Standards.pdf>
- Council for Accreditation of Counseling and Related Education Programs. (2014). *Draft # 2 of the 2016 CACREP standards*. Retrieved from <http://www.cacrep.org/wp-content/uploads/2012/07/2016-Standards-Draft-2.pdf>
- Crits-Christoph, P., Baranackie, K., Kurcais, J., Beck, A., Carroll, K., Perry, K., Luborsky, L., McLellan, A., Woody, G., Thompson, L., Gallagher, D., & Zitrin, C. (1991). Meta-analysis of therapists effects in psychotherapy outcome studies. *Psychotherapy Research*, 1(2), 81-91. doi:10.1080/10503309112331335511
- Crits-Christoph, P., & Siqueland, L. (1996). Psychosocial treatment for drug abuse: Selected review and recommendations for national health care. *Archives of General Psychiatry*, 53(8), 749-756.
doi:10.1001/archpsyc.1996.01830080103015.
- Cullbreth, J. R. (2000). Substance abuse counselors with and without a personal history of chemical dependency: A review of the literature. *Alcoholism Treatment Quarterly*, 18, 3-14.
- Daniels, J. A., & Larson, L. M., (2001). The impact of performance feedback on

- counseling self-efficacy and counselor anxiety. *Counselor Education & Supervision*, 41(2), 120-130.
- da Silva Cardoso, E., Pruett, S.R., Chan, F., & Tansey, T. N. (2006). Substance abuse assessment and treatment: The current training and practice of APA division 22 members. *Rehabilitation Psychology*, 51(2), 175-178. doi: 10.1037/0090-5550.51.2.175
- Dillman, D. A., Smyth, J. D., & Christian, L. M. (2009). *Internet, mail, and mixed-mode surveys: The tailored design method* (3rd ed.). Hoboken, NJ: John Wiley & Sons, Inc.
- Dove, H. W. (1999). Postgraduate education and training in addiction disorders: Defining core competencies. *The Psychiatric Clinics of North America*, 22(2), 481-488.
- Easton, C., Martin, W. E., & Wilson, S. (2008). Emotional intelligence and implications for counseling self-efficacy: Phase II. *Counselor Education & Supervision*, 47(4), 218-232.
- Edmundson, E., Gallon, S., & Porter, J. (2008). Education resources needed to support the teaching of evidence-based practices. *Journal of Teaching in the Addictions*, 6(2), 9-20. doi: 10.1080/15332700802127896
- Field embraces outline of core competencies for counselors. (1998). *Alcoholism & Drug Abuse Weekly*, 10(15), 4.
- Fisher, G. L. & Harrison, T. C. (2009). *Substance abuse: Information for school counselors, social workers, therapists, and counselors*. Boston: Pearson.
- Friedlander, M. L. & Snyder, J. (1983). Trainees' expectations for the supervisory

- process: Testing a developmental model. *Counselor Education and Supervision*, 22(4), 342-348.
- Goodwin, L.R. (2006). A comprehensive substance abuse counselor education program: From specialty certificate to Ph.D. *Journal of Teaching in Addictions*, 5(2), 59-80. doi: 10.1300/J188v05n02_05
- Granello, D. H., & Wheaton, J. E. (2004). Online data collection: Strategies for research. *Journal of Counseling & Development*, 82(4), 387-393. .
- Gratitude House: Here There is Hope. (2014). *About Us*. Retrieved from <http://www.gratitudehouse.org/Aboutus.php>
- Hagedorn, W. B. (2007). Accredited addiction counseling programs: The future is upon us. *Journal of Addictions & Offender Counseling*, 28(1), 2-3.
- Hagedorn, W. B. (2009). The call for a new Diagnostic and Statistical Manual of Mental Disorders diagnosis: Addictive disorders. *Journal of Addictions & Offender Counseling*, 29(2), 110-127.
- Hagedorn, W. B., Culbreth, J. R., & Cashwell, C. S. (2012). Addiction counseling accreditation: CACREP's role in solidifying the counseling profession. *The Professional Counselor: Research and Practice*, 2(2), 124-133.
- Hall, John. (2008). Cross-sectional survey design. *Encyclopedia of Survey Research Methods*. Thousand Oaks, CA: Sage.
- Heppner, P. P., & Heppner, M. J. (2004). *Writing and publishing your thesis, dissertation & research: A guide for students in the helping profession*. Belmont, CA: Brooks/Cole.
- Heppner, P. P., Kivlighan, B. E., & Wampold, D. M. (2008). *Research design in counseling* (3rd ed.) Belmont, CA: Brooks/Cole.

- Hosie, T. W., West, J. D., & Mackey, J. A. (1990). Perceptions of counselor performance in substance abuse centers. *Journal of Mental Health Counseling, 12*(2), 199-207.
- Iarussi, M. M., Perjessy, C. C., & Reed, S. W. (2013). Addiction-specific CACREP standards in clinical mental health counseling programs: How are they met? *Journal of Addictions & Offender Counseling, 34*(2), 99-113. doi: 10.1002/j.2161-1874.2013.00018.x
- Johnson, B. (2001). Towards a new classification of nonexperimental quantitative research. *Educational Researcher, 30*(2), 3-13.
- Johnson, E., Baker, S. B., Kopala, M., Kiselica, M. S., & Thompson, E. C. (1989). Counseling self-efficacy and counseling competence in prepracticum training. *Counselor Education and Supervision, 28*(3), 205-218.
- Karim, R., & Chaudhri, P. (2012). Behavioral addictions: An overview. *Journal of Psychoactive Drugs, 44*(1), 5-17. doi: 10.1080/02791072.2012.662859
- Kerwin, M. E., Walker-Smith, K. & Kirby, K. C. (2006). Comparative analysis of state requirements for the training of substance abuse and mental health counselors. *Journal of Substance Abuse Treatment, 30*, 173-181.
- Klutschkowski, F., & Troth, W. A. (1995) Components for a substance abuse counselor education curriculum: A Delphi study. *Journal of Addictions & Offender Counseling. 15*(2), 34-42.
- Kranz, K. M. (2003). Development of the alcohol and other drug self-efficacy scale. *Research on Social Work Practice, 13*(6), 724-741.
- Kranz, K. M., & O'Hare, T. (2006). The substance abuse treatment self-efficacy scale: A

