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Experience Versus Education: Empathy in Substance Use Disorder Counselors

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This is to certify that the doctoral dissertation by

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Abstract

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MSW, Walla Walla College, 2004

Submitted in Partial Fulfillment

of the Requirements for the Degree of

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Abstract

Empathy is one of the most important skills a mental health counselor can have. For instance, empathy plays a key role in retention and engagement in therapy for substance use disorder (SUD), which leads to improved client outcomes. Historically, SUD treatment has been provided by those in recovery with little formal education about counseling. Currently, academic requirements for SUD counselors vary, and most master's level education programs rarely address SUDs. To determine whether SUD experience alone is related to empathy, a 2x2 factorial ANOVA was used in this study to examine the relationship between two independent variables (education status and recovery status) against the dependent variable of empathy for 607 SUD counselors. Findings showed that recovery status was not indicative of SUD counselor empathy, and graduate level education was associated with empathy in SUD counselors. As the epidemic of addiction continues to grow, having a competent workforce of licensed/credentialed SUD counselors is imperative, and this research shows that having a master's degree in counseling may influence empathy in SUD counselors. Thus, the results of this research have the potential to shape licensure/credentialing processes for those seeking a career in the SUD field and improve outcomes for individuals with a SUD.

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Dedication

This project is dedicated to all of the individuals that are struggling with substance-use disorder and those treatment professionals striving to help. Keep searching, hoping, advocating and working for change.

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Chapter 1: Introduction to the Study

Introduction

Although decades of research have demonstrated the importance of empathy for improved patient relationships and outcomes (Buser, 2008; Elliot, Bohart, Watson, & Greenburg, 2011; Moyers & Miller, 2013; Neukrug, Bayne, Dean-Nganga, & Pusateri, 2013; Wheeler, 2000), there has been little research on the relationship between graduate-level education on counselors' ability to demonstrate empathy (Baggerly & Osborn, 2013; Gockel & Burton, 2014; Neukrug et al., 2013; Teding van Berkout & Malouff, 2015). Thus, master's level counselors may not be learning empathic skills, which indicates issues with the efficacy of counseling pedagogy. However, it is not clear whether having a master's degree is necessary to be an empathic counselor, especially in the field of substance-use disorder (SUD) treatment.

This chapter provides the premise of this study, beginning with a background of the problem followed by sections describing the purpose of the study, research questions and hypotheses, the theoretical framework and the nature of the study, objectives, and theoretical base. Operational definitions, assumptions, limitations, and the scope of the study are also described. This chapter will conclude with a description of the significance of the research and its potential impact for social change.

Background

Unlike other counseling and mental health practitioners, SUD counselors may be in recovery themselves for the disorder that they treat (Duryea & Calleja, 2013; Jones, Sells, & Rehfuss, 2009; Toriello & Strohmer, 2004). Historically, SUD has been treated

by people who have recovered, with their shared experience with SUD as the foundation of their practice and treatment centers often hiring based on recovery status (Crabb & Linton, 2007; Ham, LeMasson, & Hayes, 2013; Toriello & Strohmer, 2004; White, 2010). The assumption that those in recovery from SUD are better able to counsel SUD clients than SUD counselors not in recovery is reflected in the education requirements and licensure processes across the United States (Duryea & Calleja, 2013; Iarussi, Perjessy, & Reed, 2012; Miller, Scarborough, Clark, Leonard, & Keziah, 2010; Woo et al., 2013). Most states require graduate level education to be licensed as a mental health counselor, whereas SUD counselors can often practice with minimal education, and some states do not even have licensure (Kerwin, Walker-Smith, & Kirby, 2006). According to the National Association of Alcohol and Drug Abuse Counselors (NAADAC), licensure requirements and standards vary in all 50 states: some states allow licensure at an Associate's degree level while some require a Bachelor's degree.

Although it has been demonstrated that SUD counselors in recovery are able to quickly establish rapport and gain trust (Duryea & Calleja, 2013; Iarussi et al., 2012), there is little research supporting the efficacy of counselor recovery status (in recovery or not in recovery) in comparison to education (graduate level education or no graduate level education) in facilitating empathy with SUD clients. For most student-counselors, empathic rapport is learned and practiced during their graduate-level internship in a hands-on, experiential setting (Aladag, 2013; Donohue & Perry, 2014; Gockel & Burton, 2014). However, for the field of SUD treatment, the ability of SUD counselors to exhibit empathy may come from their own history of recovery (Doukas & Cullen, 2011; Myrick

& del Vecchio, 2016; Toriello & Strohmer, 2004). Therefore, graduate education and its associated clinical internship may not be needed to establish empathy with the SUD client population when the SUD counselor is in recovery. This study was conducted to examine whether education or experience created a difference in empathy for SUD counselors.

Problem Statement

Although the importance of empathy and therapeutic rapport between client and counselor has been documented, the methods for ensuring that counselors have these essential skills are varied and subjective (Coutinho, Silva, & Decety, 2014; DeAngelis, 2014; Elliot et al., 2011; Neukrug et al., 2013). In the field of SUD treatment, the ability to establish a therapeutic relationship and empathic rapport is especially important, as SUD clients tend to be resistant to recovery and struggle with motivation (Brownlee, Curran & Tsang, 2017; Morandi, Silva, Golay, & Bonsack, 2017). However, the field of SUD treatment is different from other mental health fields in that many counselors are often in recovery from SUD themselves (Ham et al., 2013; Myrick & del Vecchio, 2016), and the evolution of SUD treatment is of peer-support and paraprofessionals (Giordano, Clarke & Stare, 2015; Kerwin et al., 2006; Myrick & del Vecchio, 2017; White, 2010). These two dynamics give SUD counselors in recovery a unique shared experience with their clients not seen in other fields. This shared history often allows the establishment of empathy to occur quicker than in nonrecovery SUD counselors (Ham et al., 2013; Myrick & del Vecchio, 2016; White, 2010). In this study, I aimed to build on previous research

by comparing empathic ability among SUD counselors across recovery status and education.

Purpose of Study

The purpose of this study was to explore the relationship between SUD counselor empathic ability across education and recovery status. Students who seek higher education through a master's degree improve their clinical skills, which includes empathy. In the field of SUD treatment, however, many of the counselors are in recovery and have learned empathy through real-life recovery experience. Historically, SUD counselors have been paraprofessionals, often using their own recovery process to enter a professional role (Ham et al., 2013; Iarussi et al., 2012; White, 2010). Further, there are no national guidelines or standards for licensure for SUD counselors (Giordano et al., 2015; Iarussi et al., 2012), and earning a master's degree is not necessarily a step for becoming a professional SUD counselor. Thus, I conduced this quantitative study to fill the gap in the literature regarding empathy in SUD counselors, comparing education and recovery status.

Research Questions and Hypotheses

To address the gap in the literature regarding empathy in SUD counselors across recovery status and education, I aimed to answer the question "Is the expression of empathy among SUD counselors related to recovery status (in recovery or not in recovery) and/or education (graduate level training or no graduate level training)?" The following research questions and hypotheses were established to direct the study:

Research Question 1: Is recovery status associated with empathy in substance use disorder counselors?

$H1_0$ There is no relationship between recovery status and empathy in substance use disorder counselors.

$H1_1$: There is a relationship between recovery status and empathy in substance use disorder counselors such that substance use disorder counselors in recovery will have more empathy with their clients than substance use disorder counselors without recovery.

Research Question 2: Is educational attainment associated with empathy in substance use disorder counselors?

$H2_0$ There is no relationship between education status and empathy in substance use disorder counselors.

$H2_1$: There is a relationship between education status and empathy in substance use disorder counselors such that substance use disorder counselors with master's level education will have more empathy with their clients than substance use disorder counselors without master's level education.

Research Question 3: Is there an interaction between recovery status and education on empathy in substance use disorder counselors?

$H3_0$ There is no relationship between recovery status, education status and empathy in substance use disorder counselors.

$H3_1$: There is a relationship between recovery status, education status and empathy in substance use disorder counselors such that substance use disorder counselors

in recovery and with a master's degree will score higher on a measure of empathy than substance use disorder counselors not in recovery or without a master's degree.

In summary, I sought to explore whether empathic ability of SUD counselors in recovery is just as effective as SUD counselors with graduate-level education in establishing empathy with SUD clients using a 2x2 factorial ANOVA. The null hypothesis is that graduate-level education and recovery have no effect on SUD counselors' ability to demonstrate empathy. Empathy was assessed in SUD counselors using the Affective and Cognitive Measure of Empathy (ACME; Vachon & Lynam, 2016) across the variables of education status and recovery status to determine impact on the empathic ability of SUD counselors.

Theoretical Framework

Learning is a complex endeavor. Various theories of learning help teachers design and implement instruction plans to meet specific learning objectives (Ertmer & Newby, 1993). By identifying and establishing learning objectives and research-based methods of instruction, teachers and instructional designers can establish measurable benchmarks that assure the student has learned a skill. Although there are several learning theories, the constructivist theory is most appropriate for counselors learning empathic skills. The constructivist theory of learning follows the premise that absorbing knowledge, integrating it into the knowledge base of the learner, and applying the knowledge in a hands-on setting is how learning happens (Vogel-Walcutt, Gebrim, Carper, & Nicholson, 2010). Because learning to be a counselor involves absorbing knowledge (therapeutic modalities, diagnosis, intervention methods) and then practicing the application of that

knowledge (role-playing, experiential, internships), the constructivist theory of learning is the best fit for examining counselor education (Ertmer & Newby, 1993; Jones & Lynddon, 1997). Although formally educated master's level counselors follow the constructivist theory of learning by engaging in an internship, SUD counselors do not always attain a master's degree and may not complete an internship. Additionally, many SUD counselors are in recovery and their real-life recovery experience often mirrors the internship process in terms of gaining knowledge and applying recovery skills in real-life. This real-life experience also parallels the constructivist theory by demonstrating knowledge acquisition followed by hands-on experience.

Nature of the Study

This study was quantitative in nature and compared levels of empathy of SUD counselors across recovery status (in recovery or not) with education level (master's degree or not). Empathy was assessed using the ACME, which is a tool designed to assess empathy and the ability to predict the prosocial behavior that typically accompanies it (Vachon & Lynam, 2016). This study had two independent variables with two levels each: education status (with a master's degree or not) and recovery status (in recovery from a SUD or not). The dependent variable was the empathic skill ability of the SUD counselor as measured by the ACME. Data were collected via e-mail solicitation for participants from a national pool of SUD counselors who are members of the National Association of Alcohol and Drug Abuse Counselors (NAADAC). As I aimed to examine the relationship of two independent variables on the dependent variable, data were

analyzed using a 2x2 factorial ANOVA. Chapter 3 will provide more in-depth description of the method and data collection of the study.

Definitions

Empathy: This encompasses the ability to demonstrate empathy, establish therapeutic rapport, and build positive relationships with clients. It includes listening skills, communication, and trust-building with clients (Clark, 2010). Empathy is further defined as the "ability to accurately perceive the internal frames of reference of clients and to accurately communicate those feelings back to them" (Coats, 2012, p. 41). For the purpose of this study, empathy was based on the scores from the ACME (Vachon & Lynam, 2016).

Licensure/credentialing: These two terms are often used interchangeably. Unique to the field of SUD is that not all states have a license specific to SUD; however, all states have a professional counselor or clinical social work license. Requirements for licensure as an SUD counselor vary per state; some require an associate's degree and most have "levels" useful to having a bachelor's or master's degree (Kerwin et al., 2006). Some states do not issue a license for SUD counselors and instead issue a credential. NAADAC does provide for credentialing for master's level SUD counselors, but this is an endorsement and is not recognized in all states or by the majority of third-party reimbursement companies (White, 2014a).

Recovery: Being in recovery was one of the independent variables in the study. For this study, being in recovery indicates an individual that has struggled with a SUD in the past but now works a program of an abstinence-based lifestyle. Participants must have

been abstinent and in their recovery program for at least a year, which is reflective of the current *Diagnostic and Statistical Manual (DSM)* where criteria fit within a 12-month time-frame published by the American Psychiatric Association (APA) for substance-use disorder (APA, 2013).

Substance use disorder (SUD): This is defined by the APA as a pathological behavior pattern surrounding the use of a mood-altering chemical meeting at least two criteria across the categories of impaired control, social impairment, risky use, and tolerance and/or withdrawal (APA, 2013). SUD is often referred to as "addiction," and these terms are used interchangeably.

Substance use disorder counselor: Although this definition varies by state, a SUD counselor is typically a counselor who specializes in treating individuals with SUD. Some states require master's level education, and others do not. Most states have a credential or licensure that identifies a person as having specialized training in SUD treatment (Kerwin et al., 2006). For this study, a SUD counselor was an individual that has been licensed or credentialed in their state of residence and works primarily with SUD clients.

Assumptions

An assumption of the study is that attaining education in counseling equates adequate training in how to be an effective counselor, which would indicate that students have learned how to demonstrate empathy. As each participant in the study had a minimum of a bachelor's degree, it was assumed that they had met minimal education standards. Each participant also held a license or credential as a SUD counselor, and it

was assumed that they were minimally competent to conduct SUD therapy and able to establish empathy with SUD clients. It was further assumed that participants in the study responded honestly to the demographics and questionnaire. As their names were not known to me and steps were taken to protect their confidentiality, it was assumed that participants felt comfortable being honest in their responses.

Scope and Delimitations

The focus of the study was to determine the effect of two independent variables, counselor recovery status and education, on the dependent variable, counselor empathy as assessed by the ACME (Vachon & Lynam, 2016). These variables were chosen after a review of the literature on counselor education and SUD treatment because the effect of these two variables on SUD counselor empathy were the most neglected in the literature. Participants for the study were solicited from a national pool of SUD counselors to best reflect the population of SUD counselors as a whole, increasing generalizability.

Threats to internal validity were managed by defining the independent variables and choosing a measurement tool that is demonstrated to assess individual empathy. Factors that would exclude a participant include not being licensed/credentialed as a SUD counselor (as it is assumed that having a license or credential indicates a certain level of competency) and not having a degree of any kind. Appropriate participants were licensed/credentialed as SUD counselors in the state they reside in and either in recovery or educated at the master's level or both.

The variable of education status was also defined to better control internal validity. Due to the variety of master's degrees that may lead to becoming a professional

counselor, I defined a master's degree as a graduate-level degree in the field of counseling or a related field such as social work. Due to that variability, participants in the study may have a master's in family counseling, mental health counseling, social work or human services; all of these programs may have different curricula and accreditations but their core rests in preparing students to be counselors. This variability in the sample was managed by excluding participants who do not hold a master's degree in counseling or social work. Participants with a master's degree in a field other than counseling or social work were excluded because students seeking a career as a professional counselor typically attain a master's degree in counseling of social work and most of the research conducted on counselors learning empathy are conducted with students in programs for these degrees.

Choosing the quantitative method of inquiry was another attempt to better control threats to internal validity. First, as I have been a SUD counselor and teacher for over a decade, I wanted to reduce the risk of any personal bias that may affect interviews and interpretation. Quantitative research helped reduce researcher bias due to reducing influence of personal characteristics that may arise in qualitative exploration (Frankfort-Nachmias & Nachmias, 2008). The method of collecting data was also an attempt to ensure validity; data were collected via e-mail and online survey. Mail or e-mail is preferable when participants must use contemplation or self-assessment (versus immediate and face-to-face answer), as it allows for participants to fully consider their response, ensuring accuracy of data collected. Using mail or e-mail also is preferred when asking for information from participants that may be sensitive (such as recovery

status) and provides for better anonymity for participants (Frankfort-Nachmias & Nachmias, 2008).

An additional threat to validity is that the participants were not randomly assigned to groups and were self-selected to their group based on information provided in their demographics. Self-selected groups can affect validity by leaving out certain variables that may be relevant (Frankfort-Nachmias & Nachmias, 2008). As participants were all voluntary, there may be relevant information that was not collected due to individuals choosing to not be in the study. Additionally, SUD counselors who are not members of NAADAC were not part of the participant pool, providing an additional threat to validity.

Limitations

The sampling method was one limitation of the study. Using a convenience sample limited the generalizability of the study due to convenience samples not necessarily being an accurate reflection of the population (Frankfort-Nachmias & Nachmias, 2008). An additional limitation of the study is that the ACME is a self-report document, meaning that it does not measure the clients' perception of empathy of the counselors. However, ethical research often shies away from using clients as a part of the research process because they may feel obligated to participate (Fisher, 2009). Additionally, the ACME was chosen because it is designed to assess internal reflections of empathy that may better reflect empathy being demonstrated by the individual (Vachon & Lynam, 2016).

This study was also limited due to the ambiguous nature of empathy and the innate differences between human dyads and their interactions that cannot be quantified

or defined. It is also not possible to measure all factors that may affect a counselor's ability to demonstrate empathy, such as life experiences, or the client's internal resistance and internal motivation. This limitation was addressed by using the ACME the method to assess for internal capacity for empathy because mitigating factors that may affect empathy would not be possible.

