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Counselor Recovery Status and Substance Abuse Certification: A Relationship to Perceived Credibility and Counselor Preference with Hazardous Drinkers

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COUNSELOR RECOVERY STATUS AND SUBSTANCE ABUSE CERTIFICATION: A RELATIONSHIP TO PERCEIVED CREDIBILITY AND COUNSELOR PREFERENCE WITH HAZARDOUS DRINKERS

by

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Abstract

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This study investigated the role of counselor influence in substance abuse counseling. Hazardous drinkers' perceptions of a counselor's recovery and certification status were examined to determine if these counselor characteristics increased hazardous drinkers' perceptions of counselor credibility or their counselor preference. No statistically significant relationship was found between counselor recovery status and ratings of counselor credibility. Contrary to what was hypothesized participants rated themselves as less willing to choose a counselor in recovery than one who did not report a recovery history. This finding, albeit an inverse relationship from what was hypothesized, adds to the group membership similarity literature in regard to participants' perceptions of counselor recovery status. Although counselor certification in substance abuse has become more prevalent, there were no differences between certified and non-certified counselors on either dependent variable. This study did not find an interaction effect between counselor recovery status and certification status. Clinical implications for counselors working with substance abuse are discussed.

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Chapter 1

Introduction

Does a counselor need to have experienced the same problem that the client is experiencing to be effective? Can a counselor establish credibility without a common history of the client's issues? Does the counselor's credentialing status help establish credibility with the client? These are challenging research issues that counseling researchers have struggled with for several decades (Aronson, Turner, & Carlsmith, 1963; Culbreath, 2000; Miller, Scarborough, Clark, Leonard, & Keziah, 2010; Priester, Azen, Speight, & Vera, 2007). The research reported in this paper sought to provide answers that may be helpful to counselors working in the field of addiction with respect to earning additional certifications or self-disclosing their own recovery status.

In a meta-analytic review of counselor influence, Hoyt (1996) concluded that counselor credibility cues were strongly related to counselor influence using dependent measures like client self-reported satisfaction with therapy, willingness to refer a friend to this counselor, or level of self-disclosure. However, perceived credibility, from the standpoint of counselor characteristics such as having a history of addiction or possessing a specialized credential, has not been researched. Credibility of addictions counselors is at a premium because influencing clients to enter and to remain in therapy is one of the preeminent challenges that counselors face (Toriello & Strohmer, 2004).

Participants in this study were a specific at-risk population, hazardous drinkers, defined as individuals who drank over medically recommended limits for low-risk drinking (7 drinks a week, 3 drinks per occasion for women and 14 drinks a week and 4 drinks per occasion for men), but have so far either avoided or failed to recognize significant alcohol related problems (Saunders, Aasland, Babor, & Grant, 1993). The

main premise of this research was that understanding the factors, like the counselor's recovery status or a counselor's certification as a Certified Substance Abuse Counselor (CSAC), that may be related to hazardous drinkers beginning and staying in counseling can be significant in helping to reduce the personal and societal costs associated with hazardous drinking.

Statement of the Problem

The reason these questions about counselor credibility and influence are relevant is that most hazardous drinkers do not participate in alcoholism treatment programs or Alcoholics Anonymous (Regier et al., 1993). Some 23.1 million Americans aged 12 or older (9.1% of the United States population) experienced a substance abuse problem. This is defined as an early stage of dependence where repeated use of alcohol or other drug leads to problems, but does not include compulsive use or addiction, and stopping the drug does not lead to significant withdrawal symptoms (Hasin, Hatzenbuehler, Keyes, & Ogburn, 2006). However, only 2.6 million (11.2%) of those in need received treatment (SAMHSA, 2010) and many discontinue counseling prematurely. The Center for Substance Abuse Treatment (2000a, 2000b) reports that 50% to 64% of individuals who begin addictions counseling do not complete it. This is far higher than estimates of premature termination for general counseling at 20% (Swift & Greenberg, 2012). Prevalence estimates for hazardous drinkers range from 4% to 29% of the general population (Edwards, Arif, & Hodgso, 1982; Institute of Medicine, 1990; Moore & Gerstein, 1981; Reid, Fiellin, & O'Connor, 1999). Although severely dependent alcohol abusers have more serious problems, most alcohol-related costs to society stem from the behaviors of hazardous drinkers (e.g., drunk driving, days of missed work, and domestic

violence). Consequently, increasing the number of individuals from this group who receive treatment can have significantly beneficial consequences. Evidence suggests that brief counseling interventions made early in counseling are the most effective approach (Chick & Crombie, 1985; Saunders & Foulds, 1992; Swift & Greenberg, 2012).