- confirmatory factor analysis. *Journal of Social Service Research*, 32(2), 109-121.
doi: 10.1300/J079v32n03_06
- Kranz, K. M., & O'Hare, T. (2011). Revalidating the substance abuse treatment self-efficacy scale (SATSES): A replication with social work practitioners. *Journal of Social Work Practice in the Addictions*, 11(3), 270-285. doi:
10.1080/1533256X.2011.595290
- Larson, L. M. & Daniels, J. A. (1998). Review of counseling self-efficacy literature. *Counseling Psychologist*, 26(2), 179-218.
- Larson, L. M., Suzuki, L. M., Gillespie, K. N., Potenza, M. T., Bechtel, M. A., & Toulouse, A. L. (1992). Development and validation of the counseling self-estimate inventory. *Journal of Counseling Psychology*, 39(1). 105-130.
- Lawson, G. W. & Lawson, A. W. (1990). Quality substance abuse education – To be or not to be?. *Psychology of Addictive Behaviors*, 4(1), 37-39.
doi:10.1037/h0080599
- Lee, T. K. (2011). *Implementation of the 2009 CACREP standards addiction competencies* (unpublished doctoral dissertation). Western Michigan University, Kalamazoo, MI.
- Lee, T. K., Craig, S. E., Fetherson, B. T., & Simpson, C. D. (2013). Addiction competencies in the 2009 CACREP clinical mental health counseling program standards. *Journal of Addictions & Offender Counseling*, 34, 2-15. doi:
10.1002/j.2161-1874.2013.00010.x
- Lent, R. W., Hill, C. E., & Hoffman, M. A. (2003). Development and validation of the

counselor activity self-efficacy scales. *Journal of Counseling Psychology*, 50(1), 97-108. doi: 10.1037/0022-0167.50.1.97

Lent, R. W., Hoffman, M. A., Hill, C. E., Treistman, D., Mount, M. & Singley, D. (2006). Client-specific counselor self-efficacy in novice counselors: Relation to perceptions of session quality. *Journal of Counseling Psychology*, 53(4), 453-463. doi: 10.1037/0022-0167.53.4.453

Libretto, S. V., Weil, J., Nemes, S., Copeland Linder, N. C., Johansson, A. C. (2004). Snapshot of the substance abuse treatment workforce in 2002: A synthesis of current literature. *Journal of Psychoactive Drugs*, 36(4), 489-497. doi: 10.1080/02791072.2004.10524432

Linton, J. M. (2012). Ethics and accreditation in addictions counselor training: Possible field placement issues for CACREP-accredited addictions counseling programs. *Journal of Addictions & Offender Counseling*, 33(1), 48-61.

Lubin, B., Brady, K. Woodward, L., & Thomas, E. A. (1986). Graduate professional psychology training in alcoholism and substance abuse: 1984. *Professional Psychology Research and Practice*, 17(2), 151-154.

Luborsky, L., McLellan, A. T., Diguier, L., Woody, G., & Seligman, D. A. (1997). The psychotherapist matters: Comparisons of outcomes across twenty-two therapists and seven patient samples. *Clinical Psychology: Science and Practice*, 4(1), 53-65. doi: 10.1111/j.1468-2850.1997.tb00099.x

Madson, M. B., Bethea, A. R., Daniel, S., & Necaie, H. (2008). The state of substance

abuse treatment training in counseling and counseling psychology program: What is and is not happening. *Journal of Teaching in the Addictions*, 7(2), 164-178. doi: 10.1080/15332700802269177

McDermott, D., Tricker, R. & Farha, N. (1991). The effects of specialized training in alcohol information for counseling students. *Journal of Drug Education*, 21, 85-94.

Melchert, T. P., Hays, V. L., Wiljanen, L. M., & Kolocek, A. K. (1996). Testing models of counselor development with a measure of counseling self-efficacy. *Journal of Counseling & Development*, 74(6), 640-644.

Miller, G., Scarborough, J., Clark, C., Leonard, J. C., & Keziah, T. B. (2010). The need for national credentialing standards for addiction counselors. *Journal of Addictions & Offender Counseling*, 30(2), 50-57.

Morgan, O. J., & Toloczko, A. (1997). Graduate training of counselors in the addictions: A study of CACREP-approved programs. *Journal of Addictions & Offender Counseling*, 17(2), 66-77.

Morgen, K., Miller, G., & Stretch, L.S. (2012). Addiction counseling licensure issues for licensed professional counselors. *The Professional Counselor*, 2(1), 58-65.