Significance

Of the estimated 7 billion people living on the planet, an estimated 230 million use illegal drugs on an annual basis, and 27 million people are classified as addicted; of these, it is estimated that 11.8 million of these are classified as disabled due to their substance-use (Brorson, Arnevik, Rand-Hendriksen, & Duckert, 2013). The incidence of SUD and its impact on society is seen on the nightly news and effects all demographics (Druyea & Calleja, 2013). The Substance Abuse and Mental Health Services Administration (2016) estimates 20.2 million American adults have a SUD that, according to National Institute of Drug Abuse (2015), costs Americans $417 billion per year. Further, roughly 90 Americans die from drug overdose each day, and the opioid epidemic is affecting the areas of criminal justice, child protection, social welfare, and medical arenas (Bingham, Cooper, & Hough, 2016). This epidemic of SUD means that having a qualified workforce to treat SUD is imperative. But there is currently a lack of empirical evidence to indicate the most way to ensure that SUD counselors have the empathic skills required to treat SUD. The results of this study have implications for positive social change in how a workforce of SUD counselors are trained to treat this growing problem.

Summary

Ensuring that SUD counselors are proficient and capable counselors provides security for the general population as they fight the problem of SUD. This study aimed to better define the relationship of empathy for SUD counselors across education and recovery status ensuring a capable workforce and improved client outcomes. The following chapters will support the need for this research, explain how this study was structured, conducted, and explained. The literature review in Chapter 2 will provide the first portion of this process: defining and establishing that empathy and empathic skills such as therapeutic rapport are essential components of effective counseling, particularly for SUD clients. The literature review will also describe the education process for counselors and the evolution of the SUD treatment field. The opportunity for social change is that counselors will know whether their continued education will lead to improved empathic skills and improve outcomes for their patients and ensure an effective workforce to address America's SUD problem. This may help to shape a much-needed workforce and improve the long-term outcomes for SUD clients.

Chapter 2: Literature Review

Introduction

The purpose of this study was to explore the relationship between education level and recovery status with SUD counselors' ability to demonstrate empathy. This chapter will begin by describing the literature search strategy and the theoretical orientation for the study. This literature review will then identify and establish the need for further exploration of the topic by defining empathy and supporting its importance for the efficacy counseling, especially for SUD treatment. Next, this review will provide an overview of learning empathy including the neurological underpinnings of empathy and the process for teaching empathy in academic settings. Third, this review will describe the importance of empathy for SUD counselors and its importance for positive outcomes for SUD clients. This chapter will also include the education process and include how SUD counselors in recovery may have an advantage to demonstrating empathy with SUD clients. The evolution of SUD treatment will be described and set the precedent for those in recovery having experience instead of education as their mantel. Finally, this review will demonstrate the gap in literature regarding whether SUD counselors in recovery are just as competent at showing empathy as those who are not in recovery but have a higher degree.

Literature Search Strategy

To fully explore this topic, a search of literature was conducted through psychology, counseling, and medical databases such as PsycINFO, PscyARTICLES, and ProQuest. Key search words included *empathy, empathic skills, constructivism,*

education-level, substance-use, substance-use recovery, counselor learning, and *learning empathy*. To identify current research, recent dissertation publications were also searched. There is formative, seminal literature about empathy and the counseling profession and current, peer-reviewed research about education and instruction of counselors. Historical information provides a baseline for the use of and description of empathy in the therapeutic setting, whereas more current, peer-reviewed literature explores the empathic skill acquisition process, including learning theory and practice for education of student counselors. Research on the evolution of the SUD profession is also included and provides the premise of experiential, versus academic, process for empathy acquisition.

Theoretical Foundation

Theories of learning ensure that the instructional design is aligned with the fulfillment of learning objectives (Volgel-Walcutt, Gerbrin, Bowers, Carper, & Nicholson, 2011). First, the needs and purpose of learning need to be established. For instance, it is frequently argued that the most important skill for counselors to learn is empathy and how to communicate it (Coutinho et al., 2014; Elliot et al., 2011; Neukrug et al., 2013; Teding van Berkout & Malouff, 2016). After what needs to be learned has been established, instructional designers can determine which learning theory will best fulfill the learning objectives and design the course accordingly (Volgel-Walcutt et al., 2011; Wildman & Burton, 1981). Key instructional designs are behaviorism, cognitivism, and constructivism (Instructional Design Knowledge Base, 2012).

Behaviorism, with its emphasis on observable performance or demonstration, is part of learning to be a counselor, particularly with regard to the behaviors of the counselor and the body language used when establishing therapeutic rapport. Consistent use of body language to communicate with clients is essential for student-counselors to learn. Cognitivism describes the internal process of cognitively integrating concepts and ideas into previously established mental scaffolding (Volgel-Walcut et al., 2011). Learning, from a cognitivist perspective, is described as an internal process of acquiring knowledge then integrating it and applying it in an experiential setting (Instructional Design Knowledge Base, 2012).

In comparison to behaviorism and cognitivism, the constructivist theory holds that the learner is interactive with their environment and learning is partially dependent on how learners perceive what is around them and what meaning they create from it. Engaging in experiences and tasks are a cornerstone of constructivist theory (Ertmer & Newby, 1993; Jones & Lynddon, 1997). Constructivism, unlike cognitivism and behaviorism, suggest that concepts must be mentally acquired, processed, integrated and result in demonstration of skills that reflect the internal mental concepts (Ertmer & Newby, 1993; Volgel-Walcut et al., 2011). The constructivist theory of learning states that knowledge is about change, integration, and coordination with the dynamics of the surrounding environment (Campbell, 2006).

The constructivist theory is built on the work of Jean Piaget, who provided the foundation for what would become the constructivist theory of learning based on theorizing how children learn (Labinowicz, 1980; Mooney, 2013). He observed that

children learn by interacting with their environment and adjusting their thought concepts accordingly, suggesting that learning is reliant on the interactions of the environment and develops by interaction between internal knowledge and external experiences (Mooney, 2013). Intellectual development comes when individuals allow their environment and experiences to shape what they know and how it is integrated into their own scaffolding (Labinowicz, 1980). Personal past experiences, in conjunction with current situations and perceptions, create a new intellectual construct that subsequently interacts with the environment to create yet another construct, and so on and so forth (Labinowicz, 1980). In terms of learning empathy, Piaget explored how children learn and described the developmental process of emotional awareness and being able to recognize and describe emotion in oneself and others (Lane, 2000). The foundation laid by Piaget was incorporated into the practice of counseling by Carl Rogers, who defined empathy in counseling and solidified its importance for effective counseling (Coates, 2012; Elliot et al., 2011; Holm, 1997; Neukrug et al., 2013).

For a counselor, the constructivist theory describes the typical course of learning how to be a counselor—classroom learning of theories and modalities followed by hands-on practice and application in an internship (Volgel-Walcut et al., 2011). Student counselors often spend the first part of their graduate work in the classroom learning theories of counseling, history, and techniques. The latter part of their graduate program typically focuses on a clinical internship placement where student counselors begin to apply and practice what they have spent classroom time learning (Aladag, 2013; Buser, 2008; Dalgin, Bruch, & Barber, 2010; Donohue & Perry, 2014). Counseling is an

interactive relationship between the counselor and the client that relies on empathy and understanding for effectiveness (Lyons & Hazler, 2002). Learning empathic skills requires interaction and processing of the surrounding environment (Ferrari, 2014). For counselors, empathic skill acquisition occurs during the internship placement in their academic program or in their on-the-job training. Thus, completion of a graduate counseling degree should prepare a student-counselor for licensure and a professional career with empathic skills. However, there is variation in academic settings that leaves a gap in empathic skill acquisition, meaning that attaining a graduate degree does not ensure a counselor will have the ability to establish empathy (Buser, 2008; Crowe et al., 2013; Donohue & Perry, 2014; McCutcheon, 2009; Stedman et al., 2013; Woodside, Ziegler, & Paulus, 2009). The clinical competence of student-counselors relies on the student-counselor's ability to establish a therapeutic rapport and demonstrate empathic skills, both of which are believed to translate to improved client outcomes (Buser, 2008; Elliot et al., 2011; Gerdes & Segal, 2011).

Literature Review Related to Key Concepts

There are three main aspects that are relevant to this study: empathy in counseling, teaching empathy, and empathy and SUD counselors. This section will begin by describing the importance of empathy in the counseling setting and also the ambiguity in teaching empathy to counselors. Next, previous key studies on empathy in counseling and SUD counseling specifically will be examined. This section will conclude with a brief history of SUD counseling.

Empathy

Empathy connects people to each other in a fundamental way. Eisenburg defined empathy as “an affective response that mimics another person’s emotional state” (as cited in Fiske, 2010, p. 365). Empathy differs from sympathy in that sympathy indicates that the individual is experiencing the other person’s feelings, whereas empathy indicates appreciating and acknowledging the emotional state of another (Stepien & Baernstein, 2006). Thus, empathy is the ability to see things from another’s perspective (Clark, 2010; Stepien & Baernstein, 2006), and it is the ability to communicate compassion and understanding of the patient’s perspective (Lelorain, Bredart, Dolbeualt, & Sultan, 2012; Neukrug et al., 2013).

Learning to be empathetic begins in childhood as a natural act of effective communication and relationship-building (Coutinho et al., 2014; Ferrari, 2014). There is a neural basis for empathy: when observing an aversive experience or emotion in others, the amygdala and other key areas in the brain get activated (Ferrari, 2014; Fisk, 2010), helping people feel compassion and empathy toward others and form attachments to others. Further, empathy is related to healthy prosocial behavior, whereas poor empathy is associated with aggressive behavior and antisocial tendencies (Ferrari, 2014; Teding van Berkhout & Malouf, 2015).

Although empathy is an innate trait that helps connect to others (Coutinho et al, 2014), being able to have an enhanced sense of empathy and the ability to express it is a necessity for a counselor to be effective with a client. The task of learning to “be with” a client and empower them is often neglected in clinical training (Gockel & Burton, 2014;

Hill et al., 2008; Neukrug et al., 2013; Teding van Berhout & Malouff, 2016). The skills of showing empathy can and must be learned by counselors (Coll, Doumas, Trotter, & Freeman, 2013; Hill et al, 2008; Neukrug et al., 2013). However, there is variation among counselor educators as to what learning objectives are emphasized, and specific empathy training is not always included in the academic plan (Aladag, 2013; Malott, Hall, Sheely-Moore, Krell, & Cardaciotto, 2014; Neukrug, 2013; Teding van Berkhout & Malouff, 2016).

Empathy and Counseling

Empathy was initially conceptualized by psychotherapist Carl Rogers in the 1950s as something that counselors needed to be able to understand the client's experience as their own (Elliot et al., 2011; Holm, 1997; Neukrug et al., 2013). Empathy has since been defined and discussed in the psychotherapy and counseling literature and described as essential to the therapeutic relationship (Neukrug et al., 2013; Teding van Berkout & Malouff, 2016). Empathy is an other-oriented emotional response (Batson, Chang, Orr, & Rowland, 2012) and is the ability for the counselor to see things from the perspective of the client and convey that understanding back to the client. This rapport is essential in the counseling relationship and essential for effective counseling (Clark, 2010; Coutinho et al., 2014; Elliot et al., 2011; Neukrug et al., 2013; Shumaker, Ortiz, & Brenninkmeyer, 2011). Empathy is also an understanding of the clients' perspective and a desire to learn about the client, which is possible when the counselor suspends their own personal biases (Rubel & Ratts, 2011). Thus, in the field of counseling, empathy is multifaceted: it is the ability to demonstrate compassion, validation, and internalization of another's feelings or

experiences, and it allows for a relationship between the counselor and client that is beneficial and safe for the client (Coutinho et al., 2014; Gerdes & Segal, 2011; Lyons & Hazler, 2002; Miville, Carlozzi, Gushue, Schara, & Ueda, 2006; Neukrug et al., 2013). The importance of empathy on therapeutic relationships has been well-established as a predictor of positive client outcomes and has been emphasized as a foundation for change in therapy (Churchill, Susy, Bayne, & Rowan, 1998; Coutinho et al., 2014; Elliot et al., 2011; Gerdes & Segal, 2011; McLeod, 2011; Moyers & Miller, 2013). The more empathic the counselor is, the more validated the client feels and the better able the counselor is to respond to the needs of the client (Coutinho et al., 2014).

Previous studies have been conducted to show the important of empathy in counseling. For example, Joice and Mercer (2010) examined the relationships between client perceived empathy from the counselor and client outcomes in a 6-week therapy group of 66 individuals. They found a significant positive correlation ($r = .501$, $n = 58$, $p < 0.001$) between pre- and post-scores for client outcomes, suggesting that amount of empathy shown early in the therapeutic process led to continuing in the therapy program. This finding is significant to the field of SUD, where group therapy is increasingly used. Further examination of the relationship between counselor empathy and client outcomes has been conducted by Elliot et al. (2011), who determined that empathy has a moderately positive correlation to client outcomes (mean weighted $r = .31$, $p < .001$) and indicated that there is a causal model between counselor empathy and positive client outcomes, though they were unable to determine whether empathy was the cause of good therapy or merely a correlate. Finally, Kwon and Jo (2012) used client feedback and

interpretation through a correlational analysis and found that counselors with more experience had better empathic accuracy ($r = .399$, $p < 0.01$) for clients and that empathic accuracy led to better client outcomes ($r = .298$, $p < 0.05$). They also found that counselors with high empathy skills were just as effective as experienced counselors with less education in creating positive outcomes. This highlight the variables of life experience versus education, indicating that experience outweighs education in demonstrating empathy.

Empathy Education

The above research (Elliot et al., 2011; Joice & Mercer, 2010; Kwon & Jo, 2012) supports that empathy is a key component to client engagement and positive outcomes; counselors who are proficient at establishing an empathic relationship with their clients are more likely to be able to create and sustain positive change, which leads to improved outcomes. Despite its importance, the instruction of empathy is not a standard part of the academic training for counselors. The formal education process for counselors typically follows classroom knowledge acquisition followed by a hands-on, experiential process because experienced counselors are better able to establish therapeutic rapport with clients and better able to facilitate trustful communication (Nyman, Nafziger & Smith, 2010). However, professional training for the helping professional is often focused on the learning theories and concepts of counseling rather than on learning to apply those skills effectively (Ladany, as cited in Goekel & Burton, 2014).

Previous research has indicated a focus on theory in counselor education as well as a lack of consistency. To better understand the foundational skills of student-

counselors, Aladag (2013) reviewed the base counseling skills of 11 undergraduate students from 11 academic programs in Turkey and found that their coursework emphasized the theories and applications but relied on the practicum, internship, or on-the-job training to move the student from knowledge to practice. There was also little consistency across programs, which can affect counselor preparedness. Therefore, it is important to standardize counselor education (Aladag, 2013). Additional research has also supported a focus on internships or practicums to teach counseling. Shumaker et al. (2011) surveyed instructors of 82 master's level group therapy programs across 30 states and the District of Columbia that fulfilled state licensure requirements and found academic programs focused on theory and didactic teaching, relying on the internship or practicum placement to "teach" the practice of counseling. Additionally, experiential work in the academic field rested with role playing within the class cohort rather than real-life practice.

Further research has suggested the importance of experiential training over traditional course material. Coats (2012) tested the hypothesis that empathy training via video was more effective than traditional classroom didactic training in undergraduates (N = 163) by providing some students with empathy training via a video (n = 95) and some only receiving traditional course materials and discussion (n = 68). Empathy testing prior to the courses showed no difference between the two groups; post testing found that the experimental group (M = 3.51, SD = 1.53) were significantly higher than the control group (M = .68, SD = .68; $p < .001$), indicated that empathy-focused experiential training

is more effective than traditional reading and didactic discussion for teaching student counselors empathy (Coats, 2012).

The previous paragraphs described studies (Aladag, 2013; Coats, 2012; Shumaker et al., 2011) that examined academic empathy instruction in student counselors. Students pursuing a career as a professional counselor typically attain a bachelor's degree followed by a counseling-specific graduate degree (Dalgin et al., 2010; Gockel & Burton, 2014; Stedman et al., 2013). Methods and techniques of counseling are varied, and counseling students are exposed to them in various ways such as reading, role playing, and writing. Core classes are structured around therapeutic modalities and theories as well as courses on self-awareness, ethics, and human development (Coll et al., 2013; Tschopp & Chronister, 2008). The utility of these skills and knowledge provide the foundation for hands-on practice (Gockel & Burton, 2014) and academic programs must insure that the classroom learning is integrated into the field practice (Voelker, 2015). Therapeutic rapport and developing this skill is emphasized in graduate counseling classes and specifically practiced in the internship (Bearman, Wadkins, Bailin & Doctoroff, 2015; Miville et al., 2006).