One possible way to increase utilization of appropriate health care options for populations such as hazardous drinker in need is to study their help-seeking processes (Marlatt, Tucker, Donovan, & Vuchinich, 1997). Help-seeking for medical and mental health problems has been well researched (Cockerham, 2007; Jorm, 2000; Whaley 2001), but research on help-seeking for alcohol and other drug problems is a more recent development (Blanco et al., 2013; Faraone, Spencer, Aleardi, Pagano, & Biederman, 2004; Galdas, Cheater, & Marshall, 2005), particularly as compared to the long history of substance abuse as a social problem. Most problematic drinkers are in a state of denial and do not see the need for treatment (Cunningham, Sobell, Sobell, Agrawal, & Toneattot, 1993; Grant, 1997). Furthermore, Grant (1997) reported that significant barriers to alcoholism treatment include a lack of confidence in the alcoholism treatment system and its effectiveness and stigmatization of counseling for alcoholism. Many alcohol abusers who express the need for treatment do not believe that treatment will be effective (Cunningham et al., 1993; Hingson, Mangione, Meyers, & Scotch, 1982)**.** Thus, it appears that two major problems in the help-seeking process for alcohol abusers are denial and a perceived lack of confidence in treatment.

While most individuals are able to resolve drinking problems without formal treatment (Dawson et al., 2006; Sobell, Ellingstad, & Sobell, 2000), many are unable to do so. Because of the great need to reduce any barriers to access, having a range of

treatment options that are perceived in a positive light is in great demand (Epler, Sher, Loomis, & O'Malley, 2009). Even with the availability of effective treatment choices, those individuals who would consider counseling must also perceive therapy as a potential source of help and support (Lopez, Melendez, Sauer, Berger, & Wyssman, 1998). Given this, it is important to determine what counselor factors influence help-seeking and positive perceptions of treatment options for the hazardous drinker population (Tucker & Gladsjo, 1993).

Elliot and Williams (2003) reported that the majority of literature on counseling examines issues from the practitioner viewpoint rather than from the client perspective. They reported that clients seem to have little regard for theory or technique, but do recognize the importance of the person who is the counselor. While there has been some research on the perception of counselor credibility in the area of addiction (Culbreath, 2000; Priester et al., 2007; Toriello & Strohmer, 2004; White, 2000), there is little or no research examining the counselor perceptions of hazardous drinkers.

Given that there are a number of barriers to seeking and staying in treatment, an essential question would seem to be, what counselor characteristics influence hazardous drinkers' perceptions of counselor credibility? The study used a long recognized theory of social influence as a research foundation. Applying the theory and methodology developed by Strong (1968), the role of two variables, counselor recovery status and credentialing status, were explored. Both of these counselor characteristics seemed likely to be relevant to hazardous drinkers' perceptions of counselor credibility and, as a result, their willingness to seek treatment. The following sections review the literature related to social influence theory, paying specific attention to previous research examining

counselor recovery status and counselor credentialing as possible social influence variables.

Social Influence Theory

The importance of counselor recovery status and credentialing was examined from the theoretical perspective of counseling as a social influence process proposed by Stanley Strong (1968). In a milestone article advocating the application of social psychological theory to counseling research, Strong (1968) proposed that counseling could be viewed as a social influence process. The premise was that the greater the credibility of the communicator, the greater the change of opinion of the listener (Aronson et al., 1963; Bochner & Insko, 1966; Lorge, 1936). Social influence in counseling is the interpersonal power the counselors have because the client perceives them as credible. Interventions and interpretations by the counselor are likely to place the client in a state of cognitive dissonance, and the client will strive to return to a state of equilibrium (Festinger, 1957).

The counselor's level of credibility, and resulting social influence, affects whether or not the client resolves the dissonance by accepting the counselor and acting on the counselor's input or by discrediting the counselor and ignoring the suggested interventions. The more credible the counselor, the less likely the client will be able to reduce his/her dissonance by devaluing the counselor (Leierer et al., 1998). Credibility is defined as encompassing all the characteristics of client perceptions of counselor expertness, attractiveness, and trustworthiness that contribute to the counselor's influence power (Hoyt, 1996). As a result, the degree to which clients perceive counselors as

credible directly influences counselors' potential to facilitate change in clients (Guinee & Tracey, 1997; Heppner & Claiborn, 1989).