Mulvey, K. P., Hubbard, S., & Hayashi, S. (2003). A national study of the substance abuse treatment workforce. *Journal of Substance Abuse Treatment*, 24, 51-57.

Munson, W. W., Zoerink, D. A., & Stadulis, R. E. (1986). Training potential therapeutic recreators for self-efficacy and competence in interpersonal skills. *Therapeutic Recreation Journal*, 20(1), 53-62.

Murdock, T. B., Wendler, A. M., & Nilsson, J. E. (2005). Addiction counseling self-

- efficacy scale (ACSES): Development and initial validation. *Journal of Substance Abuse Treatment*, 29, 55-64. doi:10.1016/j.jsat.2005.03.005
- Mustaine, B. L., West, P. L., & Wyrick, B. K. (2003). Substance abuse counselor certification requirements: Is it time for a chance?. *Journal of Addictions & Offender Counseling*, 23(2), 99-107.
- Najavits, L. M., & Weiss, R. D. (1994). Variations in therapist effectiveness in the treatment of patients with substance use disorders: An empirical review. *Addiction*, 89, 679-688. doi:10.1111/j.1360-0443.1994.tb00954.x
- National Institute on Drug Abuse. (2014). National Institute on Drug Abuse: The science of drug abuse & addiction. *Trends & Statistics*. Retrieved from <http://www.drugabuse.gov/related-topics/trends-statistics>.
- Page, R.C., & Bailey, J.B. (1995). Addictions counseling certification: An emerging counseling specialty. *Journal of Counseling & Development*, 74(2), 167-171.
- Pajares, F. (1996). Self-efficacy beliefs in academic settings. *Review of Educational Research*, 66(4), 543-578.
- Pajares, F. (2002). Overview of social cognitive therapy and of self-Efficacy. Retrieved from <http://www.emory.edu/EDUCATION/mfp/eff.html>.
- Philipp, M. (2000). Qualitative content analysis. *Forum: Qualitative Social Research*, 1(2). Retrieved from <http://nbn-resolving.de/urn:nbn:de:0114-fqs0002204>.
- Project MATCH Research Group. (1998). Therapist effects in three treatments for alcohol problems. *Psychotherapy Research*, 8(4), 455-474. doi: 10.1080/10503309812331332527
- Rieckman, T., Farentinos, C., Tillotson, C. J., Kocarnik, J., & McCarty, D. (2011). The

- substance abuse counseling workforce: Education, preparation, and certification. *Substance Abuse*, 32(4), 180-190. doi: 10.1080/08897077.2011.60010022
- Salyers, K. M., Richie, M. H., Luellen, W. S., & Roseman, C. P. (2005). Inclusion of substance abuse training in CACREP-accredited programs. *Counselor Education & Supervision*, 45(1), 30-42.
- Schmidt, J. J. (1999). Two decades of CACREP and what do we know?. *Counselor Education & Supervision*, 39(1), 34-46.
- Scott, C.G. (2000). Ethical issues in addiction counseling. *Rehabilitation Counseling Bulletin*, 43(4), 209-214.
- Selin, J. A., & Svanum, S. (1981). Alcoholism and substance abuse training: A survey of graduate programs in clinical psychology. *Professional Psychology*, 12(6), 717-721.
- Sias, S. M., & Lambie, G. W. (2008). An integrative social-cognitive development model of supervision for substance abuse counselors-in-training. *Journal of Teaching in the Addictions*, 7(1), 57-74. doi: 10.1080.15332700802072282
- Sias, S. M., Lambie, G. W., & Foster, V. A. (2006). Conceptual and moral development of substance abuse counselors: Implications for training. *Journal of Addictions & Offender Counseling*, 26(2), 99-110.
- Sipps, G. J., Sugden, G. J., & Faiver, C. M. (1988). Counselor training level and verbal response type: Their relationship to efficacy and outcome expectations. *Journal of Counseling Psychology*, 35(4), 397-401. doi: 10.1037/0022-0167.35.4.397
- Substance Abuse and Mental Health Services Administration. (2013). *Results from the*

2012 National Survey on Drug Use and Health: Summary of National Findings, NSDUH Series H-46, HHS Publication No. (SMA) 13-4795. Rockville, MD: Substance Abuse and Mental Health Services Administration.

Substance Abuse and Mental Health Services Administration. (2010). *The DAWN report: Highlights of the 2009 drug abuse warning network (DAWN) findings on drug-related emergency department visits*. Rockville, MD. Substance Abuse and Mental Health Services Administration.

Substance Abuse and Mental Health Services Administration. (2014). *The NSDUH report: Substance use and mental health estimates from the 2013 national survey on drug Use and health: Overview of findings*. Rockville, MD. Substance Abuse and Mental Health Services Administration.

Sweeney, T. J. (1992). CACREP: Precursors, promises, and prospects. *Journal of Counseling & Development*, 70(5), 667-672.

Taleff, M. J., & Martin, M. (1996). The Pennsylvania state university's chemical dependency counselor training program: Addressing the needs of educators and addiction specialists. *Journal of Addictions & Offender Counseling*, 17(1), 12-21.

Tang, M., Addison, K. D., LaSure-Bryant, D., Norman, R., O'Connell, W., & Stewart-Sicking, J. A. (2004). Factors that influence self-efficacy of counseling students: An exploratory study. *Counselor Education & Supervision*, 44(1), 70-80.

Vacc, N. A. & Loesch, L. C. (2000). *A Professional Orientation to Counseling (3 ed.)*. Philadelphia, PA: Brunner-Routledge.