Internship

The counseling internship during graduate school is the established place for student-counselors to practice counseling skills, particularly empathy (Aladag, 2013; Crowe et al., 2013; Gockel & Burton, 2014; Stedman et al., 2013; Woodside et al., 2009). Academic programs teach the foundational theories and modalities of counseling followed by the application of this knowledge during an internship or practicum

placement. However, there is great variability in the design and structure of internship placements (Buser, 2008; McCutcheon, 2008; McCutcheon, 2009; Stedman et al., 2013; Woodside et al., 2009). Goals of the internship placement, while varied, consistently reflect the student-counselor being able to synthesize their academic knowledge into real-life practice and context. Although the importance of empathic skills has been established in the counseling setting, there has been little to no standardization for ensuring that student-counselors complete their education with the ability to demonstrate empathy and effectively establish therapeutic rapport, leaving the efficacy of higher education, in specific terms of learning empathy, ambiguous (Aladag, 2013; Buser, 2008; McCutcheon, 2008; McCutcheon, 2009; Stedman et al., 2013; Teding van Berkhout & Malouff, 2015; Woodside et al., 2009).

To explore and gain better understanding of how student-counselors best learn empathic skills, Teding van Berkhout and Malouff (2015) conducted a meta-analysis of 18 randomized controlled trials, some unpublished, of empathy training and found that empathy training is effective (medium effect size $g = 0.63$ adjusted to 0.51) but could not define the specific criteria (size of the group, type of student, type of empathy, and training conditions to name a few) that ensures empathy is learned. Interestingly, they did find that teaching a mix of cognitive and behavioral skills appears to lead to effective empathy instruction but could not specifically define a standard curriculum that could be effective. This indicates that learning empathic skills varies and requires not only a thinking process, but also an action element. This research (Teding van Berkhout & Malouff, 2015) was pivotal in that it found that experiential practice is what appears to

make empathy training effective; this follows the constructivist theory of learning. This research, however, was conducted outside of the academic setting and focused on counselors already in practice in the field versus student-counselors. They pointed out that more research is needed, particularly in the academic setting.

Lenz and Sangganjanavanich (2013), via a quasi-experimental design, tested the hypothesis that experiential training utilizing a specific technique called photovoice is as effective as traditional didactic teaching of empathy. They compared two groups of master's level student counselors (N = 38) utilizing two approaches: their control group (n = 18) received classroom didactic education and their experimental group (n = 20) utilized photovoice (a method of participatory pedagogy). Photovoice specifically utilizes images, sound, and group interactions to stimulate social empowerment, making it an exceptional tool for empathy education. Student empathy was assessed using an unnamed empathy skill acquisition tools. At the conclusion of the study, the group that received the photovoice training had significantly improved empathy scores (α = .05; p<.01). This study reflects that tangible experiences and interactions facilitate empathic skill acquisition better than classroom-based tasks. A significant limitations of this study is that the authors do not describe the tools that they used for assessing empathy, only that there was a Likert-type scale and that the tool required students to provide empathy statements.

The results of Lenz and Sangganjanavanich (2013), that empathy can be learned within an experiential context, were mirrored by Barden and Cashwell (2014). Barden and Cashwell (2014) utilized a qualitative study to test the hypothesis that students in a

Council for Accreditation of Counseling and Related Educational Programs (CACREP) counselor education program were effectively prepared, through their academic process, to work with diverse groups. Using experiential education (immersion in other cultures) participants (N = 10) were immersed in a different culture for a minimum of 10 days. Barden and Cashwell (2014) analyzed the results with consensual qualitative research approach and yielded 7 different domains, including empathy. Of the participants, 8 described an improvement in empathy change; participants noted that it was the interaction with the culture around them and the opportunity to discuss it with their cohorts that made the experience impactful for them. The researchers did not indicate why two of the participants did not experience this empathic effect but did ascertain that an experiential pedagogical approach is needed to improve empathy towards other cultures and out-groups and that most academic settings for student-counselors do not provide this. They point out the importance of connections within the group and with the counselor in order to promote safety and the ability create cohesion. Barden and Cashwell (2014) stated the limitations of their study rest in the sample (small, convenience) and its lack of generalizability. An additional limitation of this study is that being immersed in a culture for a relatively short period of time is not reflective of true counseling education or practice. This study is also limited in its qualitative assessment of empathy versus a quantitative one. This particular study is germane to the research as it highlights the importance of cultural differences and how empathy can connect counselors to groups that they are not a part of; for the field of SUD, those with addiction often feel marginalized and must deal with stigma (Giordano et al., 2013; Morandi et al., 2017).

The research by Barden and Cashwell (2014) may point to the necessity for SUD counselors to be able to able to empathize with a group they would normally not associate with.

To test the hypothesis that master's level students ($N = 87$) in a practicum (similar to internship) setting gain empathy skills, DePue and Lambie (2014) used a quasi-experimental design and measured empathy pre- and post-practicum. Student counselor empathy was assessed using the Interpersonal Reactivity Index, a 28-item self-report Likert-type tool that assesses cognitive empathy across four domains. Testing of student's self-rated ability of empathy using the Interpersonal Reactivity Index, pre- and post-practicum, and the instructor's assessment of improvement data were analyzed using Within Groups Hotelling's Trace, repeated measures MANOVA and MANCOVA, and two-tailed Pearson product–moment correlations. They found that student empathy and related counseling skills improved through the practicum ($p < .001$) but noted that there was no control group and that the study needed to be replicated. Strengths included the real-time supervision and hands-on practicum experience as well as the method of assessing empathy, the Interpersonal Reactivity Index, as it is an older, well-validated tool. Limitations of the study include only having one sample group versus being able to have a control group to assess differences between students receiving practicum versus those that did not. Additionally the assessment tools did not meet all statistical assumptions and the MANCOVA results were not statistically significant; this may attributed to the smaller sample size.

The studies by Barden and Cashwell (2014), DePue and Lambie (2014), and Lenz and Sangganjanavanich (2013), were unable to show support for the hypothesis that graduate-level education leads to improved empathy in counselors. These studies were able to that experiential work, typically demonstrated via internship, is the preferred pedagogy for learning empathy and appears to be moderately effective. These studies did find that experiential education appears to be a strong correlate to learning empathy. Even though the industry expectation is that the internship is the venue for learning, there is limited research that explores the mechanism for learning empathy, being able to demonstrate it effectively, or specific measurement for empathic skills and therapeutic rapport within internship programs (Neukrug et al., 2013; Stedman et al., 2013; Stepien & Baernstein, 2006).

Why Empathy is Important for Substance Use Disorder Counseling

As in other fields, the amount of empathy and rapport between SUD client and SUD counselor appears to affect long-term outcomes (Giordano et al., 2015; Kasarabada, Hser, Boles & Huang, 2002). Particularly for the field of SUD, having a solid empathic relationship to confront problematic behaviors and address ambivalence is extremely important (Giordano et al, 2015; Iarussi et al., 2012). Client engagement and trust with their SUD counselor leads to increased retention and engagement which leads to more positive outcomes (Brownlee, et al., 2017; Morandi et al., 2017). A review of the literature shows that for SUD clients, having a therapeutic relationship based on empathy lends itself to the client being retained and engaged in the program for a longer period of time. Both of these factors, engagement and retention, are identified as being key to

effective SUD treatment (Brownlee et al., 2017; Darke, Campbell, & Popple, 2012; Kasarabada et al., 2002; Moyers, Houck, Longabaugh, Rice & Miler, 2016) and are further discussed in the following sections.

Retention

The ability of the SUD counselor to keep a client in treatment may be key to the success of that patient: length of stay in SUD treatment is widely accepted as one of the key factors to positive outcomes. A review of literature finds that retention, defined as length of stay or number of sessions, in treatment for SUD clients is frequently connected to positive outcomes. (Ball, Carroll, Canning-Ball, Rounsaville, 2006; Darke et al., 2012; McHugh et al, 2013).

Using multiple regression analysis across four different types of treatment programs (11 outpatient sites, n = 269; four residential sites, n=139, two detox sites, n= 48 and two methadone treatment sites, n = 55), Kasarabada et al. (2002) sought to test the hypothesis that positive client perception of their SUD counselor leads to positive client outcomes. They asked participants (N = 511) to assess their SUD counselor (N = 267 with 37% completing college, 35.1% having some graduate level education, and only 20% having a master's degree) across 14 factors including empathy; one year later (actual mean length was 391 days with a SD = 91), the participants were re-interviewed and the severity of their SUD was assessed. The findings of Kasarabada et al. (2002) supported their hypothesis that a positive relationship between client and SUD counselor led to positive treatment outcomes and mirrored results of previous research. Using an ANOVA, they found that SUD clients that perceived their SUD counselor as being more

empathetic and had stronger rapport while in treatment were significantly more likely to have remained in treatment longer and have symptoms of SUD decreased over time ($p < .01$). Limitations of this study rest in the inability to fully account for all treatment factors that may influence outcomes, the nature of a self-report tool and the researchers also modified a tool that had been used with student populations (Kasarabada et al., 2002). For this research, the study by Kasarabada is limited in its terms of age. However, it does attempt to account for not only the skills of the counselor, but also measurement of SUD severity to determine if one affects the other.

In order to test the hypothesis that certain client characteristics are predictive of a SUD client remaining in treatment, Darke, et al. (2012) conducted a longitudinal follow up ($N = 191$) admissions to a therapeutic community for SUD. Using logistic regressions, they identified that different variables led to different length of stay in the program: recent release from prison, lifetime incarcerations, the client not believing they could complete the program, gender, overall health, and previous treatment all appeared to influence length of stay. Despite all the factors that they did look at, they did not study the impact of counselor empathy. One factor studied by Darke et al. (2012) that is germane to the study is they identified that early drop-out was precipitated by the client not having a sense of hope that they could complete the program (odds ratio 2.38, confidence interval 1.01-5.46). Jones et al. (2009) pointed out that having SUD counselors in recovery could provide this sense of hope, indicating that having an SUD in recovery could improve hope for the client which, in turn, could lead to completion of treatment and better long-term outcomes.

Likewise, by using a mixed methods study (N = 999) over a three year period in a group program to address addiction, Brownlee et al. (2017) sought to explore the variables of age, gender, referral source, previous engagement in treatment, previous referrals to treatment, and their impact on client outcome. The factors of gender ($x2$ (1, N = 999) = 5.423; p < 05), age (χ2(2, N = 999) = 35.120; p < .0001), and previous engagement in treatment ($x2$ (1, N = 667) = 16.054; p < .0001) were shown to be predictors of engagement in therapy. Semi-structured interviews were conducted with some clients (n = 6); these interviews found that trusting other members of their group and feeling comfortable talking to others in the group influenced their decision to drop-out. They found that clients with SUD often struggled to engage citing that they felt that their needs could not be met by relying on others. These authors supported the hypothesis that when SUD clients were referred by a more intimate, trusted source (their general medical provider) they were more likely to be open to trusting in the group therapy program (Brownlee et al., 2017) and that trust and safety appeared to affect retention.

With retention in therapy as one of the key factors that leads to positive outcomes for SUD clients, the ability for an SUD counselor to be readily able to connect with the client and establish rapport is key. This makes engagement, and the empathy required for engagement, and retention not only one of the most difficult facets of working with SUD patients but also one of the most important.

Engagement

As important as retention is, simply staying in treatment or completing a program does not necessarily equate a good outcome, clients must go through internal changes and

be engaged in the program (Brorson et al., 2013; Brownlee et al., 2017; Graff et al., 2009; Guerrero, Genwick, Kong, Grella & D'Aunno, 2015). Engagement has come to be defined as attendance in programming, level of motivation, completion of task work, and connection with the counselor (Graff et al., 2009); it is tightly linked to retention and one typically compliments the other.

Using a phenomenological study of SUD counselors in recovery (N = 10), Ham et al. (2013) explored the lived experiences of SUD counselors in recovery and their use of self-disclosure when working with SUD clients. Half of the participants held more than a bachelor's degree (four had master's degrees in counseling or social work, one had a doctorate in psychology) and all had a minimum of five years of practice as an SUD counselor. The majority of the participants in this study shared that it had been common practice when they entered the field of SUD counseling, an average of 14 years ago, to share personal recovery experience with clients as part of the therapeutic process, but have now shifted to a more selective use of self-disclosure for a specific therapeutic gain. The authors of this study noted Roger's theory that counselor self-disclosure was a key method to attaining rapport. Limitations of this study were the qualitative process in general and the older, predominantly male participants.

Henretty, Curier, Berman and Levitt (2014) conducted a meta-analysis of studies (N = 53) to explore if counselor self-disclosure favorably impacts client perceptions of their counselor. Not only did Henretty et al. (2014) find counselor self-disclosure translated to patients feeling more connected to therapy but they were also more likely to remain in treatment (Q = 189.72, p < .001). Specifically, clients perception of counselor

self-disclosure had an overall positive effect on clients perception of alliance and connection (d = 0.15), on client perception of genuineness from the counselor (d = 0.24), and on counselor similarity to the client (d = .27). All of these factors are elements of rapport and empathy. Weakness of this study is the nature of meta-analysis and that not all studies included utilized a control group and the high likelihood of Type I errors (Henretty et al., 2014). Although this study did not specifically focus on clients with SUD, it does point to rapport via self-disclosure as a factor for clients staying engaged in treatment.

The above studies found that the components of retention (Brownlee et al., 2017; Darke, 2012; Kasarabada et al., 2002) and engagement (Ham et al., 2013; Henretty et al., 2014) were important for working with SUD clients. Their studies find common themes of empathy all pertain to the outcomes: of trust, rapport, openness and connection. These factors, as a part of an empathic relationship, may help address another important facet of working with SUD clients: resistance.

Resistance

One factor that makes SUD treatment unique is the amount of resistance from clients: SUD clients tend to be more resistant to treatment and struggle with internal motivation (Brownlee et al., 2017; Morandi et al., 2017; Toriello & Stohmer, 2004). Unlike other mental health disorders, SUD clients are often extremely unmotivated and ambivalent, if not downright resistant, for treatment (Hagedorn, 2011). Being proficient in addressing resistance leads to improved engagement in SUD treatment. Rogers' definition of empathy includes the counselor having an understanding of the client's

world as if it were one's own (Holm, 1997). For the field of SUD, this may help the client to lower resistance as they may believe that the counselor is aligned with them and not against them.

To examine factors that lead to drop-out, Brorson et al., (2013) conducted a box score review of previous studies that investigated drop-out risk (N = 122). Of these studies, only 5% (n = 6) studied therapeutic alliance as a predictor of dropout and only 11% (n = 14) examined interactions related to motivation and empathy. The researchers pointed out that some of their results did not match previous research and left this as an area of further research (Brorson et al., 2013). Germane to this study, the results by Brorson et al (2013) also pointed out the limited research specifically exploring empathy in SUD counselors and is indicative of the gap in literature.

To test the hypothesis that intense case management focused on improving engagement leads to improved treatment adherence, Morandi et al. (2017) used a repeated measures ANOVA (N = 30) and found that there was a significantly reduced number of emergency room (73% to 50%, p = -.36) and psychiatric emergency visits (Wilcoxon z = -1.997; p = .046; r = -.36) and follow-up showed improved treatment adherence (F(1,23) = 15.754, p = .001, ηp 2 = .407) and decreased substance use (F(1,28) = 24.852, p < .001, ηp 2 = .141). Their study found that multi-disciplinary care, specifically with case management, that was directed by the needs and perspective of the client led to these results: allowing the client-identified needs drive treatment improved engagement and reduced resistance. The researchers (Morandi et al, 2017) noted that the limitations included not having a control group, and a modest sample size, thus restricting

generalizability. For the purpose of this study, however, these results indicate that allowing the client-identified needs and alliance, including trust and empathy, drive the treatment improved rapport and engagement and created more client buy-in to their treatment and that this appeared to result in improved outcomes

Solution: Empathy for Substance Use Disorder Clients

For the field of SUD, the understanding of clients' perspective more readily occurs when the SUD counselor has their own history of recovery (Ham et al., 2003; Myrick & del Vecchio, 2016) as client and counselor have a ready-made commonality that creates the foundation for their therapeutic relationship. Jones et al. (2009) emphasized that SUD counselors in recovery bring to the field unique insight, a sense of non-judgment and provide hope; all of these are born from the shared experience of SUD. Additionally, as pointed out by Neukrug et al (2013), empathy is often established by the counselor sharing their own personal story or experience. Especially in the field of SUD treatment, empathy appears to weigh heavily on client outcomes (Brownlee et al., 2017; Kasarabada et al., 2002; Moyers & Miller, 2013; Myrick & del Vecchio, 2016).

To study the effect of empathy in SUD counseling, Moyers and Miller (2013), by using a meta-analysis of four past studies of empathy and client outcomes, found that positive empathy is directly related to positive client outcomes in substance-use treatment (Moyers & Miller, 2013). They described "a robust relationship between therapeutic alliance and client outcomes…improved treatment outcomes could be expected if therapists were trained to develop and maintain strong alliances, including capacity for

genuineness, empathy and unconditional positive regard" (Moyers & Miller, 2013, p. 879).

Additionally, Moyers et al. (2016) conducted a secondary analysis of a large, multisite, randomized controlled trial, to test the hypothesis that there is a positive relationship between therapist empathy and treatment outcomes in treatment of alcohol-use disorder. These authors (Moyers et al., 2016) analyzed the audio recordings for 38 SUD counselors, all with master's degrees, and 700 clients; sessions were rated for content and level of empathy expressed by the SUD counselor. Their results identified a strong correlation between SUD counselors demonstrating empathy and a decrease in alcohol use in their clients (B = -0.381, SE = 0.103, $p < .001$). Despite having a high confidence rating, Moyers et al. (2016) pointed out that a weakness of the study is that the empathy scores were determined by other counselors and researchers versus from the clients themselves and the overall competence of counselors was not a factor. For this study, the research by Moyers et al. (2016), points to the importance of empathy for SUD counselors but does not address the variables of recovery status or education status.