Researchers studying social influence theory have attempted to identify specific counselor cues that are associated with client perceptions of counselor credibility. According to Strong (1968), three categories of cues affect clients' perceptions of counselor credibility: behavioral, evidential, and reputational. Behavioral cues are the counselor's verbal and nonverbal behavior, such as tone of speech, body movement, and body positioning. For example, positive attending skills have proven to be powerful cues of counselor credibility (Leierer, Strohmer, Leclere, Cornwell, & Whitten, 1996). Evidential cues include non-behavioral aspects of the counselor, such as situational and setting characteristics, appearance, and attire. Previous examples of evidential cues introduced to clients by stimuli include client-counselor stepfamily history similarity (Higginbotham & Myler, 2010), racial identity (Townes, Chavez-Korell, & Cunningham, 2009), the presence or absence of a disability (Freeman & Conoley, 1986; Leierer et al., 1996, 1998; Nosek, Fuhrer, & Hughes, 1991; Strohmer & Biggs, 1983), counselor attire (Roll & Roll, 1984), the presence of counselor's diplomas and certificates in the clinical setting (Siegel & Sell, 1978). A counselor's reputational cues include indications of the counselor's professional or social role made known by introductions or inferred from information made available about the counselor's background, prior accomplishments, or theoretical or philosophical orientation (Corrigan, Dell, Lewis, & Schmidt, 1980; Humeidan, 2011; Goates-Jones, & Hill, 2008; Hoyt, 1996). Other examples include the following: counselor title (Reed & Holmes, 1989), veteran identity (Gade & Wilkins, 2012), and inclusion of Islam in counseling (Priester & Jana-Masri, 2009).

The research examining social influence theory in counseling and the variety of cues affecting counselor credibility has been extensive. As mentioned, in an attempt to establish a comprehensive understanding of Strong's model of interpersonal influence, Hoyt (1996) conducted a meta-analytic literature review of studies published examining effects of perceived counselor credibility. Hoyt (1996) concluded that the results conformed to the predictions of the model that cues of counselor credibility or "influence power" (Strong, 1968, p. 223) are relevant indicators of potential client influence prior to the formation of a therapeutic alliance between the participant and counselor.

Evidential Cue

Counselor recovery status is a specific evidential counselor cue that merits exploration of its influence on the counselor perceptions of clients who are hazardous drinkers. Addiction counselors have often relied on their ability to influence clients based upon their personal experience. The history of recovered alcoholics as wounded healers dates back to late 18th century Native American cultural revitalization movements (White, 2000). The notion of the wounded healer led to the field of addictions counseling and is still present in Alcoholics Anonymous (Jackson, 2001; Pagano, White, Kelly, Stout, & Tonigan, 2013). It is primarily developed by individuals with personal experience with recovery from alcohol and other substance abuse issues and based on the assumption that being in recovery leads to enhanced credibility (Hall, 1993; Yalisove, 1998).

The recovery status of a counselor suggests group membership similarity. The group membership premise is that clients from special populations are likely to perceive counselors from the same special population group as more credible due to similar life

experiences (Atkinson, Maruyama, & Matsui, 1978; Banks, Berenson, & Carkhuff, 1967; Sue, 1975). This has led to debates between the recovering paraprofessionals and non-recovering professionals regarding how to counsel clients (Yalisove, 1998) and how addictions counselors should be trained (West, Mustaine, & Wyrick, 2002). For example, is a professional without a drinking history going to be perceived as more or less credible than a paraprofessional peer who has a similar drinking history? And would the shared group membership inherent in the peer to peer relationship enhance the client's likelihood of choosing that particular counselor?