Webber, J. M., & Mascari, J. B. (2009). Critical issues in implementing the new

- CACREP standards for disaster, trauma, and crisis counseling. *Compelling Counseling Interventions: Vistas 2009*, 125-138.
- Wendler, A.M. (2007). *Validation of the addiction counseling self-efficacy scale (ACSES)* (Unpublished doctoral dissertation). University of Missouri-Kansas City, Missouri.
- West, P., & Hamm, T. (2012). A study of clinical supervision techniques and training in substance abuse treatment. *Journal of Addictions & Offender Counseling*, 33(2), 66-81.
- White, W. (1998). *Slaying the dragon: The history of addiction treatment and recovery in America*. Bloomington IL: Chestnut Health Systems.
- White, W. (1999). A lost world of addiction treatment. *Counselor* 17(2), 8-11.
- White, W. (2000a). Addiction counseling: The birth and maturation of a new profession. *Counselor* 18, 9-12.
- White, W. (2000b). The history of recovered people as wounded healers: I. From native America to rise of the modern alcoholism movement. *Alcoholism Treatment Quarterly*, 18(1), 1-23.
- White, W. (2003). The road not taken: The lost roots of addiction counseling. *Counselor*, 4(2), 22-23.
- White, W. (2004). The historical essence of addiction counseling. *Counselor*, 5(3), 43-48.
- Whittinghill, D. (2006). A preliminary investigation of the components of a curriculum for the preparation of master's-level addiction counselors. *Journal of Drug Education*, 36(4), 357-371.
- Whittinghill, D., Carroll, J., & Morgan, O. (2005). Curriculum standards for the

education of professional substance abuse counselors. *Journal of Teaching in the Addictions*, 3(2), 63-76. doi: 10.1300/J188v03n02_06

Whittinghill, D., Whittinghill, L. & Loesch, L. C. (2000). The benefits of a self-efficacy approach to substance abuse counseling in the era of managed care. *Journal of Addictions & Offender Counseling*, 20(2), 64-75.

Yalisove, D. L. (1998). The origins and evolution of the disease concept of treatment. *Journal of Studies and Alcohol*, 59, 469-476.

Yalisove, D. L. (2005). Considerations in the development of a research to practice curriculum for alcoholism and substance abuse counselors. *Journal of Teaching in the Addictions*, 3(2), 77-93. doi: 10.1300/J188v03n02_07

APPENDIX A

IRB Approval Form

^{EP}
**AUBURN UNIVERSITY INSTITUTIONAL REVIEW BOARD for RESEARCH INVOLVING HUMAN SUBJECTS
 REQUEST FOR EXEMPT CATEGORY RESEARCH**

For information or help completing this form, contact: THE OFFICE OF RESEARCH COMPLIANCE, 115 Ramsay Hall
 Phone: 334-844-5966 e-mail: IRBAdmin@auburn.edu Web Address: <http://www.auburn.edu/research/vpr/ohs/index.htm>

Revised 2/1/2014 Submit completed form to IRBsubmit@auburn.edu or 115 Ramsay Hall, Auburn University 36849.
 Form must be populated using Adobe Acrobat / Pro 9 or greater standalone program (do not fill out in browser). Hand written forms will not be accepted.
Project activities may not begin until you have received approval from the Auburn University IRB.

1. PROJECT PERSONNEL & TRAINING

PRINCIPAL INVESTIGATOR (PI):

Name Stephanie D. Carroll Title Graduate Student Dept./School SERC
 Address 4570 Sutton Ter., WPB, FL, 33415 AU Email sd0011@auburn.edu
 Phone 561-758-7903 Dept. Head Dr. Davis Martin

FACULTY ADVISOR (if applicable):

Name Dr. Suhyun Suh Title Associate Professor Dept./School SERC
 Address 2058 Haley Center, Auburn, AL 36849-5218
 Phone 334-844-2837 AU Email susuhy@auburn.edu

KEY PERSONNEL: List Key Personnel (other than PI and FA). Additional personnel may be listed in an attachment.

Name	Title	Institution	Responsibilities

The Auburn University Institutional Review Board has approved this document for use from 8/29/14 to 8/28/15
 Protocol # 14-292EP1408

KEY PERSONNEL TRAINING: Have all Key Personnel completed CITI Human Research Training (including elective modules related to this research) within the last 3 years? YES NO
TRAINING CERTIFICATES: Please attach CITI completion certificates for all Key Personnel.

2. PROJECT INFORMATION

Title: Addiction Counseling Self-Efficacy of Mental Health Counselors-in-Training

Source of Funding: Investigator Internal External

List External Agency & Grant Number: _____

List any contractors, sub-contractors, or other entities associate with this project.

List any other IRBs associated with this project (including those involved with reviewing, deferring, or determinations).