While much of the research (Morandi et al., 2017; Moyers & Miller, 2013; Moyers et al., 2016) on SUD focused on outcomes or predictors on outcome (such as counselor empathy), none of it has focused specifically on examining the influence of education and recovery status on counselor empathy. This may be, in part, due to the unique evolution of SUD treatment and education. The next section will describe the history of SUD treatment and how empathy has inherently been involved through shared recovery.

Evolution of Substance Use Disorder Treatment and Education

Substance-use treatment and recovery is different than other mental health disorders in its origins: unlike other forms of therapy, SUD treatment was founded and grown from a peer-based support system rather than a professional one (Kerwin et al., 2006; White, 2010; White, 2014a; White, 2014b). Rather than coming from a classroom or a formal theory base, the origins of SUD treatment and recovery can be found in rooms of Alcoholics Anonymous and other similar 12 Step support groups beginning in the 1930s (White, 2010; White, 2014a) where the marker of success is engagement with the group and participation. The efficacy of 12-Step programs has been shown in not only it's longevity as an institution, but also in its quantifiable outcomes: these peer-based programs are able to keep individuals engaged in the program and facilitate sustained remission in its participants (Kelly, 2016). Prior to the birth of AA, persons in recovery were sought for their ability to connect with those still suffering and part of their counseling process was self-disclosure as a means of connection (Ham et al., 2013; Myrick & del Vecchio, 2016; White, 2010).

Historically, the field of SUD treatment has relied on lay-persons and peer supports such as Alcoholics Anonymous (AA) for the primary model of recovery (White, 2014a; White, 2014b). The early 1900s saw not only the beginning of the formal creation of the fields of social work and psychology, but began the concept of alcoholism as a disease and the person with SUD as a "patient" that deserved treatment instead of a "culprit" (White, 2014a, p. 69). Prior to the 1900's individuals with SUD were treated in inebriate asylums and seen by "friendly visitors." The requirements of these "friendly

visitors" was being in recovery from SUD; these individuals were seen as more capable in effecting change for those suffering from SUD than those with an academic background or professional role (White, 2014a; p. 72; White, 2014b). It has only been in the last decade that the field of SUD treatment is being seen as a specialized field all its own; in some areas, no formal education is required to treat SUD (Iarussi et al., 2012; West & Hamm, 2011) and most states allow one to practice as an SUD counselor without a master's degree (Kerwin et al., 2006).

During the period of roughly 1970 through 1990, the field of SUD treatment was still emerging as its own distinct field; there was yet to be a system of licensure or credentialing (Doukas & Cullen, 2011) and many professional counseling schools had yet to acknowledge specific training (Duryea & Calleja, 2013; Iarussi et al., 2012). Historically, treatment centers have preferred hiring those in recovery for their credibility and experience with the recovery process (Crabb & Linton, 2007). Individuals in recovery entered the field, utilizing their experience and history of SUD and recovery as the foundation for their practice. In the early 1900's individuals in recovery practiced as lay-counselors as a part of their own recovery process (White, 2014b). These individuals were often older and had less education than their younger and more educated peers that were also just entering the professional field (Doukas & Cullen, 2011). SUD treatment services were often being provided by individuals in recovery and the first official SUD counselors were untrained individuals whose qualification was being in recovery from SUD (Ham et al., 2013; White, 2014a; White, 2014b). Rife with life experience but low on structured education and clinical skills (Iarussi et al., 2012), these individuals used

self-disclosure to establish and grow a therapeutic relationship and create sustaining change in the individuals that they worked with.

More recently, those in recovery have in entered the field in an official capacity: rather than their recovery being an unofficial asset, their recovery has become an official component of a multidisciplinary team. Persons in recovery from SUD can now gain the title of recovery specialist, peer support specialist, peer mentors and other names (Myrick & del Vecchio, 2016; White, 2014b). These titles have come to mean individuals in recovery that use their unique recovery-experience history to connect with, engage with, provide hope and provide support to those still struggling (Myrick & del Vecchio, 2016; White, 2010; White, 2014b). This "new" field is more of an official title for what those in recovery have been doing for decades: sharing their experience, strength and hope. This relationship is unique in that it uses lived experiences of recovery and empathy to promote insight and help the struggling individual to engage in treatment and healthy lifestyle choices: human connection facilitates change (Myrick & del Vechhio, 2016; White, 2010). SUD recovery status becoming part of the professional identity and role is suggestive of recognition and evidence that peers help each other make choices and decisions without the judgment or coercion from authority that may be seen in the counselor (Myrick & del Vecchio, 2016). This realm of the peer support specialist shows that licensure for SUD practitioners in recovery is valuable, but a peer support does not fulfill the role of a counselor (Myrick & del Vecchio, 2016). For a disorder such as SUD that is so mired in stigma, counselors in recovery are often able to offer validation and empathy and be heard when non-recovery counselors may not due to their first-hand

knowledge rather than second-hand textbook knowledge (Myrick & del Vecchio, 2016; White, 2010). However, this is not currently part of the professional requirements for SUD counselors. SUD counselors in recovery may find that their recovery history helps them to bridge the confrontation gap with their clients; finding authority from those with a shared recovery history eases the resistance by assisting and guiding them in initiating and sustaining recovery (Myrick & del Vecchio, 2016).

The recovery experience of SUD counselors in recovery parallels the constructivist learning theory: the learner gains knowledge and skill based on their interactions and interpretation of the environments around them. Individuals seeking recovery from SUD are able to change and learn recovery skills based on their interactions with the world around them. The SUD counselor is a key part of that world.

Education for Substance Use Disorder Counselors

Kerwin et al. (2006) noted traditional counselor education is structured through academics while SUD counselor training follows an apprentice model grown by recovery experience. In order to examine what training staff need to support recovery for SUD clients with co-occurring mental health, Crowe et al. (2013) used a repeated measure design to evaluate the effect of on-site internship for interns ($N = 54$) with no previous work with the SUD population. Their findings indicated that even though knowledge about SUD and mental health did not significantly change, they did find that having an attitude of humility and openness to allowing the client drive the treatment seemed to be beneficial ($p < .05$; Crowe et al., 2013). Essentially, having openness and humility appeared to work with this population and that the interns' attitudes became more

positive towards working with clients with SUD. As in other studies, Crowe et al. (2013) supported hands-on, experiential education through internship as a crucial component of counselor training. Although this study did find hands-on education important for counselor's skill growth and mentorship, it did not specifically look at empathy-specific training, only on attitudes and beliefs towards SUD clients.

Noting that SUD counselors often have less formal education and rely on supervision for much of their training, West and Hamm (2012) sought to have a better understanding of the qualities of SUD counselor supervisors and their training practices. Using a survey, West and Hamm (2012) asked SUD clinical supervisors ($N = 57$) from 53 different treatment programs across a mid-Atlantic state complete a self-report instrument to assess their expertise in clinical supervision knowledge. Average years of work as an SUD clinical supervisor was 9.8 ($SD = 7.93$), 26% had taken a clinical supervision workshop/training, and 75% had a master's degree or above. Less than half of the participants (42%) held a state license. Graduate level education did not appear to influence perception of supervisor expertise and an independent t test showed no significant difference ($\alpha = .05$) in self-rating of supervisor skills with master's degree or without and significance across the supervisory skill levels ranged from .353 to .891 (West & Hamm, 2012). Their study noted that higher education for SUD clinical supervisors had little affect on their perceived ability as SUD clinical supervisors and that most states have different requirements for licensure/certification for SUD counselors versus professional counselors, whose standards are more universal. This further calls into question the efficacy or importance of education standards and licensure for SUD

counselors. Indeed, based on personal discussions with clinical supervisors and advocacy groups, the lack of standardization and consensus on how to license and regulate SUD counselors in the field creates a significant barrier for reimbursement and acceptance of SUD professionals as a legitimate behavioral health professional.

Recognizing that educational standards for SUD counselors are minimal as compared to other fields of counselors, Iarussi et al. (2012) used the 2009 CACREP standards to survey CACREP programs for clinical mental health counseling; they received 43 responses from 35 CACREP approved programs and represented all regions of the country. Only 27.9% (n = 12) reported that their state licensure board required education in addiction and 69.8% (n = 30) reported no addiction-specific education was required by the state licensure board. There are seven CACREP specific standards that pertain to SUD and even though the majority of respondents (n = 31) stated that their program meets the standards, it is noted that there were still several programs (n = 12) that did not meet the standards (Iarussi et al., 2012). Limitations of this study were the small response rate (only 20% of appropriate programs responded) and the researchers did not require evidence of meeting the standards, only self-report. Pertinent to this study, data from Iarussi et al. (2012) pointed to variation even within CACREP approved programs and the disconnection between education standards and state licensure/credentialing requirements.

To examine if hands-on supervision and mentoring improves SUD counselor skills (including improving SUD counselor competence), Laschober, deTormes Eby and Sauer (2013) surveyed pairs of clinical supervisors and counselors (N = 392) in 27 SUD

treatment centers. More than half of the counselors (55.06%) were licensed/credentialed, 52% held a masters' degree or higher and 39.36% were in recovery from SUD. The researchers (Laschober et al., 2013) supported their hypothesis that quality clinical supervision improves counselor performance ($\beta = .08$, $p < .003$) and that counselors who received more mentoring and sponsorship were rated significantly higher on performance ($\beta = .15$, $p < .03$ and $\beta = 17$, $p < .002$). Strikingly, however, length of time a counselor has been practicing professionally was not significantly related to task performance ($p > .05$). Despite the ambiguous nature of "effective clinical supervision" and "job performance," their findings demonstrated that mentoring outweighs task proficiency with regard to producing more effective counselors and improved client outcomes (Laschober et al., 2013); counselors better learned empathy through hands-on mentorship versus traditional academic tasks.

Substance Use Disorder Counselors in Recovery

For SUD counselors, learning to be empathic and establish therapeutic rapport is even more essential as SUD patients often struggle with stigma and struggle to engage in treatment (Morandi et al., 2017). SUD counselors in recovery appear less threatening to SUD clients, function as a resource and source of hope (Doukas & Cullen, 2011) and often offer validation to patients (Myrick & del Vecchio, 2016); for all these reasons they establish rapport quicker. The SUD treatment field often relies on para-professionals or counselors that are in recovery from SUD (Stoffelmayr, Mavis, Sherry & Chiu, 1999; Woo et al., 2013), leaving a great variation to their skill-sets, education level, and what they may bring to the clinical setting. Despite this lack of formal education, they still

appear to be effective at establishing empathy and creating positive outcomes (Kelly, 2016; Toriello & Stohmer, 2004).

Summary

Recent research has examined several key factors that affect efficacy of SUD counseling. Through the review of literature, empathy with clients appears to be a significant factor for retention and engagement in treatment which lead to improved outcomes for SUD clients. Empathy is an integral, if not the most important, facet of being an effective counselor. Using the constructivist theory of learning, this essential skill is often relegated to the internship portion of a student-counselors' academic career. However, empathy acquisition for SUD counselors in recovery comes from a lived recovery experience rather than an academic setting. The efficacy of graduate level education versus SUD recovery is an area that has yet to be fully examined. This study tested the hypothesis that SUD counselors in recovery from SUD are just as effective at establishing empathy with SUD clients as their non-recovery peers that have a graduate counseling degree. This study compared two groups of SUD counselors, one with a master's degree but not in recovery and one without a master's degree but in recovery, to determine if recovery is just as effective as the graduate-level education for engaging in empathic skills with SUD clients. For comparison, the interaction between SUD counselors with both a master's degree and in recovery was also examined.

Demonstrating empathy is key to effective counseling (Clark, 2010; Elliot et al., 2011; Coutinho et al., 2014; Moyers & Miller, 2003; Neukrug et al., 2013) and ensuring that student counselors that are pursing professional counseling careers can demonstrate

this essential skill is an important, if not the most important, facet of their academic training (Buser, 2008; Crowe et al., 2013; Donohue & Perry, 2014; McCutcheon, 2009; Stedman et al., 2013; Woodside et al., 2009). Despite its importance, empathy-specific training is often neglected in academia (Coll et al., 2013; Hill et al., 2008; Malott et al., 2014; Neukrug et al., 2013). Particularly for SUD counselors, being able to demonstrate empathic skills is especially important as it is shown to improve retention, engagement and outcomes (Brownlee et al., 2017; Kasarabada et al., 2002; Moyers & Miller, 2013; Myrick & del Vecchio, 2016). This research will help fill the gap in the literature by comparing empathy in SUD counselors across the variables of education and recovery status. The next chapter will describe the methodology for this research and will describe how the study was conducted including the variables, process for data collection, and analysis. Considerations of validity and research ethics will also be discussed.

Chapter 3: Research Method

Introduction

I sought to examine how the independent variables of education status and recovery impacted the dependent variable of empathic ability of SUD counselors. The previous chapters provided an overview of the study and a comprehensive review of the literature to highlight a gap in the literature. The following chapter describes the method and design of the research study. I aimed to fill the gap in the literature by comparing empathic ability among SUD counselors across the independent variables of recovery status and education. This chapter describes the design of the study including rationale, sampling methods, tools, data collection and analysis, and ethical considerations.

Research Design and Rationale

There were two independent variables for the study: education status (with a master's degree or not) and recovery status (in recovery from SUD or not). The dependent variable in the study was SUD counselor empathy as assessed by the ACME (Vachon & Lynam, 2016). For education status, a master's degree was considered a 2-year degree attained after a baccalaureate degree. Only participants with a master's degree in counseling or social work were included because students seeking a career as a professional counselor typically attain a master's degree in counseling or social work (Dalgin et al., 2010; Gockel & Burton, 2014; Stedman et al., 2013), and most of the research for the study was found to be conducted on student-counselors in these degree programs. Recovery status required participants to have been abstinent and in their

recovery program for at least a year. Finally, empathy was based on the scores from the ACME (Vachon & Lynam, 2016).

To determine whether recovery was just as effective as graduate-level education for engaging in empathic skills for SUD counselors, I used a two-way factorial ANOVA to compare the empathic ability of each group. A two-way factorial ANOVA allowed for the examination of the main effect of each independent variable (education status and recovery status) on the dependent variable (ability to demonstrate empathy in SUD counselors). By using this statistical analysis, the main effect of each independent variable was also able to be examined. A factorial ANOVA can also determine if the effect of one independent variable has a different effect on the dependent variable (Field, 2009).

Methodology

This next section will describe the target population of the study, sampling procedures, and process of recruitment for the study. It is unknown how many SUD counselors exist in the United States, but the sample was pulled from a national database to better enhance generalizability.

Population

Although there is no national database on the number of SUD counselors in the United States, the NAADAC has a membership of over 10,000 professionals in the field of SUD in all 50 states and the District of Columbia (NAADAC, 2018). The target population for this study was individuals with either a master's degree in counseling who were not in recovery or SUD counselors who were in recovery from SUD but do not have

a master's degree. Those who may benefit from this research are students entering the field and educators who may choose to modify their instructional design or coursework. Organizations that treat SUD may also benefit in their hiring practices when determining which potential counselors may be better able to conduct effective therapy that leads to positive client outcomes.

Sampling and Sampling Procedures

A convenience sample from a national population was used for this research. This was done via NAADAC's contact and membership lists for soliciting participants. NAADAC offers a service for members pursuing their PhD where the membership can be asked to participate in research to fulfill academic PhD requirements; I have been a longstanding member of NAADAC and was able to use this service. This process will be further described in the following sections.

To be included in the study, participants had to hold a license or credential as a SUD counselor in their state of practice; this was assumed to designate a SUD counselor to be minimally competent. Participants were in four groups: (a) those with a master's degree but not in recovery, (b) those with a master's degree and in recovery, (c) those without a master's degree and in recovery, and (d) those without a master's degree and not in recovery. Examples of participants in the last two groups were individuals who have a bachelor's degree. Individuals who did not have a license or credential as a SUD counselor or who did not have formal education were not included in this study.

To determine appropriate sample size, a G*Power Analysis (American Statistical Association, 2017) was used with the following criteria: f-tests family was selected with

the statistical test as ANOVA: Fixed effects. Because I planned to explore the hypothesis that the empathic ability of SUD counselors in recovery is just as effective as graduate-level education in establishing empathy with SUD clients, the type of power analysis was a priori. The effect size of *f* was .25 and power = .80, which established a sample size of 179.

Procedures for Recruitment, Participation and Data Collection

Participants for the study were recruited from a national database made up of members and contacts of NAADAC after receiving e-mail approval from NAADAC to use their membership list. Participants were recruited via a letter e-mailed to NAADAC membership and contacts. The e-mail outlined the goals of the study and research questions; obligations of the participant, potential ramifications of participation, and informed consent; and provided my contact information should the participant need it. If individuals chose to participate in the research, they indicated their agreement by clicking on the SurveyMonkey link, which took them to the demographics (Appendix A) and ACME survey questions (Appendix C). The ACME may be used for research and education purposes without prior approval (see Appendix B; Vachon & Lynam, 2016).

Demographic information was collected to ensure participants met inclusion criteria. Additionally, demographic information was used to determine participant appropriateness for the study as well as which group they were in (those with a master's degree but not in recovery, those with a master's degree and in recovery, those without a master's degree and in recovery, and those without a master's degree and not in recovery). Once the participants completed the demographics and survey, they were

thanked for their participation and provided with my contact information should they have questions or concerns. Completed surveys were accessed through SurveyMonkey and were downloaded as a PDF. Additionally, all responses were exported to Excel and then to SPSS (IBM, 2017)

Instrumentation & Operationalization of Constructs

Empathic ability of participants was assessed using the ACME. The ACME is a 36-item Likert-scale tool designed to assess a person's ability to recognize the emotional states of another (Vachon & Lynam, 2016). This tool was initially designed by Vachon (2013) to better assess empathy, particularly as related to antisocial activities such as bullying and criminal behaviors, and it is a newer empathy-assessment tool. The ACME is distinct from other empathy-assessment measures in two ways: first, it accounts for affective dissonance and, second, it also assesses the empathy process. Affective dissonance, is a measure of how a person's emotional response is contrary to what would be expected (Vachon, 2013)—for example, rather than being appalled at someone being hurt, finding pleasure in it. The empathy process describes how behaviors may be contingent on an empathy response (Vachon, 2013).

The ACME has been identified as a reliable measure of empathy across three independent samples (N = 210-708; Vachon & Lynam, 2016). Across all three studies, internal consistency on ACME scales have been good (coefficient alpha = .85-.91) and higher than two previous empathy-assessment tools (Vachon, 2013; Vachon & Lynam, 2016). Although Vachon originally designed the ACME to assess for empathy and the prosocial behaviors that accompany it, it has also been useful in assessing accurate

displays of emotion as a key component in effective therapy (Vachon, 2013). The ACME was selected as the instrument for this research because it assesses the empathic skill of participants and their ability to detect emotional states in others, it is easy to use and accessible, it is newer than previous empathy assessment tools, and it can be completed quickly.

Data Analysis Plan

Data were cleaned by eliminating any participants who did not meet the inclusion criteria for the study (individuals with a master's degree not in counseling or social work; individuals with no education but are in recovery; individuals not licensed or credentialed as an SUD counselor; individuals with no degree and not in recovery from SUD; individuals not at least 18 years of age). Any participant who did not complete the ACME in its entirety was also excluded.

As the study utilized a 2x2 factorial ANOVA to analyze the data, six statistical assumptions were made. The first assumption of an ANOVA is that the dependent variable (empathy as assessed by the ACME) is a continuous variable and the second assumption is that both independent variables have two or more categorical groups (Field, 2009; Laerd Statistics, n.d). The ACME is a 36-Likert type tool that produces a score ranging from 36-180 (Vachon & Lynam, 2016). Both independent variables are categorical (master's degree or not; in recovery or not).

The third assumption of ANOVA is that there is no relationship between the participant groups (Field, 2009; Laerd Statistics, n.d); through collecting the data, each participant was placed in the appropriate group (master's degree and in recovery;

master's degree but not in recovery; bachelor's degree and in recovery; bachelor's degree but not in recovery) to ensure that this assumption is met.

The fourth assumption in an ANOVA is that there are no significant outliers in the data set (Laerd Statistics, n.d); until data was collected, it was unknown if there were any outliers. The fifth and sixth assumptions of ANOVA are that there is relatively normal distribution for each of the independent variable groups and that there is homogeneity of variances (Field, 2009; Laerd Statistics, n.d). Assumption of normality of variance between the groups was assessed using a Shapiro-Wilks. Homogeneity of variance was assessed using Levene's test (Field, 2009) on each group. More on how these assumptions were addressed is in Chapter 4.

To examine the research questions, a 2x2 factorial ANOVA was conducted utilizing SPSS (IBM, 2017) software. In this analysis, the dependent variable was scores on the ACME. This dependent variable was compared to both education level (with a master's degree or without) and recovery status (in recovery from SUD or not).

Research Question 1: Is recovery status associated with empathy in substance use disorder counselors?

$H1_0$ There is no relationship between recovery status and empathy in substance use disorder counselors.

$H1_1$: There is a relationship between recovery status and empathy in substance use disorder counselors such that substance use disorder counselors in recovery will have more empathy with their clients than substance use disorder counselors without recovery.

Research Question 2: Is educational attainment associated with empathy in substance use disorder counselors?

$H2_0$ There is no relationship between education status and empathy in substance use disorder counselors.

$H2_1$: There is a relationship between education status and empathy in substance use disorder counselors such that substance use disorder counselors with master's level education will have more empathy with their clients than substance use disorder counselors without master's level education.

Research Question 3: Is there an interaction between recovery status and education on empathy in substance use disorder counselors?

$H3_0$ There is no relationship between recovery status, education status and empathy in substance use disorder counselors.

$H3_1$: There is a relationship between recovery status, education status and empathy in substance use disorder counselors such that substance use disorder counselors in recovery and with a master's degree will score higher on a measure of empathy than substance use disorder counselors not in recovery or without a master's degree.

To determine the effect of the independent variables (recovery status and education status) on the dependent variable (SUD counselor ability to have empathy) an ANOVA was conducted utilizing SPSS (IBM, 2017). Data was exported from SurveyMonkey to Excel and from Excel to SPSS (IBM, 2017). The results of the analysis will be presented in Chapter 4.

Threats to Validity

There were a few threats to external validity for the study. Primarily the dearth of previous research that examines these two variables makes it difficult to know what has been tried in the past or what the results were. It was hoped, with a large and national participant pool, that the results of the study can be replicated and be a representation of SUD counselors as a whole.

Threats to internal validity rest primarily in the assessment of empathy: the nature of empathy is inherently ambiguous and difficult to quantify. Additionally, this study only measured SUD counselor-perceived empathy, not the empathy perceived by the client. Although the two independent variables have attempted to be operationalized, there are dynamics that affect an SUD counselor's ability to demonstrate empathy that cannot be measured or adjusted for. Although the ACME is shown to be a valid measure of empathy, it is also newer than previous measures of empathy. Thus, the ACME does not have the historical use, and potential validation that may come from decades of use, which some older tools may have.

Ethical Considerations

As this study required a participant to self-disclose their recovery status, participants were provided with informed consent as well as the option to withdraw from the study at any time. As participants were pulled from NAADAC membership and contact lists, this researcher did not have access to their actual e-mail address or name, protecting the anonymity of the participants. Approval from Walden University's IRB and compliance with their recommendations was attained and followed; IRB approval

number 08-24-18-0404885. Only this researcher had access to data; all data were secured on thumb-drives and stored in a safe; they will be kept for the required time period.

This chapter has provided the rationale for the research design including a robust description of the methodology and process. The population, sampling procedures for the population and process to collect and analyze data for the study has also been described. Operational definitions and threats to validity have been discussed. This chapter has provided an in-depth description of the methodology for the research in order to help the reader understand how the research questions and hypotheses were addressed and provided a template should the study need to be replicated.

Conclusion

With substance use disorder and mental health care becoming more integrated in traditional medical practices, the importance of having appropriately skilled and trained counselors will not only improve short-term individual client outcomes, but there is the potential for a ripple effect through society of having a healthier population overall.

Chapter 4: Results

Introduction

The purpose of this study was to explore the relationship between SUD counselor empathic ability across their education and recovery status. There were three research questions for this study that were tested using a 2x2 factorial ANOVA: Is recovery status associated with empathy in SUD counselors?, Is educational attainment associated with empathy in SUD counselors?, and Is there an interaction between recovery status and education on empathy in SUD counselors? The overall hypothesis was that there is a relationship between recovery status, education status, and empathy in SUD counselors such that SUD counselors in recovery and with a master's degree will score higher on a measure of empathy than SUD counselors not in recovery or without a master's degree. This chapter is organized to describe the process of collecting the data and report the baseline descriptive and demographic characteristics of the sample. This chapter will also describe the results of the study including descriptive statistics and factors influencing validity.

Data Collection

The study was opened on 9/22/2018 and closed on 10/7/2018 with a total of 950 responses. There were no discrepancies between the plan in Chapter 3 and the actual collection of data with one exception: the proposed plan was to not solicit participants who were not SUD counselors, but it was not possible to separate them from the NAADAC membership and contact list. On 9/22/2018 an e-mail invitation was sent out to 48,521 NAADAC members (Appendix D for verification of number of respondents)

and opened by 9,003 individuals. There were 950 total respondents (N = 950) by 10/7/2018 when the survey was closed. According to the G*Power Analysis, 179 participants were needed for the study to be valid. Of the 950 total respondents, 343 were excluded for various reasons described in the demographic sections in this chapter, leaving a total of 607 included in the ANOVA analysis.

Data were processed in the following manner: all 950 responses were downloaded from SurveyMonkey and saved to thumb-drives. All demographics and ACME scores were downloaded as PDF documents and transferred to an Excel spreadsheet. From the Excel spreadsheet, the data were downloaded into SPSS. The response rate was roughly less than 1% of the total NAADAC membership/contact list. Only 10% of the 9,003 opened the invitation e-mail. Several factors may have influenced the low response rate, which these are described in Chapter 5.

Demographics

This section will provide an overall demographic view of all respondents and indicate why individuals were excluded. The sections immediately after will provide details about the included participants and describe the groups being studied. This group may not be reflective of the overall SUD counselor population, which will be further discussed in the following paragraphs and in Chapter 5.

Of the 950 respondents, nine neglected to answer the demographic question on age and two indicated that they were less than 18 years of age; these 11 respondents were excluded. Additionally, 60 respondents did not complete all the questions on the ACME and 35 indicated licensure/credential was not needed in their state, so these were also

excluded. This left 844 participants; 237 of these were excluded from the statistical analysis because they either had a master's degree not in social work or counseling; did not have a degree and were not in recovery; were in recovery but did not have a degree; or had pending licensure/credential. These excluded groups are also described in depth in the Excluded Groups section.

Recovery status is an independent variable for this study. Of the 950 responses, 10 declined to answer the demographic question "Are you in recovery from a substance-use disorder for at least 1 year?" Of the remaining 940 responses, 389 indicated they were in recovery from a SUD for at least 1 year, 170 indicated "no," and 381 indicated they had never had a SUD. Education status was also an independent variable for this study. Of the 950 respondents, 487 had a master's degree in social work or counseling, 78 had a master's degree that was not in social work or counseling, 159 had a bachelor's degree, and 88 did not have any degree. As this study defined a master's degree as one in social work or counseling, the 98 respondents who had a master's degree not in social work or counseling were not included in the statistical analysis.

In summary, of the 950 total responses, 106 were excluded for not being of age, not answering all demographic questions, or not answering all ACME questions; this left 844 responses. Of these 844, 237 were excluded as they did not meet the inclusion criteria outlined in Chapter 3 (did not have a master's degree in social work or counseling; did not have a degree and were not in recovery; were in recovery but did not have a degree; licensure/credential was pending). This left 607 participants, who will be described in-depth based on groups in the following sections.

To test the hypotheses, four groups of respondents (N = 607) were created and analyzed: master's degree with recovery, master's degree not in recovery, bachelor's degree with recovery, and bachelor's degree not in recovery. The specifics for these groups are described in the following sections regarding the demographics of the 607 participants of the four groups analyzed in the ANOVA. There were also four groups that, although not specifically analyzed statistically, were of interest to the study: master's degree not in social work or counseling, no degree and not in recovery (individuals that are licensed/credentialed but do not have a degree), recovery from SUD with no degree, and licensure/credential pending. These respondents are described as they help to provide a picture of the general SUD counselor population that is reflected in the sample. Table 2 provides a summary of the ACME (Vachon & Lynam, 2016) scores for all groups. The rest of this section will describe the unique traits of each group including the highest and lowest ACME scores for the group and noticed traits of their demographics. See Table 1 for a summary of the demographics of the included groups.

Master's Degree in Social Work or Counseling and in Recovery

This group had 163 participants. Scores on the ACME ranged from 180 (there were five participants with this score) to 126. The average ACME score was 160.36 with a *SD* of 10.6. This group did not have the highest average ACME score; the groups "master's degree in social work or counseling and not in recovery" and "master's degree not in social work or counseling" both had higher average ACME scores of 160.71 and 160.74, respectively. The groups with master's degrees all had the highest average ACME scores, which support the second hypothesis of the study that education is

positively related to empathy in SUD counselors. For this group, 12 were in the field for 0-2 years, 23 were in the field for 3-5 years, 35 were in the field for 6-10 years, and 93 were in the field for 10 or more years. This group had the most experienced group, with 57% of them being in the field for 10 or more years. In this group there were 135 participants who were employed full time, three who were employed part time, and seven were unemployed. This group also had 60 male participants, 98 female participants, one participant skipped this question, and two preferred not to answer.

Master's Degree in Social Work or Counseling and not in Recovery

This was the largest group with a total of 324 participants. Scores on the ACME ranged from 180 (there were seven participants with this score) to 131 (there were two participants with this score). The average ACME was 160.71 with a *SD* of 10.39. For this group, 43 were in the field for 0-2 years, 68 were in the field for 3-5 years, 52 were in the field for 6-10 years, and 160 were in the field for 10 or more years. This group had 266 participants employed full time, 48 employed part time, nine unemployed, and one participant skipped the question. This group had 69 males and 253 females; one participant identified as transgender and one identified as "other."

Bachelor's Degree in Recovery

There were 66 participants in this group. Scores on the ACME ranged from 180 to 117. The average ACME score for this group was 158.88 with a *SD* of 10.98. For this group, 15 were in the field for 0-2 years, 13 were in the field for 3-5 years, eight were in the field for 6-10 years, and 30 were in the field for 10 or more years. This group had 53

participants employed full time and 11 employed part time. In this group, 25 were male and 41 were female.

Bachelor's Degree not in Recovery

There were 54 participants in this group. Scores on the ACME ranged from 180 to 131 with an average of 158.98 and a *SD* of 10.51. For this group, 14 were in the field for 0-2 years, seven were in the field for 3-5 years, eight were in the field for 6-10 years, and 24 were in the field for 10 or more years; one participant skipped this question. Of the 54 in this group, seven worked part time, one was unemployed, one declined to answer, and the rest were employed full time. In this group, 12 were female and 41 were male, with one participant who declined to answer.

Table 1
Demographics of Included Groups

Group	Master's Degree in Recovery	Master's Degree not in Recovery	Bachelor's Degree in Recovery	Bachelor's Degree not in Recovery
N	163	324	66	54
Gender				
Male	60	69	25	12
Female	98	253	41	41
Transgender	0	0	0	0
Skipped/preferred not to answer	5	2	0	1
Employment				
Full Time	135	266	53	45
Part Time	21	48	11	7
Unemployed	7	9	2	1
Skipped	0	1	0	1
Years in the Field				
0-2	12	43	15	14
3-5	23	68	13	7
6-10	35	52	8	8
10+	93	161	30	24

Excluded Groups

There were four groups that were not included in the statistical analysis: master's degree not in social work or counseling, no degree and not in recovery from SUD, recovery from SUD with no degree, and pending licensure/credential. Although not relevant to the research questions, the data from these groups provides more information on the population. Summary demographics for these groups are also described in the following paragraphs.

Master's degree not in social work or counseling. One of the independent variables for this study was having a master's degree. Due to the large variability of graduate degrees, the definition of master's degree was defined as a master's degree in social work or counseling to try to control internal validity. There were 78 respondents to the invitation to participate in this study who indicated in the demographics that, although they had a master's degree, it was not in social work or counseling. Although this group did have graduate-level education, because it was not in social work or counseling, it was unknown if their formal education contained any counseling or empathy specific skills. For this group, scores on the ACME ranged from 179 to 134 with a mean of 160.74. For this group, 12 participants were in the field for 0-2 years, 15 were in the field for 3-5 years, 10 were in the field for 6-10 years and 41 were in the field for 10 or more years. In this group, 63 participants were employed full time and 12 were employed part time. There were 51 females and 26 males and one participant did not answer this demographic question.

No degree and not in recovery from substance use disorder. There was a small group that did not have a degree and did not have any history of recovery for SUD (*n*=13). As recovery status and education status were the independent variables for this study, a group that has neither formal education nor recovery from SUD provide an informal look at how these variables may impact an SUD counselors' ability to have empathy. Scores on the ACME ranged from 174 to 125 with an average ACME of 156.6. This group had three individuals who were in the field for 0-2 years, two were in the field for 3-5 years, two were in the field for 6-10 years, and six were in the field for 10 or more years. In this group, there were eight females and five males.

Recovery from substance use disorder with no degree. Not included in the statistical analysis was the group in recovery from a SUD but with no formal education; there were 55 in this group. This group was examined as recovery status was one of the independent variables for this study. If being in recovery from SUD indicates an individual would be better able to show empathy, per the first hypothesis of this study, then this group would be able to demonstrate empathy regardless of their education status. Scores on the ACME ranged from 177 to 140 with a mean of 159.78. For this group, 12 were in the field for 0-2 years, nine were in the field for 3-5 years, eight were in the field for 6-10 years, and twenty-six were in the field for 10 or more years. In this group, 42 were employed full time, eight were employed part-time, and five were unemployed. In this group, 14 were male and 41 were female.