FOR ORC OFFICE USE ONLY			
DATE RECEIVED IN ORC:	<u>8/8/14</u>	by <u>BK</u>	APPROVAL # <u>14-292 EP 1408</u>
DATE OF IRB REVIEW:	_____	by _____	APPROVAL CATEGORY: <u>45 CFR 46.110(7)</u>
DATE OF ORC REVIEW:	_____	by _____	INTERVAL FOR CONTINUING REVIEW: <u>1 year</u>
DATE OF APPROVAL:	<u>8/29/14</u>	by <u>BO</u>	
COMMENTS:			

3. PROJECT SUMMARY

- a. Does the research involve any special populations?
- YES NO Minors (under age 19)
- YES NO Pregnant women, fetuses, or any products of conception
- YES NO Prisoners or Wards
- YES NO Individuals with compromised autonomy and/or decisional capacity
- b. Does the research pose more than minimal risk to participants? YES NO
Minimal risk means that the probability and magnitude of harm or discomfort anticipated in the research are not greater in and of themselves than those ordinarily encountered in daily life or during the performance of routine physical or psychological examinations or tests. 42 CFR 46.102(i)
- c. Does the study involve any of the following?
- YES NO Procedures subject to FDA Regulation Ex. Drugs, biological products, medical devices, etc.
- YES NO Use of school records of identifiable students or information from instructors about specific students
- YES NO Protected health or medical information when there is a direct or indirect link that could identify the participant
- YES NO Collection of sensitive aspects of the participant's own behavior, such as illegal conduct, drug use, sexual behavior or use of alcohol
- YES NO Deception of participants

If you checked "YES" to any response in Question #3 STOP. It is likely that your study does not meet the "EXEMPT" requirements. Please complete a PROTOCOL FORM for Expedited or Full Board Review. You may contact IRB Administration for more information. (Phone: 334-844-5966 or Email: IRBAdmin@auburn.edu)

4. PROJECT DESCRIPTION

- a. Subject Population (Describe, include age, special population characteristics, etc.)

The population includes current mental health graduate students in their practicum or internship course(s) and recent master's program graduate students within the past nine months. The minimum age for participation will be 19 years of age. The minimum number of participants is 100.

- b. Describe, step by step, all procedures and methods that will be used to consent participants.
- N/A (Existing data will be used)

An email flyer (Appendix A) will be sent to counseling listservs (appendix B) along with snowball sampling through various counseling and academic contacts of the researcher (Appendix C). Those who chose to participate will be directed to an online survey created in Qualtrics. The Information Letter (Appendix D) will be available prior to the participant completing the survey. Participants will acknowledge their consent upon beginning the survey and will be allowed to leave the survey at any time, as outlined in the Information Letter.

- c. Brief summary of project. (Include the research question(s) and a brief description of the methodology, including recruitment and how data will be collected and protected.)

The purpose of the study is to assess the self-efficacy in providing addiction counseling among mental health counselors-in-training. In order to achieve the purpose, four research questions were developed: (a) What are the levels of self-efficacy among mental health counselors-in-training?; (b) What is the modality of education that mental health counselors-in-training receive in addiction counseling?; (c) Is there a statistical difference in the overall self-reported counseling self-efficacy by modality of education received?; and (d) Is there a statistical difference in the factors of counseling self-efficacy by modality of education received? As a method to recruit participants, an email flyer (Appendix A) will be distributed to counseling listservs (Appendix B) and emails will be sent to various counseling and academic contacts of the researcher (Appendix C). The email flyers will be used to provide information on the nature of the study. If necessary, follow up reminder emails will be sent week two, week four, and week five with a total of six weeks maximum for participant recruitment. As an incentive to complete the survey, the researcher will be donating \$1.00 for every complete response to Gratitude House: Women's Alcohol and Drug Rehabilitation Program. Volunteering participants will complete an on-line survey created in Qualtrics and an Informational Letter (Appendix D) will be included at the beginning of the survey. The survey will include the Addiction Counselor Self-Efficacy Scale (ACSES) and a demographic questionnaire (Appendix E). The Qualtrics survey data will be anonymous and will be setup to not gather identifiable information or IP addresses.

- d. Waivers. Check any waivers that apply and describe how the project meets the criteria for the waiver.

- Waiver of Consent (Including existing de-identified data)
- Waiver of Documentation of Consent (Use of Information Letter)
- Waiver of Parental Permission (for college students)

- e. Attachments. Please attach Informed Consents, Information Letters, data collection instrument(s), advertisements/recruiting materials, or permission letters/site authorizations as appropriate.

Signature of Investigator	<u>Stephanie Cault</u>	Date	<u>8/7/2014</u>
Signature of Faculty Advisor	<u>Seaborn P. Salk</u>	Date	<u>8/7/2014</u>
Signature of Department Head	<u>[Signature]</u>	Date	<u>8/7/14</u>

Signature Authority for Dr. E. Davis Martin, Jr.

3 of 3

APPENDIX B

Email Flyer



AUBURN UNIVERSITY

DEPARTMENT OF
SPECIAL EDUCATION,
REHABILITATION, AND COUNSELING

Dear Counselors-in-Training,

My name is Stephanie Carroll, doctoral candidate in the Department of Special Education, Rehabilitation, and Counseling at Auburn University. I would like to invite you to participate in my research study to investigate self-efficacy in providing addiction counseling. The minimum age for participation is 19 years of age or older, a current graduate student of a master's program that is preparing you to work as a mental health counselor or a recent graduate of a master's program within the past 9 months.

Participants will be asked to complete an anonymous online survey. Your total time commitment will be approximately 10-15 minutes.

As an incentive to complete the survey, the researcher will be donating \$1.00 for every complete response to Gratitude House: Women's Alcohol and Drug Rehabilitation Program. The donation will aid in their efforts "to offer rehabilitation and support services with dignity and respect to females with substance abuse and co-occurring issues in a nurturing, safe and caring environment."

The Auburn IRB has approved the study titled "Addiction Counseling Self-Efficacy of Mental Health Counselors-in-Training" Protocol # 14-292 EP 1408. If you would like to more information or have any questions about this study, an information letter or IRB approval letter can be obtained by contacting me at (sdc0011@auburn.edu) or my advisor, Dr. Suhyun Suh, at (suhsuhy@auburn.edu).

To complete the survey please click on the link or cut and paste the following link into your browser.

https://auburn.qualtrics.com/SE/?SID=SV_afxQlcbQ5ylqiuF

Thank you in advance for your consideration and participation.

Stephanie Carroll, MS.
Doctoral Candidate
Counseling Education and Supervision
Department of Special Education, Rehabilitation, and Counseling
Auburn University

2084 Haley Center, Auburn, AL 36849-5222; Telephone: 334-844-7676; Fax: 334-844-7677
www.auburn.edu/serc

APPENDIX C

Professional Contact Email Flyer



AUBURN
UNIVERSITY

DEPARTMENT OF
SPECIAL EDUCATION,
REHABILITATION, AND COUNSELING

Dear Professional Contact,

I am writing this email in efforts to enhance my data collection pool. Please pass this email flyer (I have included the letter in this email and as an attachment) to individuals that you believe would be eligible to participate in this study. I have included the IRB protocol approval # 14-292 EP 1408. If additional information is needed in order to distribute this email flyer please contact me at sd0011@auburn.edu or my faulty advisor at suhsuhy@auburn.edu. I thank you in advance for your cooperation and/or participation.

Email Flyer:

Dear Counselors-in-Training,

My name is Stephanie Carroll, doctoral candidate in the Department of Special Education, Rehabilitation, and Counseling at Auburn University. I would like to invite you to participate in my research study to investigate self-efficacy in providing addiction counseling. The minimum age for participation is 19 years of age or older, a current graduate student of a master's program that is preparing you to work as a mental health counselor or a recent graduate of a master's program within the past 9 month.

Participants will be asked to complete an anonymous online survey. Your total time commitment will be approximately 10-15 minutes.

As an incentive to complete the survey, the researcher will be donating \$1.00 for every complete response to Gratitude House: Women's Alcohol and Drug Rehabilitation Program. The donation will aid in their efforts "to offer rehabilitation and support services with dignity and respect to females with substance abuse and co-occurring issues in a nurturing, safe and caring environment."

The Auburn IRB has approved the study titled "Addiction Counseling Self-Efficacy of Mental Health Counselors-in-Training" Protocol # 14-292 EP 1408. If you would like to more information or have any questions about this study, an information letter or IRB approval letter can be obtained by contacting me at (sd0011@auburn.edu) or my advisor, Dr. Suhyun Suh, at (suhsuhy@auburn.edu).

To complete the survey please click on the link or cut and paste the following link into your browser.

https://auburn.qualtrics.com/SE/?SID=SV_afxQlcbQ5ylqiuF

Thank you in advance for your consideration and participation.

Stephanie Carroll, MS.
Doctoral Candidate
Counseling Education and Supervision
Department of Special Education, Rehabilitation, and Counseling
Auburn University
Sdc0011@auburn.edu
561-758-7903

2084 Haley Center, Auburn, AL 36849-5222; Telephone: 334-844-7676; Fax: 334-844-7677
www.auburn.edu/serc

APPENDIX D

Information Letter

Information Letter

The Auburn University Institutional Review Board has approved this document for use from <u>8/29/14</u> to <u>8/28/15</u> Protocol # <u>14-292 EP1408</u>

**INFORMATION LETTER
for a Research Study entitled
"Addiction Counseling Self-Efficacy of Mental Health Counselors-in-Training"**

You are invited to participate in a research study to assess self-efficacy in providing addiction counseling among mental health counselors-in-training. This study will examine the self-reported addiction counseling self-efficacy levels of participants. The study is being conducted by Stephanie Carroll, doctoral candidate, under the direction of Suhyun Suh, Ed. D. in the Auburn University Department of Special Education, Rehabilitation, and Counseling. You are invited to participate because you are current graduate student in a practicum or internship course(s) in a mental health counseling program or recently graduated from a mental health counseling program within the past nine months, and are age 19 or older.

What will be involved if you participate? Your participation is completely voluntary. If you decide to participate in this research study, you will be asked to complete an anonymous online survey. Your total time commitment will be approximately 10-15 minutes.

Are there any risks or discomforts? The risks associated with participating in this study are minimal but may include: possible stress related to inward reflection on self-efficacy in providing addiction counseling or discomfort when completing the survey questionnaire. Further, the research procedures may involve risks that are currently unforeseeable. However, should taking this survey result in any distress or you change your mind about participating, you may withdraw at any time (example: closing your browser window).

If you change your mind about participating, you can withdraw at any time during the study. Your participation is completely voluntary. Once you have submitted anonymous data, it cannot be withdrawn since it will be unidentifiable. Your decision about whether or not to participate or to stop participating will not jeopardize your future relations with Auburn University, the Department of Special Education, Rehabilitation, and Counseling or the College of Education.

Will you receive compensation for participating? As an incentive to complete the survey, the researcher will be donating \$1.00 for every complete response to Gratitude House: Women's Alcohol and Drug Rehabilitation Program. The donation will aid in their efforts "to offer rehabilitation and support services with dignity and respect to females with substance abuse and co-occurring issues in a nurturing, safe and caring environment."

Any data obtained in connection with this study will remain anonymous. The data you provide will be in an aggregated form so that no individual can be identified. Information collected through your participation may be used to fulfill an educational requirement, published in a professional journal, and/or presented at conferences.