Pending licensure/credential. Also not included in the statistical analysis was the group with licensure/credentialing pending (individuals practicing as SUD counselors

but not fully licensed/credentialed). This group was examined as they may be a good reflection of the upcoming workforce for SUD counselors, part of the target audience of this study. This group had 91 participants. Scores on the ACME for this group ranged from 180 to 99 with an average of 159.27. Of interest, the lowest ACME was in this group. This group was nearly equally divided in recovery status: 43 indicated they were in recovery from SUD and 47 indicated they were not. Education status was also an interesting demographic for this group: 49 had a master's degree in social work or counseling, eight had a master's degree that was not in social work or counseling, 21 had a bachelor's degree, and 12 did not have a bachelor's or master's degree. If this group is a reflection of the emerging SUD counselor workforce, most individuals seeking to be SUD counselors have master's degrees and most of the master's degrees have a social work or counseling focus. This group was the most inexperienced group: 75 were in the field for 0-2 years, 10 were in the field for 3-5 years, four were in the field for 6-10 years, and two were in the field for 10 or more years. Logically, this group had the least experience, with the majority of these respondents in the field for 0-2 years. Of this group, 67 were employed full time, 16 were employed part time and eight were unemployed. Of this group, 21 were male and 66 were female, and one was transgender; there was one participant that skipped this question and one that identified as "other." Table 2 provides a summary of the demographics of the excluded groups.

Table 2
Demographics of Excluded Groups

Group	Master's Degree not in Social Work or Counseling	No Degree, not in Recovery	Recovery but no Degree	Pending Licensure/Credential
N	78	13	55	91
Gender				
Male	26	5	20	21
Female	51	8	35	66
Transgender	0	0	0	11
Skipped/preferred not to answer	1	0	0	3
Employment				
Full Time	63	9	42	67
Part Time	12	3	8	16
Unemployed	3	1	5	8
Skipped	0	0	0	0
Years in the Field				
0-2	12	3	12	75
3-5	15	2	9	10
6-10	10	2	8	4
10+	41	6	26	2

Summary of the Groups

Table 3 provides a summary of the ACME scores for all groups. The highest possible score on the ACME is 180; there were 17 participants with this score. Of these 17, one was in recovery from SUD with a bachelor's degree; one had a bachelor's degree but was not in recovery from SUD; one was in recovery and did not have a degree at all; two were in recovery and had a master's degree that was not in social work or counseling; five were in recovery and had a master's degree in social work or counseling; and seven were not in recovery but had a master's degree in social work or counseling. This information is relevant as it helps show the ambiguous nature of empathy and

education: although most of the perfect scores were in groups with master's degrees (14), there were those without master's degrees that had a perfect score (three). It also shows that recovery status may not be a clear-cut path to empathy for SUD counselors as only nine of the 17 scores came from those in recovery.

There were more females in all groups with the exception of the "bachelor's degree not in recovery" group (only 12 females and 42 males). Given that the counseling field is predominantly female (Hall, Hays, Michel, & Runyan, 2013), it makes sense that of the 607 participants, 445 were female. The groups with master's degrees (master's degree in social work or counseling and in recovery; master's degree in social work or counseling and not in recovery; master's degree not in social work or counseling) all had high numbers of participants in the field for more than 10 years. The group that was "pending licensure/credential" had the fewest years of experience with most of those participants only being in the field for 0-2 years; this also makes sense as these individuals may be new to the field and not yet attained licensure/credential.

It did not appear that being in the field for a long time translated into having a higher empathy score, indeed, after 10 years the mean empathy score decreased. For the included groups (N = 607), the mean ACME scores for years in the field are as follows: those in the field for 0-2 years had a mean score of 160.76; those in the field for 3-5 years had a mean scores of 160.69; those in the field for 6-10 years had a mean score of 161.12; those in the field for 10 or more years had a mean score of 160.36. All groups of years (0-2 years, 3-5 years, 6-10 years, and 10 or more years) had at least one participant with a perfect score of 180; the lowest ACME score (117) was in the group that had 10 or more

years of experience. This may mean that, after a certain amount of time in the field, SUD counselors begin to lose empathy.

Table 3

Summary of ACME Scores

Group	Average Score	Highest Score	Lowest Score
Master's Degree in Recovery	160.36	180	126
Master's Degree not in Recovery	160.71	180	131
Bachelor's Degree in Recovery	158.88	180	117
Bachelor's Degree not in Recovery	158.98	180	131
Master's Degree not in Social Work or Counseling	160.74	179	134
Recovery, but no Degree	159.78	177	140
Pending Licensure/Credential	159.27	180	99
No Degree, not in Recovery	156.6	174	125

Results

Homogeneity of variance was tested using Levene's test. Levene's test indicated that the assumption of homogeneity of variance was met $F(3,603) = .151$, $p = .929$. This indicates that the variances across the groups are considered equal. Normality of variance was assessed using the Shapiro-Wilks test. This test indicated non-normal distribution of data $p < .001$. As large data sets can sometimes skew the normality test (Field, 2009), a Kolmogorov-Smirnov and Q-plots were also run in SPSS. These also reflected non-

normality of variance. This indicates that the observed value is statistically different than the expected value, a threat to external validity. There were numerous outliers and this also likely affected the normality of variance. As eliminating the outliers would have significantly decreased the data, it was decided it keep the outliers (Ferguson, 2018). The wide variation in group size also likely contributed to non-normality of variance (Grace-Martin, n.d; Shanmuganthan, 2015). After taking these factors into account and that all other ANOVA assumptions were satisfied, the researcher continued with the ANOVA analysis (see Table 2).

Hypothesis one predicted that there is a relationship between recovery status and empathy such that SUD counselors in recovery from SUD will have more empathy with their clients than SUD counselors not in recovery. This hypothesis was tested using an ANOVA and was not statistically significant $F(1,605) = 1.44$, $p = .230$, indicating recovery status is not significantly related to empathy in SUD counselors.

Hypothesis two predicted that there is a relationship between educational attainment and empathy such that SUD counselors with master's degrees will have more empathy with their clients than those without master's degrees. A look at the ACME (Vachon & Lynam, 2016) scores for education status showed that those with a master's degree had an average empathy score of 160.84 versus those with a bachelor's degree where the mean score was 158.93. This hypothesis was tested using an ANOVA and was significantly significant ($F(1,605) = 3.75$, $p = .053$), indicating that education status is significantly related to empathy in SUD counselors.

Hypothesis three predicted that there is a relationship between recovery status, education status and empathy in SUD counselors such that SUD counselors in recovery and with a master's degree will score higher on a measure of empathy than SUD counselors not in recovery or without a master's degree. This hypothesis was tested using a two-way ANOVA that examined the effect of education status and recovery status on SUD counselor's ability to have empathy as assessed by the ACME. This ANOVA found no statistically significant interaction $F(1,606) = .158$, $p = .69$. See Table 4 for descriptive statistics.

Table 4

Descriptive Statistics

	N	Mean	Std. Deviation	Std. Error Mean
Master's Degree Not Recovery	324	161.32	10.39	
Master's Degree In Recovery	163	160.36	10.60	
Total Master's Degree	487	161.00	10.46	.474
Bachelor's Degree Not Recovery	54	158.98	10.51	
Bachelor's Degree In Recovery	66	158.88	10.98	
Total Bachelor's Degree	120	158.92	10.73	.979
Total In Recovery from SUD	229	159.93	10.71	.708
Total Not in Recovery from SUD	378	160.99	10.422	.536
Total Combined	607	160.59	10.535	

Summary

The results of this study were mixed. It appears that recovery status is not statistically significant in terms of SUD counselors' ability to have empathy, whereas education status does. This research was designed to address three research questions: Is

recovery status associated with empathy in SUD counselors? Is educational attainment associated with empathy in SUD counselors? Is there an interaction between recovery status and educational attainment on empathy in SUD counselors? Of the first question, it appears that education does correlate to increased empathy. Of the second research question, it does not appear that recovery status is associated with empathy in SUD counselors as evidenced by the ANOVA results. The third research question, given the answers to the first two are mixed, is also mixed. A brief look at the means of the groups indicates that having a master's degree does lead to higher empathy while being in recovery from SUD does not. This was borne out in the ANOVA: there was not statistically significant interaction between the effects of education status and recovery status on the ability to show empathy. The next chapter will provide an interpretation of the findings of this research and how they relate to the literature. The limitations of this study will also be discussed as will the recommendations and implications for the field and future research.

Chapter 5: Discussion, Conclusion, and Recommendations

Introduction

The purpose of this study was to determine the impact of education status and recovery status on SUD counselor's ability to demonstrate empathy. Empathy is one of the most important components of counseling (Neukrug et al., 2013; Teding van Berkout & Malouff, 2016), but is often not directly taught in the academic setting (Gockel & Burton, 2014; Neukrug et al., 2013; Teding van Berhout & Malouff, 2016). But in the field of treating SUDs, where the population is often resistant to change (Brownlee et al., 2017; Hagedorn, 2011; Morandi et al., 2017), establishing empathy and rapport may help influence positive client outcomes by improving engagement (Brorson et al., 2013; Brownlee et al., 2017; Guerrero, Genwick, Kong, Grella, & D'Aunno, 2015) and length of treatment (Brownlee et al., 2017; Darke, Campbell, & Popple, 2012; Moyers, Houck, Longabaugh, Rice, & Miler, 2016). Therefore, I conducted this quantitative study to compare empathy scores of SUD counselors across recovery status (in recovery or not) and education level (master's degree or not) using a 2x2 ANOVA. This chapter will include interpretation the findings compared to the literature, followed by a description of the limitations of this study. This chapter will finish with recommendations based on this research and implications for the field.

Interpretation of the Findings

This study was centered on the ideas that empathy is important in counseling, especially SUD counseling, and it is important to examine how empathy is taught to counselors. Counselors with empathy can convey compassion and understanding to their

clients and having empathy helps facilitate relationships and prosocial behaviors (Coutinho et al, 2014; Ferrari, 2014; Lelorain et al., 2012; Neukrug et al., 2013; Rubel & Ratts, 2011; Teding van Berkhout & Malouf, 2015). Learning to convey empathy is also imperative for helping clients change (Coutinho, 2014) and for improving outcomes in clients (Elliot et al., 2011; Gerdes & Segal, 2011; McLeod, 2011; Moyers & Miller, 2013). For SUD clients, who tend to be high on ambivalence and resistant to change (Giordano et al, 2015; Iarussi et al., 2012), SUD counselors who are better able to establish and build empathic relationships with their clients may be better able to increase engagement and length of stay (Brownlee, et al., 2017; Morandi et al., 2017).

Despite its importance, learning empathy is often neglected in counselors' clinical training (Aladag, 2013; Gockel & Burton, 2014; Malott et al, 2014; Teding van Berhout & Malouff, 2016). Counselors pursuing a career in the field typically learn empathy skills during their clinical internship (Aladag, 2013; Crowe et al., 2013; Gockel & Burton, 2014; Stedman et al., 2013; Woodside et al., 2009), but learning objectives can be vague and ambiguous regarding empathy skills (Buser, 2008; McCutcheon, 2008; McCutcheon, 2009; Stedman et al., 2013; Woodside et al., 2009). Although this research did not address how student counselors learn empathy skills, results indicated that higher education does equate with improved empathy for SUD counselors. This supports one of the hypotheses of the study and previous research that having a master's degree improves counselor empathy (Aladag, 2013; Crowe et al., 2013; Gockel & Burton, 2014; Stedman et al., 2013; and Woodside et al., 2009). The mean empathy scores of the participant groups with master's degrees (master's degree and in recovery, master's degree not in

recovery, and master's degree not in social work or counseling) all had higher mean scores (160.36, 160.71, and 160.74, respectively) than those with bachelor's degrees (bachelor's degree in recovery and bachelor's degree not in recovery), which had mean scores of 158.88 and 158.98, respectively. This was also indicated in the ANOVA ($F(1,605) = 3.75$, $p = .053$), supporting previous research that education is strongly correlated to improved counselor empathy.

Though findings regarding education status supported previous research, results differed regarding recovery status. SUD counselors can often be licensed/credentialed with minimal education (Kerwin et al., 2006; White, 2010), often using their history of SUD recovery to connect with and help others who are were struggling (Ham et al., 2013; Iarussi et al., 2012; Myrick & del Vecchio, 2016; White, 2010). However, contrary to the literature, this study's findings did not show a significant effect of recovery status on SUD counselors' ability to demonstrate empathy. In this study, both groups not in recovery (master's degree not in recovery and bachelor's degree not in recovery) had higher average empathy scores (160.71 and 158.98, respectively) than the groups in recovery (master's degree in recovery and bachelor's degree in recovery), which had average empathy scores of 160.36 and 158.88, respectively. The ANOVA also did not support this hypothesis ($F(1,605) = 1.44$, $p = .230$; see Table 3 for a summary of ACME scores). Table 5 provides the results of the ANOVA.

Table 5.

ANOVA Results

	Sum of Squares	*DF*	Mean Square	*F*	Sig
H1	160.02	1	160.02	1.44	.23
H2	414.53	1	414.53	3.75	.053
H3	17.47	1	17.47	.158	.69

Limitations of the Study

The first limitation of the study was that the assessment of empathy was self-report of the SUD counselor, meaning that a counselor believes themselves to be empathetic, but the clients do not have the same impression. Additionally, this study did not assess empathy skills that a counselor may be able to demonstrate, focusing on only the feelings of empathy as assessed by the ACME. Additionally, there may be internal issues that affected counselors' ACME score. Experiencing burnout or being in a negative mood on the day they participated in the study may have influenced their interpretation and answering of questions on the ACME and thus their overall empathy score. An example would be the item "If I could get away with it, there are some people I would enjoy hurting" (six respondents agreed with this statement); this answer would not be reflective of a person being overall empathetic and would skew their score.

Empathy itself was a limitation of this study because it is ambiguous and difficult to quantify. The ACME was chosen to try to mitigate this limitation, but it is designed to assess feelings of empathy, not necessarily empathy skills; a person may feel empathy but not show it and vice versa. Although the literature suggests the importance of learning empathy skills (Coll et al., 2013; Hill et al, 2008; Neukrug et al., 2013), this is ambiguous

in the learning pedagogy (Aladag, 2013; Malott et al., 2014; Neukrug, 2013; Teding van Berkhout & Malouff, 2016), making this variable even more difficult to quantify.

The sample may also be a limitation of this study. Although there was the potential for generalizability by using a national group for SUD professionals, there was a relatively low response rate given the size of the sample. There a several potential reasons for this. First, members of organizations may not check the mass e-mails they get from large organizations, and the e-mail invitations may have gone directly to a junk or spam folder. Second, the invitation discussed that the purpose of the research was to examine SUD counselor empathy and pointed out that not being a SUD counselor would exclude someone from the research; not all of the 48,521 recipients would have been SUD counselors and may have disregarded the e-mail, knowing their responses would be excluded.

Although there were enough participants to make the sample valid, the sample itself may not be an accurate reflection of SUD counselors as a whole, affecting external validity. As described in Chapter 4, a threat to external validity is the unknown nature of the general SUD counselor's population. There is no national database of SUD counselors and no way to know if the predominance of SUD counselors are bachelor's level or master's level trained, or if their master's degree is in social work or counseling. There were more participants with master's degrees than bachelor's degrees in this study and this may not be accurate of the population as a whole. Overall, this sample may not accurately reflect the overall population of SUD counselors as it reflects a majority of SUD counselors with master's degrees. With such variation across states for

licensure/credential, and no national database of counselors, it is difficult to know if the majority of practicing SUD counselors are master's level counselors or not. It could be that those with a master's degree are more likely to be more progressed in their career and be more financially able to afford membership to a national association, and this could explain the predominance in master's degrees reflected in the sample.

Participants not being randomly assigned to groups was an additional threat to validity that could not be mitigated and meant that there was no control over the size of the groups. Participants were assigned to groups based on how they answered the demographic questions about recovery status and education status. The majority of the total respondents held master's degrees (n = 565) compared to those with bachelor's degrees (n = 120); this contributed to the overall dissimilarity in the size of each group and affected normality of variance. Not only did this create irregular group sizes, it also reflected a more educated population, which may not be generalizable to the population as a whole.

An additional limitation and threat to internal validity is the demographic question "Are you in recovery from a Substance-Use Disorder for at least 12-months?" Of the 950 total respondents, 389 answered "yes"; 381 answered "no"; and 381 answered "Never had a substance-use disorder." The intent of this item was to determine which participants were in recovery and which were not, but upon interpretation, it could be that there are a number of participants that are in recovery from a substance-use disorder but for less than 12 months. This would affect the results of the data and as there may be individuals that are in recovery (for less than 12 months) but their scores would be counted in the "no"

category. This leaves the question if those that answered “no” simply meant they consider themselves active substance-users and not in recovery or to have never had a SUD.

In Chapter 3 it was discussed how the assumptions of ANOVA would be addressed. One of the assumptions of ANOVA is that there are no outliers and, per the plan in Chapter 3, any outliers would be discarded. However, the span of ACME (Vachon & Lynam, 2016) scores was broad; throwing out the highest and lowest scores would have eliminated a great deal of data, so no scores were excluded (see Table 1). The last threat to internal validity is the non-normal variance assumption of ANOVA; while this may be attributed to the vast different in size of groups, it is still troubling. The variation in the group sizes was significant: master’s degree and in recovery (n = 163); master’s degree not in recovery (n = 324); bachelor’s degree and in recovery (n = 66); and bachelor’s degree not in recovery (n = 54). To make each group similar in size, around 50-60, would have meant throwing out 275 of the scores for the master’s degree not in recovery and 100 of the scores for the master’s degree and in recovery.

Recommendations

This study can be improved upon in two significant ways by addressing the two main weaknesses: client report of empathy and similar group sizes. Client report of empathy, rather than the SUD counselors’ perspective of their ability to show empathy, would be a more accurate reflection of empathy. While the ACME is a good tool to assess empathy, it did not allow for the researcher to truly gauge if the SUD client felt their SUD counselor had empathy for them. Replicating this study with the use of client-report of SUD counselor empathy would mean that additional safeguards would need to

be in place to protect the participants, but it would be a worthwhile endeavor and further help the field understand if SUD recovery status or education directly relates to the SUD client feeling their counselor has empathy. As empathy can be a relatively qualitative trait, using a mixed methods approach may give a better understanding of how empathy in the counseling relationship works.

The second significant weakness of this study that could be addressed would be the wide variation of group sizes. This may have affected the overall validity of the study as it meant the ANOVA assumption of a normal distribution of data was not met. It could be that replicating this study with similar group sizes would mitigate that issue. This may mean needing a large participant pool in order to get enough participants to meet the appropriate sample size for validity. Adjusting the demographic question “Are you in recovery from a Substance-Use Disorder for at least 12-months?” to better clarify recovery status may also help mitigate this weakness.

By understanding how SUD counselors can best learn and cultivate empathy, we can better train a much-needed workforce to address the epidemic of SUD. Educators, licensure boards, and future SUD counselors can all be better informed as to what components are needed to create empathic rapport with clients and, ultimately, better outcomes for SUD clients. Based on the results of this study, further research into how to best train SUD counselors is needed. While this research does indicate that having a master’s degree in counseling or social work does indicate a SUD counselor would be better able to have empathy, there are limitations, described above, that need to be further controlled.

Implications

Despite the ambiguity in learning objectives for master's level counselors, the results of this study support that SUD counselors with master's degrees, particularly in social work or counseling, appear to have more empathy. As the literature points to having empathy as a key skill for improved outcomes for SUD clients, building a workforce of SUD counselors that have earned a master's degree in social work or counseling may go far in addressing the SUD epidemic. Positive social change happens when our programs and systems change in order to create better long-term processes and outcomes. This study helps create social change by adding to the literature and helping us have better understanding of how to shape a competent SUD counselor workforce.

While research points to the importance of counselors learning empathy (Coll, Doumas, Trotter & Freeman, 2013; Hill et al, 2008; Neukrug et al., 2013) and that empathy is often learned in the clinical internship (Aladag, 2013; Crowe et al., 2013; Gockel & Burton, 2014; Woodside et al., 2009; Stedman et al., 2013) SUD counselors learning pedagogy is often different from traditional counselors and frequently comes from a place of peer history rather than formal education (Kerwin et al., 2006; White, 2010; White, 2014a; White, 2014b). Although having a shared history of SUD may lead to an empathic relationship (Ham et al., 2003; Myrick & del Vecchio, 2016) for SUD clients and counselors, this research does not bear this out. While SUD clients appear to benefit from having counselors with a shared history of SUD in terms of improved outcomes (Brownlee et al., 2017; Kasarabada et al., 2002; Moyers & Miller, 2013; Myrick & del Vecchio, 2016), there has not been enough research to adequately examine

the variable of SUD recovery and master's level education. This study attempted to add to the body of literature that explores empathy and SUD counselors.

This research points to the importance of having SUD counselors attain a master's level education. Not only in terms of being able to have empathy for their clients and increase the chances of a positive outcome, the SUD population frequently has complex, co-occurring issues that SUD counselors with higher education are better trained to address (Bertrand, Brochu, Brunelle, Flores-Aranda, Landry, Motto-Ochoa & Patenaude, 2017; Mitsis, 2019).

Conclusion

SUDs continue to be a problem, with ramifications in the criminal justice, education, and social systems (Brorson, Arnevik, Rand-Hendriksen, & Duckert, 2013; Druyea & Calleja, 2013). Developing an adequate workforce to address this issue is one that may lead to improved outcomes, decreased criminal justice interactions, and cost-savings (Bingham, Cooper, & Hough, 2016). This research has helped fill the gap in the literature by adding another piece to the equation of what makes SUD counselors effective with their clients and improving long-term outcomes.

References

Aladag, M. (2013). Counseling skills pre-internship training at guidance and counseling undergraduate programs: A qualitative investigation. *Educational Sciences: Theory & Practice, 13*(1), 72-79. doi:10.12738/estp.2014.3.1958

American Psychiatric Association. (2013). *Diagnostic and statistical manual* (5th ed). Washington, DC: Author.

American Statistical Association. (2017). *G*Power 3.1 manual,* March 1, 2017. Retrieved from http://www.gpower.hhu.de/fileadmin/redaktion/Fakultaeten/Mathematisch-Naturwissenschaftliche_Fakultaet/Psychologie/AAP/gpower/GPowerManual.pdf

Baggerly, J., & Osborne, D. (2013). A survey of counselor education comprehensive exam types and procedural recommendation for clinical supervisors and counseling faculty. *The Clinical Supervisor, 32*(1), 90-104. doi:10.1080/07325223.2013.780933

Ball, S. A., Carroll, K. M., Canning-Ball, M., & Rounsaville, B. J. (2006). Reasons for dropout from drug abuse treatment: Symptoms, personality, and motivation. *Addictive Behaviors, 31,* 320-330. doi:10.1016/j.addbeh.2005.05.013

Barden, S. M., & Cashwell, C. S. (2014). International immersion in counselor education: A consensual qualitative research investigation. *Journal of Multicultural Counseling and Development, 42*(1), 42-60. doi:10.1002/j.2161-1912.2014.00043.x

Batson, C. D., Chang, J., Orr, R., & Roland, J. (2002). Empathy, attitudes, and action:

Can feeling for a member of a stigmatized group motivate one to help the group? *Personality and Social Psychology Bulletin*, 28(12), 1656-1666. doi:10.1177/014616702237647

Bearman, S. K, Wadkins, M., Bailin, A., & Doctoroff, G. (2015). Pre-practicum training in professional psychology to close the research-practice gap: Changing attitudes towards evidence-based practice. *Training in Education and Professional Psychology*, *9*(1), 13-20. doi:10.1037/tep0000052

Bingham, K. M., Cooper, T., & Hough, L. M. (2016). *Fighting the opioid crisis: An ecosystem approach to a wicked problem*. Retrieved from https://dupress.deloitte.com

Brorson, H. H., Arnevik, E. A., Rand-Hendriksen, K., & Duckert, F. (2013). Drop-out from addiction treatment: A systematic review of risk factors. *Clinical Psychology Review, 33*, 1010-1024. doi:10.1016/j.cpr.2013.07.007

Brownlee, N., Curran, D., & Tsang, S. M. (2017). Client engagement with a manualized group therapy program. *Journal of Groups in Addiction & Recovery, 12*(1), 45-61. doi:10.1080/1556035X.2016.1272073

Buser, T. J. (2008). Counselor training: Empirical finding and current approaches. *Counselor Education & Supervision, 48*(2), 86-100. doi:10.1002/j.1556-6978.2008.tb00065

Campbell, R. L. (2006). *Jean Piaget's genetic epistemology: Appreciation and critique*. Retrieved from http://myweb.clemson.edu

Churchill, S., & Bayne, R. (1998). Psychological type and conceptions of empathy in

experienced counselors. *Counselling Psychology Quarterly, 14*(3), 379-390. doi:10.1080/09515079808254069

Clark, A. J. (2010). Empathy and sympathy: Therapeutic distinctions in counseling. *Journal of Mental Health Counseling, 32*(2), 95-101. doi:10.17744/mehc.32.2.228n116thw397504

Coats, V. (2012). A rubric for use in training and evaluating empathy skills. *Arizona Counseling Journal, 27*, 41-54. Scottsdale, AZ: Arizona Counselors Association.

Coll, K. M., Doumas, D. M., Trotter, A., & Freeman, B. J. (2013). Developing the counselor as a person and as a professional: Attitudinal changes in core counseling courses. *Journal of Humanistic Counseling, 52*(1), 54-66. doi:10.1002/j.2161-1939.2013.00032.x

Coutinho, J. F., Silva, P. O., & Decety, J. (2014). Neurosciences, empathy, and healthy interpersonal relationships: Recent finding and implications for counseling psychology. *Journal of Counseling Psychology, 61*(4), 541-548. doi:10.1037/cou0000021

Crabb, A. C., & Linton, J. M. (2007). A Qualitative study of recovery and nonrecovery substance abuse counselors' belief systems. *Journal of Addiction & Offender Counseling, 28*(1), 4-17. doi:10.1002/j.2161-1874.2007.tb00028.x

Crowe, T. P., Kelly, P., Pepper, J., McLennan, R., Deane, F. P., & Buckingham, M. (2013). Service based internship training to prepare workers to support the recovery of people with co-occurring substance abuse and mental health disorders. *International Journal of Mental Health Addiction, 11*, 269-280.

doi:10.1007/s11469-012-9419-9

Dalgin, R. S., Bruch, L. A., & Barber, G. (2010). Rehabilitation counseling practicum: A national survey of design and implementation. *Rehabilitation Education 24*(1&2), 75-84. doi:10.1891/088970110805029877

DePue, M. K., & Lambie, G. W. (2014). Impact of a university-based practicum experience on counseling students' levels of empathy and assessed counseling competencies. *Counseling Outcome Research and Evaluation, 5*(2) 89-101. doi:10.1177/2150137814548509

Darke, S., Campbell, G., & Popple, G. (2012). Retention, early dropout and treatment completion among therapeutic community admissions. *Drug and Alcohol Review, 31*, 64-71. doi:10.1111/j.1465-3362.2011.00298.x

DeAngelis, T. (2014). An APA task force has created guidelines that promise to make clinical supervision a more evidence-based and codified pert of psychology training. *Monitor on Psychology, 45*(8), 43-45. Washington, DC: American Psychological Society.

Donohue, K. M., & Perry, K. E. (2014). Bringing theory to life for trainees in professional psychology: The role of setting, assignments, and supervision. *Training and Education in Professional Psychology, 8*(2), 119-126. doi:10.1037/tep0000016

Doukas, N., & Cullen, J. (2011). Addiction counselors in recovery: Perceived barriers in the workplace. *Addiction Research & Therapy, 2*(3), 1-7. doi:10.4172/2155-6015.1000112

Duryea, D. G., & Calleja, N. G. (2013). Current expectation and existing deficits among addiction specialists. *Alcoholism Treatment Quarterly*, *31*(2), 254-269. doi:10.1080/07347324.2013.771990

Elliot, R., Bohart, A. C., Watson, J. C., & Greenburg, L. S. (2011). Empathy. *Psychotherapy*, *48*(1), 43-49. doi:10.1037/a0022187

Ertmer, P., & Newby, T. (1993). Behaviorism, cognitivism, constructivism: Comparing critical features from an instructional design perspective. *Performance Improvement Quarterly*, *6*(4), 50-72. doi:10.1111/j.1937-8327.1993.tb00605.x

Ferguson, K. (2018, March 6). When should you delete outliers you're your dataset? [Blog post]. Retrieved from https://blog.socialcops.com/academy/resources/when-delete-outliers-dataset/

Ferrari, P. F. (2014). The neuroscience of social relationship. A comparative-based approach to empathy and to the capacity of evaluating others' action value. *Behavior*, *151*, 297-313. doi:10.1163/1568539x-00003152

Field, A. (2009). *Discovering statistics using SPSS* (3rd ed.). Thousand Oaks, CA: Sage.

Fisher, C. (2009). *Decoding the ethics code: A practical guide for psychologists* (2nd ed.). Thousand Oaks, CA: Sage.

Fisk, S. (2010). *Social beings: Core motives in social psychology* (2nd ed.). Hoboken, NJ: John Wiley & Sons.

Frankfort-Nachmias, C., & Nachmias, D. (2008). *Research methods in the social sciences* (7th ed). New York, NY: Worth.

Gerdes, K. E., & Segal, E. (2011). Importance for social work practice: Integrating new

science. *Social Work, 56*(2), 141-148. doi:10.1093/sw/56.2.141

Giordano, A. L., Clarke, P. B. & Stare, B. G. (2015). Overcoming obstacles to empathy: The Use of experiential learning in addictions counseling courses. *Journal of Creativity in Mental Health, 10*(1), 100-113. doi:10.1080/15401383.2014.947011

Gockel, A. & Burton, D.L. (2014). An Evaluation of pre-practicum helping skills training for graduate social work students. *Journal of Social Work Education, 50*(1), 101-110. doi: 10.1080/10437797.2014.856234

Grace-Martin, K. (n.d). When Unequal Sample Sizes are Not a Problem in ANOVA. [Blog post]. Retrieved from https://www.theanalysisfactor.com/when-unequal-sample-sizes-are-and-are-not-a-problem-in-anova/

Graff, F.S., Morgan, T.J., Epstein, E.E., McCrady, B.S., Cook, S.M., Jensen, N.K., & Kelly, S. (2009). Engagement and Retention in Outpatient Alcoholism Treatment for Women. *The American Journal on Addictions*, 18: 277–288. doi: 10.1080/10550490902925540

Guerrero, E.G., Genwick, K., Kong, Y., Grella, C., & D'Aunno, T. (2015). Paths to improving engagement among racial and ethnic minorities in addiction health services. *Substance Abuse Treatment, Prevention and Policy, 10*(40). doi: 10.1186/s13011-015-0036z

Hagedorn, W.B. (2011). Using Therapeutic Letters to Navigate Resistance and Ambivalence: Experiential Implications for Group Counseling. *Journal of Addictions & Offender Counseling. 31*(2), 108-126. doi*:* 10.1002/j.2161-1874.2011.tb00071.x

Hall, S.B., Hays, D.G., Michel, R.E., & Runyan, H.I. (2013). A mixed methods study of male recruitment in the counseling profession. *Journal of Counseling & Development, 91*(4), 475-482. https://doi.org/10.1002/j.1556-6676.2013.00120.x

Ham, C.C., Stauffer LeMasson, K.D. & Hayes, J.A. (2013). The use of self-disclosure: Lived experiences of recovering substance abuse counselors. *Alcoholism Treatment Quarterly, 31*(3), 348-374. doi: 10.1080/07347324.2013.800399

Henretty, J.R., Curier, J.M., Berman, J.S. & Levitt, H.M. (2014). The impact of counselor self-disclosure on clients: A meta-analytic review of experimental and quasi-experimental research. *Journal of Counseling Psychology, 61*(2), 191-207. doi: 10.1037/a0036189

Hill, C.E., Roffman, M., Stahl, J., Friedman, S., Hummel, A. & Wallace, C. (2008). Helping skills training for undergraduates: Outcomes and prediction of outcomes. *Journal of Counseling Psychology, 55*(3), 359-370. doi: 10.1037/0022-0167.55.3.359

Holm, O. (1997). Ratings of empathic communication: Does experience make a difference? *The Journal of Psychology*, *131*(6), 680-682. http://dx.doi.org/10.1080/00223989709603851.

Iarussi, M.M., Perjessy, C.C. & Reed, S.W. (2012). 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

IBM Corp. Released 2017. IBM SPSS Statistics for Windows, Version 25.0. Armonk,

NY: IBM Corp.

Instructional Design Knowledge Base. (2012). Retrieved from http://cehdclass.gmu.edu/ndabbagh/Resources/IDKB/models_theories.htm

Joice, A. & Mercer, S.W. (2010). An evaluation of the impact of a large group psycho-education programme (Stress Control) on patient outcome: Does empathy make a difference? *The Cognitive Behaviour Therapist, 3*(1), 1-17. doi:10.1017/S1754470X10000012

Jones, J.V & Lyddon, W.J. (1997). Adlerian and constructivist psychotherapies: A constructivist perspective. *Journal of Cognitive Psychotherapy: An International Quarterly, 11*(3), 195-210. Retrieved from https://search-proquest-com.ezp.waldenulibrary.org/docview/89071115?accountid=14872.

Jones, T., Sells, J.N., and Rehfuss, M. (2009). How wounded the healers? The prevalence of relapse among addiction counselors in recovery from alcohol and other drugs. *Alcoholism Treatment Quarterly, 27*(4), 389-408. doi: 10.1080/07347320903209863

Kasarabada, N.D., Hser, Y., Boles, S.M., &Huang, Y. (2002). Do patients' perceptions of their counselors influence outcomes of drug treatment? *Journal of Substance Abuse Treatment 23*(4) 327– 334. http://dx.doi.org/10.1016/S0740-5472(02)00276-3.