If you have questions about this study, please ask them now or contact Stephanie D. Carroll by email at sd0011@auburn.edu or Dr. Suhyun Suh at suhsuh@auburn.edu. You are welcome to print this document for your personal records.

If you have questions about your rights as a research participant, you may contact the Auburn University Office of Research Compliance or the Institutional Review Board by phone (334)-844-5966 or e-mail at IRBadmin@auburn.edu or IRBChair@auburn.edu.

The Auburn University Institutional Review Board has approved this document for use from August 29, 2014 to August 28, 2015. Protocol #14-292 EP1408.

HAVING READ THE INFORMATION PROVIDED, YOU MUST DECIDE WHETHER OR NOT YOU

WANT TO PARTICIPATE IN THIS RESEARCH PROJECT. BY CLICKING "NEXT," THAT INDICATES YOUR WILLINGNESS TO PARTICIPATE.

The Auburn University Institutional Review Board has approved this document for use from 8/29/14 to 8/28/15
 Protocol # 14-292 EP 1408

Addiction Definition

This survey is looking at the perceived self-efficacy in providing addiction counselling. The following is the short definition of addiction from the American Society of Addiction Medicine (ASAM). ASAM adopted a comprehensive definition of the term addiction to encompass the current research (American Society of Addiction Medicine, 2011).

"Addiction is a primary, chronic disease of brain reward, motivation, memory and related circuitry. Dysfunction in these circuits leads to characteristic biological, psychological, social and spiritual manifestations. This is reflected in an individual pathologically pursuing reward and/or relief by substance use and other behaviors.

Addiction is characterized by inability to consistently abstain, impairment in behavioral control, and craving, diminished recognition of significant problems with one's behaviors and interpersonal relationships, and a dysfunctional emotional response. Like other chronic diseases, addiction often involves cycles of relapse and remission. Without treatment or engagement in recovery activities, addiction is progressive and can result in disability or premature death"

ACES SCALE

Directions: For each of the following, please rate how confident you are in your ability to perform these skills. There are no right or wrong answers. This is your opinion only. Use the following rating scale: 1 = no confidence to 6 = absolute confidence.

Assess a client's previous experience with self-help groups like AA, NA, CA, etc.

No Confidence						Absolute Confidence
1	2	3	4	5	6	

Show empathy towards a client.

No Confidence						Absolute Confidence
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APPENDIX E

ACES Questions

Addiction Counseling Self-Efficacy Scale (ACES)

<p>Directions: For each of the following, please rate how confident you are in your ability to perform these skills. There are no right or wrong answers. This is your opinion only. Use the following rating scale: 1= no confidence to 6 = absolute confidence.</p>	<p>No Confidence Absolute Confidence</p>					
1. Assess a client’s previous experience with self-help groups like AA, NA, CA, etc.	1	2	3	4	5	6
2. Show empathy towards a client.	1	2	3	4	5	6
3. Create a therapeutic environment where a client will feel that I understand them.	1	2	3	4	5	6
4. Convey an attitude of care and concern for all group members.	1	2	3	4	5	6
5. Work effectively with a client who has both a substance use and an anxiety disorder.	1	2	3	4	5	6
6. Develop trust and cohesion among members of a counseling group.	1	2	3	4	5	6
7. Screen clients for co-occurring mental health disorders.	1	2	3	4	5	6
8. Help a client determine who is available to support her/his recovery.	1	2	3	4	5	6
9. Work effectively with a client who has both a substance use and a psychotic disorder (e.g., schizophrenia).	1	2	3	4	5	6
10. Use assessment data to develop a treatment plan.	1	2	3	4	5	6
11. Help members of a counseling group challenge each	1	2	3	4	5	6

other responsibly.						
12. Work effectively with a client who has both a substance use and a personality disorder.	1	2	3	4	5	6
13. Assess a client's readiness to change substance use.	1	2	3	4	5	6
14. Help a client develop realistic expectations about recovery.	1	2	3	4	5	6
15. React spontaneously and responsively in a group counseling situation.	1	2	3	4	5	6
16. Work effectively with a client who has both substance use and trauma-related issues.	1	2	3	4	5	6

Directions: For each of the following, please rate how confident you are in your ability to perform these skills. There are no right or wrong answers. This is your opinion only. Use the following rating scale: 1= no confidence to 6 = absolute confidence.	No Confidence						Absolute Confidence
	1	2	3	4	5	6	
17. Teach a client about self-help support networks and related self-help literature.	1	2	3	4	5	6	
18. Help a client figure out what behaviors will support recovery.	1	2	3	4	5	6	
19. Help a client recognize what triggers her/his substance use.	1	2	3	4	5	6	
20. Write accurate and concise assessment reports.	1	2	3	4	5	6	
21. Assess a client's financial concerns.	1	2	3	4	5	6	
22. Summarize a client's treatment and recovery information for other professionals.	1	2	3	4	5	6	

23. Establish a warm, respectful relationship with a client.	1	2	3	4	5	6
24. Gather information about a client's prior experiences with substance abuse treatment.	1	2	3	4	5	6
25. Challenge behaviors that interfere with a client's recovery.	1	2	3	4	5	6
26. Form a counseling group, including determining the type of group and selecting members.	1	2	3	4	5	6
27. Help members of a counseling group support each other.	1	2	3	4	5	6
28. Work effectively with a client who has both a substance use and a mood disorder (e.g., depression).	1	2	3	4	5	6
29. Explore the interpersonal dynamics among members of a counseling group.	1	2	3	4	5	6
30. Use active listening techniques when working with a client.	1	2	3	4	5	6
31. Maintain a respectful and nonjudgmental atmosphere with a client.	1	2	3	4	5	6

APPENDIX F

Demographic Questionnaire

- A. I received addiction counseling education in my master's degree program through (Please select only one):
- An addiction-specific course only
 - Integration throughout my curriculum with no addiction-specific course
 - A combination of an addiction-specific course and integration throughout my curriculum
 - No formal education from my master's degree program

B. Gender:

- Female
- Male
- Self-Identified:

C. My age: (fill in blank)

D. Ethnicity:

- Asian
- Black/African American
- Hispanic / Latino(a)
- American Indian
- White/ Caucasian
- Biracial/Multiracial (fill in the blank)
- Self-Identified (fill in the blank)

E. My master's degree program area is:

- Clinical Mental Health Counseling
- Community Counseling
- Mental Health Counseling
- Other, specify:

F. My master's program is:

- CACREP
- Non CACREP
- I don't know

G. My progress in my master's counseling education:

- _____ Current practicum student
- _____ Current internship student
- _____ Recent graduate within the past nine months
- _____ Other, specify:

H. My master's program is located in:

- _____ Midwestern Region (IL, IN, IA, KS, MI, MN, MO, NE, ND, OH, OK, SD, WY)
- _____ North Atlantic Region (CT, DE, District of Columbia, Europe, ME, MA, NH, NJ, NY, PA, Puerto Rico, RI, VT, Virgin Islands)
- _____ Southern Region (AL, AR, FL, GA, KY, Latin America, LA, MD, MS, NC, SC, TN, TX, VA, WV)
- _____ Western Region (AK, AZ, CA, CO, HI, ID, MT, NV, MN, OR, Philippines, UT, WA, WY)

I. What additional information would be helpful to know to serve individuals with an addiction(s) or addition related issue(s)? Please describe.

APPENDIX G

Donation Page

Thank you for your participation. A \$1.00 donation will be given to Gratitude House.

Gratitude House's primary mission is to offer rehabilitation and support services with dignity and respect to females with substance abuse and co-occurring issues in a nurturing, safe and caring environment. They provide top quality individualized programs to women in need of help in a loving, wholesome atmosphere, without regard for race, religion, political preference, or national origin. The primary purpose is to return such women to society as self-sufficient, productive citizens.

See more at: <http://www.gratitudehouse.org/>



The researcher, faculty advisor, and Auburn University is no way associated with Gratitude House.

APPENDIX H

Conclusion Page

Participant,

This completes the survey portion. During this study, you were asked to complete multiple questionnaires. You were told that the purpose was to study counselors-in-training self-efficacy and this was in fact the actual purpose of this study.

If you have any concerns about your participation or the data you provided, please discuss this with us. We will be happy to provide any information we can to help answer questions you have about this study.

If your concerns are such that you would now like to have your data withdrawn, and the data is identifiable, we will do so. However, due to the anonymous nature of the data, it is likely that once you have entered data, there will be no way to identify your responses for removal.

If you have any questions about your participation in the study, please contact Stephanie D. Carroll by email at sd0011@auburn.edu or Dr. Suhyun Suh at suhsuh@auburn.edu

If you have questions about your rights as a research participant, you may contact the Office of Human Subject Research at (334-844-5966, hsubjec@auburn.edu) or Auburn University's Institutional Review Board (IRBChair@auburn.edu).

APPENDIX I

ACSES Approval Email

RE: Permission to use ACSES

Wendler, Alicia M. [Alicia.Wendler@va.gov]

Sent: Monday, September 23, 2013 7:59 AM

To: Stephanie Carroll

Stephanie, let me know if the attachments went through.

From: Wendler, Alicia M.

Sent: Monday, September 23, 2013 7:57 AM

To: 'Stephanie Carroll'

Subject: RE: Permission to use ACSES

Stephanie, of course you have my permission to use the ACSES. I will attach a copy of my dissertation that explains the most recent scale, as well as the scale itself. Best wishes.

From: Stephanie Carroll [mailto:sd0011@auburn.edu]

Sent: Friday, September 20, 2013 8:24 AM

To: Wendler, Alicia M.

Subject: Permission to use ACSES

Dear Dr. Wendler,

My name is Stephanie Carroll and I am a doctoral student at Auburn University. I am writing to ask your permission to use the Addiction Counseling Self-Efficacy Scale (ACSES) in my dissertation research. I recently contacted Dr. Murdock regarding the ACSES scale and she informed me that you are the individual to whom I should communicate with. I initially located Dr. Murdock's contact information on the Alcohol & Drug Abuse Institute Library website. If you grant permission to use the scale, acknowledgement will be given and I would be willing to share my research findings with you.

My dissertation proposal is an investigation of master level counseling students' self-efficacy in providing addiction counseling. I plan to study their self-efficacy in both substance and process addiction counseling. Your scale would be used in conjunction with an additional survey measurement specific to process addiction.

Please reply at your earliest convenience whether using the ACSES scale is a possibility and if there are any further steps that may be needed to obtain permission to use this scale.

Thank you for your time,

Stephanie Carroll

Doctoral Student - Counseling Education and Supervision

Special Education, Rehabilitation, Counseling Department

Auburn University

sd0011@auburn.edu