Kelly, J. (2016). Is Alcoholics Anonymous religious, spiritual, neither? Finding from 25 years of mechanisms of behavior change research. *Addiction, 112*(6), 929-936. doi: 10.1111/add.13590

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*(3), 173-181. doi: 10.1016/j.jsat.2005.11.004

Kwon, K.I. & Jo, S.Y. (2012). The relationship among counselor experience level, empathic accuracy, and counseling outcome in the early phase of counseling. *Asia Pacific Education Review, 13*(4), 771–777. doi 10.1007/s12564-012-9235-8

Labinowicz, E. (1980). *The Piaget primer: Thinking, learning, teaching*, 19-50, 146-158. Menlo Park, CA: Addison-Wesley Publishing Company.

Laerd Statistics (n.d). *Two-way ANOVA in SPSS Statistics*. Retrieved 3/17/17 from https://statistics.laerd.com/spss-tutorials/two-way-anova-using-spss-statistics.php

Lane, R.D. (2000). Levels of emotional awareness: Neurological, psychological and social perspectives. In R. Bar-On & J.D.A. Parker (Eds). *The Emotional Intelligence Handbook* (pp. 171-187). San Francisco, CA: Jossey-Base.

Laschober, T.C., deTormes Eby, L.T., & Sauer, J.B. (2013). Effective clinical supervision in substance use disorder treatment programs and counselor job performance. *Journal of Mental Health Counseling, 35*(1), 76-94. doi:http://dx.doi.org/10.17744/mehc.35.1.50n6w37328qp86.

Lelorain, S., Bredart, A., Dolbeualt, S., & Sultan, S. (2012). A systematic review of the associations between empathy measures and patient outcomes in cancer care. *Psycho-Oncology, 21,* 1255-1264. doi:10.1002/pon.2115

Lenz, A.S. & Sangganjanavanich, V.F. (2013). Evidence for the utility of a photovoice

task as an empathic skill acquisition strategy among counselors-in-training. *The Journal of Humanistic Counseling, 52*(1), 39-53. doi: 10.1002/j.2161-1939.2013.00031.x

Lyons, C. & Hazler, R.J. (2002). The influence of student development level an improving counselor student empathy. *Counselor Education & Supervision, 42* (2), 119-130. doi:10.1002/j.1556-6978.2002.tb01804.x

Malott, K.M., Hall, K.H., Sheely-Moore, A., Krell, M.M., & Cardaciotto, L. (2014). Evidence-based teaching in higher education: Application to counselor education. *Counselor Education & Supervision, 53*(4), 294-305. doi: 10.1002/j.1556-6978.2014.00064.x

McLeod, B.D. (2011). Relation of the alliance with outcomes in youth psychotherapy: a meta-analysis. *Clinical Psychology Review, 31*, 603-616. doi:10.1016/j.cpr.2011.02.001.

McCutcheon, S.R. (2008). Addressing problems of insufficient competence during the internship year. *Training and Education in Professional Psychology, 2*(4), 210-214. doi: 10.1037/a0013535

McCutcheon, S.R. (2009). Competency benchmarks: Implications for internship training. *Training and Education in Professional Psychology, 3*(4Suppl.), S50-S53. doi: 10.1037/a00016966

McHugh, R.K., Murray, H.W., Hearon, B.A., Pratt, E.M., Pollack, M.H., Safren, S.A., & Otto, M.W. (2013). Predictors of dropout from psychosocial treatment in opioid-dependent outpatients. *The American Journal on Addiction, 22*(1), 18-22. doi:

10.1111/j.1521-0391.2013.00317.x

Miller, G., Scarborough, J., Clark, C., Leonard, J.C., & Keziah, T.B. (2010). The need for national credentialing standards for addiction counselors. *Journal of Additions & Offender Counseling, 30*(2), 50-57. doi: 10.1002/j.2161-1874.2010.tb00056.x

Miville, M.L., Carlozzi, A.F., Gushue, G.V., Schara, S.L. & Ueda, M. (2006). Mental health counselor qualities for a diverse clientele: Linking empathy, universal diverse orientation, and emotional intelligence. *Journal of Mental Health Counseling*, *28*(2), 151-165. doi:http://dx.doi.org/10.17744/mehc.28.2.6khc06t87c2fr7y3.

Mooney, C.G. (2013). *Theories of childhood: An introduction to Dewey, Montessori, Erickson, Piaget, and Vygotsky. (2nd Ed*.), 77-98. St. Paul, MN: Redleaf Press.

Morandi, S., Silva, B., Golay, P., & Bonsack, C. (2017). Intensive case management for addiction to promote engagement with care of people with severe mental and substance use disorders: an observations study. *Substance Abuse Treatment, Prevention, and Policy, 12*(26), doi: 10.1186/s13011-017-0111-8

Moyers, T.B., Houck, J., Longabaugh, R., Rice, S.L, & Miller, W.R (2016). Therapist empathy, combined behavioral intervention, and alcohol outcomes in the COMBINE research project. *Journal of Consulting and Clinical Psychology, 84*(3), 221-229.

Moyers, T.B. & Miller, W.R. (2013). Is low therapist empathy toxic? *Psychology of Addictive Behaviors*, 27(3), 878-884. doi: 10.1037/a0030274

Morandi, S., Silva, B., Golay, P., & Bonsack, C. (2017). Intensive case management for

addiction to promote engagement with care of people with severe mental and substance use disorders: an observations study. *Substance Abuse Treatment, Prevention, and Policy, 12*(26), doi: 10.1186/s13011-017-0111-8

Myrick, K. & del Vecchio, P. (2016). Peer support services in the behavioral healthcare workforce: State of the field. *Psychiatric Rehabilitation Journal, 39*(3), 197-203. doi: 10.1037/prj0000188

National Association of Alcohol and Drug Abuse Counselors. (2017). edhttps://www.naadac.org/

National Institute of Drug Abuse. (2015). *Trends and Statistics*. Retrieved from https://www.drugabuse.gov/related-topics/trends-statistics.

Neukrug, E., Bayne, H.B., Dean-Nganga, L. & Pusateri, C. (2013). Creative and novel approaches to empathy: A neo-Rogerian perspective. *Journal of Mental Health Counseling, 35*(1), 29-42. doi*:*10.1080/03004430903414679

Nyman, S.J., Nafziger, M.A., & Smith, T.B. (2010). Client outcomes across counselor training level within multitiered supervision model. *Journal of Counseling & Development, 88*(2), 204-209. doi: 10.1002/j.1556-6678.2010.tb00010.x

Riess, H., Kelley, J.M., Bailey, R.W., Dunn, E.J., & Phillips, M. (2012). Empathy training for resident physicians: A randomized controlled trial of a neuroscience-informed curriculum. *Journal of General Internal Medicine, 27*(10), 1280-1286. doi:10.1007/s11606-012-2063-z

Rubel, D.J. & Ratts, M. (2011) Diversity and social justice issues in counseling and psychotherapy. In D. Capuzzi & D.G. Gross (Eds), *Counseling and*

psychotherapy; Theories and interventions, (pp. 29-51). Alexandria, VA: American Counseling Association.

Shanmuganthan, A. (2015). What does one do while doing one way ANOVA with unequal sample size? [Blog post]. Retrieved from https://www.researchgate.net/post/What_does_one_do_while_doing_one_way_ANOVA_with_unequal_sample_size

Shumaker, D., Ortiz, C., & Brenninkmeyer, L. (2011). Revisiting experiential group training in counselor education: A survey of master's level programs. *The Journal for Specialists in Group Work*, *36*(2), 111-128. doi:10.1080/01933922.2011.562742

Stedman, J.M., Schoenfeld, L.S., & O'Donnell, L. (2013). An investigation of internship directors' perspectives on the learning objectives required by the commission on accreditation. *Training and Education in Professional Psychology*, *7*(2), 134-138. doi:10.1037/a0031660

Stepien, K.A. & Baernstein, A. (2006). Educating for empathy. *Journal of General Internal Medicine*, *21*(5), 524-530. doi:10.1111/j.1525-1497.2006.00443x

Stoffelmayr, B.E, Mavis, B.E, Sherry, L.A, & Chiu, C.W. (1999). The influence of recovery status and education on addiction counselors' approach to treatment. *Journal of Psychoactive Drugs* 31(2). http://dx.doi.org/10.1080/02791072.1999.10471734

Substance Abuse and Mental Health Services Administration. (March 8, 2016). *Mental and Substance Use Disorders*. Retrieved 2/21/2017 from

https://www.samhsa.gov/disorders.

Teding van Berkout, E. & Malouff, J.M. (2015). The efficacy of empathy training: A meta-analysis of randomized controlled trials. *Journal of Counseling Psychology 63*(1) 32-41. doi:10.1037/cou0000093

Toriello, P.J. & Stohmer, D.C. (2004). Addictions counselors' credibility: The impact of interactional style, recovery status, and nonverbal behavior. *Journal of Addictions & Offender Counseling, 25*(1), 43-57. doi:10.1002/j.2161-1874.2004.tb00192.x

Tschopp, M.K. & Chronister, J.A. (2008). Clinical and applied experience in rehabilitation counselor education. *Rehabilitation Education, 22*(3&4), 295-306. doi**:**http://dx.doi.org/10.1891/088970108805059318.

Vachon, D. D. (2013). *Development and validation of the affective and cognitive measure of empathy (ACME)* (Order No. 3605163). Available from ProQuest Dissertations & Theses Global. (1477861844). Retrieved from http://ezp.waldenulibrary.org/login?url=https://search-proquest-com.ezp.waldenulibrary.org/docview/1477861844?accountid=14872

Vachon, D.D. & Lynam, D.R. (2016). Fixing the problem with empathy: Development and validation of the affective and cognitive measure of empathy. *Assessment, 23*(2), 135-149. doi: 10.1177/1073191114567941

Voelker, R. (2015). Ready for practicum? Advice on preparing for and getting the most out of your practicum experience. *GradPSYCH 13*(1), 26-27. Washington, D.C: American Psychiatric Association.

Volgel-Walcutt, J.J., Gerbrin, J.B., Bowers, C., Carper, T.M., & Nicholson, D. (2010).

Cognitive load theory vs. constructivist approaches: Which best leads to efficient, deep learning? *Journal of Computer Assisted Learning, 27*(2), 133-145. doi:10.1111/j.1365-2729.2010.00381.x

West, P.L. & Hamm, T. (2012). A study of clinical supervision techniques and training in substance abuse treatment. *Journal of Addictions & Offender Counseling (33),* 66-81. doi:10.1002/j.2161-1874.2012.00005.x

Wildman, T.M. & Burton, J.K. (1981). Integrating learning theory with instructional design. *Journal of Instructional Development, 4*(3), 5-14. doi:10.1007/BF02905318

Wheeler, S. (2000). What makes a good counselor? An analysis of ways in which counselor trainers construe good and bad counseling trainees. *Counseling Psychology Quarterly 13(*1), 65-83. doi/pdf/10.1080/09515070050011079.

White, W.L. (2010). Nonclinical addiction recovery support services: History, rationale, models, potentials, and pitfalls. *Alcoholism Treatment Quarterly, 28*(3), 256-272. doi: 10.1080/07347324.2010.488527

White, W.L. (2014a). *The History of Addiction Counseling in the United States; Promoting Person, Family, and Community Recovery*. NAADAC; Alexandria, VA.

White, W.L. (2014b). *Slaying the dragon: The history of addiction treatment and recovery in America.* Chestnut Health Systems; Bloomington, IL.

Woo, S.M., Hepner, K.A., Gilbert, E.A., Osilla, K.C., Hunter, S.B., Munoz, R.F. & Watkins, K.E. (2013). Training addiction counselors to implement and evidence-

based intervention: Strategies for increasing organizational and provider acceptance. *Cognitive and Behavioral Practice, 20*(2). 232-244. doi: https://dx.doi.org/10.1016%2Fj.cbpra.2012.03.004.

Woodside, M, Ziegler, M., & Paulus, T. M. (2009). Understanding school counseling internships from a communities of practice framework. *Counselor Education and Supervision, 49*(1), 20-38. doi:10.1002/j.1556

Appendix A: Demographic Questions

Demographics:

The following questions are to collect basic demographic information pertinent to the study of empathy across the variables of SUD (substance use disorder) counselors across education status and recovery status.

1. Are you at least 18 years of age?
    a. Yes
    b. No
2. Gender
    a. Male
    b. Female
    c. Transgender
    d. Other
    e. Prefer not to say
3. Employment status
    a. Full-time
    b. Part- time
    c. Unemployed
4. Licensed/certified for your state of practice
    a. Yes
    b. No
    c. Pursuing licensure
    d. Not needed in my state
5. Number of years licensed/certified
    a. 0-2
    b. 3-5
    c. 5-10
    d. 11 or more
6. Are you in recovery from SUD for at least 1 year?
    a. Yes
    b. No
    c. Never had an SUD
7. Do you have a master's degree?
    a. Yes
    b. If yes is it a master's in counseling, social work or other counseling-oriented field?
    c. No

Appendix B: ACME Permission

PsycTESTS

Affective and Cognitive Measure of Empathy
Version Attached: Full Test

PsycTESTS Citation:
Vachon, D. D., & Lynam, D. R. (2016). Affective and Cognitive Measure of Empathy [Database record]. Retrieved from PsycTESTS. doi: http://dx.doi.org/10.1037/t49392-000

Instrumen
t Type:
Inventory/
Questionn
aire
Test Format:
Responses for the 36 items are on a 5-point Likert-type scale ranging from Strongly disagree (1) to Strongly agree (5).

Source:
Vachon, David D., & Lynam, Donald R. (2016). Fixing the problem with empathy: Development and validation of the affective and cognitive measure of empathy. Assessment, Vol 23(2), 135-149. doi: 10.1177/1073191114567941. by SAGE Publications. Reproduced by Permission of SAGE Publications
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American Psychological Association

Appendix C: Affective and Cognitive Measure of Empathy (ACME)

1 I have a hard time reading people's emotions
2 I think it's fun to push people around once and a while
3 I can tell when someone is afraid
4 It's obvious when people are pretending to be happy
5 I love watching people get angry
6 I enjoy seeing strangers get scared
7 It makes me feel good to help someone in need
8 I get excited to give someone a gift that I think they will enjoy
9 I usually understand why people feel the way they do
10 When my friends are having a good time I often get angry
11 People who are cheery disgust me
12 I don't worry much about hurting people's feelings
13 I don't really care if other people feel happy
14 I have a hard time figuring out what someone else is feeling
15 I can tell when people are about to lose their temper
16 I can usually predict how someone will feel.
17 I don't really care if people are feeling depressed
18 I like making other people uncomfortable
19 I get a kick out of making other people feel stupid
20 When my friends get angry I often feel like laughing
21 Sometimes I enjoy seeing people cry
22 Other people's feelings don't bother me at all
23 I feel awful when I hurt someone's feelings
24 Other people's misfortunes don't bother me much
25 I can usually tell how people are feeling
26 Sometimes it's funny to see people get humiliated
27 If I could get away with it, there are some people I would enjoy hurting
28 If I see that I am doing something that hurts someone, I will quickly stop
29 I often try to help people feel better when they are upset
30 I enjoy making others happy
31 I am not good at understanding other people's emotions
32 People have told me that I'm insensitive
33 I can usually guess what's making someone angry
34 People don't have to tell me when they're sad, I can see it in their faces
35 I find it hard to tell when someone is sad
36 I admit that I enjoy irritating other people

Cognitive Empathy (COG) = 1r, 3, 4, 9, 14r, 15, 16, 25, 31r, 33, 34, 35r
Affective Resonance (RES) = 7, 8, 12r, 13r, 17r, 22r, 23, 24r, 28, 29, 30, 32r
Affective Dissonance (DIS) = 2r, 5r, 6r, 10r, 11r, 18r, 19r, 20r, 21r, 26r, 27r, 36r

Note. r = reverse scored item (6—original score). The items are administered on 5-point Likert-type scale ranging from Strongly disagree (1) to Strongly agree (5). On all three scales (including DIS), high scores indicate greater empathy.

Appendix D: NAADAC Verification of Respondents

From: Kristin Hamilton [mailto:[redacted]
Sent: Thursday, December 13, 2018 11:19 AM
To: Malcolm Horn [redacted]
Subject: RE: PHD service update

Hi Malcolm,

Your invitation went out to 48,521 individuals, was opened by 9,003 individuals, and clicked on by 1,233 individuals.

Unfortunately, we don't have numbers regarding how many of those people are counselors v. other professionals.

Regarding your question about bachelor's v. master's level counselors, are you looking for numbers among NAADAC membership or among the e-mail list to which we sent your mailing? If it's the latter, we do not have numbers for that.

Our mailing list is not set up in such a way that we require that people put in education or employment information to be included, so unfortunately, we do not have that information about them.

Kristin Hamilton, JD
Sr. Communications Manager
NAADAC, the Association for Addiction Professionals