The findings from research examining the influence of counselor recovery status on client perceptions are mixed. To assess the influence of group membership similarity with respect to substance abuse, Culbreath (2000) reviewed existing research on differences between substance abuse counselors who did and did not have a personal history of chemical addiction. Following extensive database searches, 16 studies were found that addressed the issue of differences based on counselor recovery status. These findings suggest that clients do not perceive recovering counselors differentially from nonrecovering counselors. However, Priester et al. (2007) pointed out that there were methodological limitations with many of the articles in Culbreath's review that may have contributed to this conclusion. First, many of the studies confounded recovery status with professional training (Aiken, LoSciuto, Aiken Ausetts, & Brown, 1984), so that it was impossible to differentiate between the effects of a professional counselor in recovery without a master's degree and counselor with a master's-level not in recovery. A second concern was that participants in some of the studies were in treatment for acute, active addiction (Argeriou & Manohar, 1978; Brown & Thompson, 1975; Johnson & Prentice,

1990; Kirk, Best, & Irwin, 1986), while other studies used non-clinical student samples (Lawson & Gaushell, 1995). It has been suggested that individuals who are in acute treatment for addiction have not yet had the opportunity to internalize a new self-concept that includes the presence of having a disability (Livneh &Antonak, 2005). The use of a nonclinical sample potentially raises the question of whether results from nonalcoholic participants will generalize to results from alcoholic samples.

In light of the limitations presented in the review, Priester et al. (2007) conducted their own study on the impact of counselor recovery status. Contrary to Culbreath's findings recovering alcoholics in the Priester et al. study perceived recovering counselors more positively than they perceived nonrecovering counselors. Their participants were post-treatment recovering alcoholics, who would likely have different reactions to the counselor recovery status than what might be observed in someone who did not have this known identity. This is important because the participant in recovery may align themselves to a recovering counselor as a result of similar backgrounds as opposed to participants in research reported here who may have been unaware (or in denial) of the hazards of their drinking and might view the counselor in recovery as different from themselves. The current study addressed some of the limitations of previous literature by clearly defining the counselor's recovery status and also by including participants who were hazardous drinkers who were not likely to have formed an awareness of their at-risk behavior. The premise was if those who could benefit from treatment were less willing to seek treatment due to a lack of confidence in the counselor, perhaps a perceived increase in counselor credibility would lead to those more reluctant and at-risk to seek more treatment options.

Reputational Cue

Another possible way for counselors to enhance their credibility with problematic drinkers is for counselors to possess certain credentials related to training in substance abuse counseling (e.g., certifications). Miller et al. (2010) suggested that there is a need for national credential standards and that credentialing is important to the field of addiction counseling because (a) grassroots addiction counseling is increasingly less recognized professionally; (b) many organizations, such as funding groups, currently require counselor credentials for reimbursement of client services; (c) the credentialing process furthers the education of the addiction counselor. Certification in addiction counseling is gaining in popularity; in 2005, SAMHSA reported that there were more than 115,000 certified addiction counselors.

In Strong's theory, counselor certification is a reputational cue. Other examples of examined reputational cues include the following: counselor introduction (Bernstein & Figoli, 1983; Freeman & Conoley, 1986; McCarthy, 1982; McKee & Smouse, 1983), level of training (Freeman & Conoley, 1986; Nosek et al., 1991), and level of experience (Nosek et al., 1991; Strohmer & Biggs, 1983). Similar to certifications in other counseling disciplines (e.g., Certified Rehabilitation Counselor-CRC) studied by Leierer et al. (1998), the attainment of a certification as a Substance Abuse Counselor status in addiction counseling seems plausible to be a cue that clients might use to infer counselor credibility.

As with the research on evidential cues, the research on the influence of such reputational cues has been mixed. Even dating back over 30 years, there were vigorous debates about the benefits and liabilities of certification and licensure as authors argued

for or against regulation, or debated the usefulness of various regulatory tools (Cottingham, 1980; Danish & Smyer, 1981; Davis, 1981; Fretz & Mills, 1980; Gross, 1977, 1978; Hogan, 1980; Rogers, 1973; Witmer, 1978). As Leierer et al. (1996) summarized, characteristics such as counselor licensures and certifications have had a reliable effect on clients' perceptions (Corrigan et al., 1980; Strong, Welsh, Corcoran, & Hoyt, 1992). Yet, Hoyt (1996) found in the absence of other informational cues or a longer therapeutic relationship, evidence of credibility, such as diploma on the wall, did little to enhance a counselor's influence power. As Thomas (1993) suggested with respect to the Certified Rehabilitation Counselor (CRC), there is an "intended inference" that people who attain a passing score are more competent to practice in their respective discipline. As the mixed findings about the efficacy of certifications continue, there is a prevalence of such certifications.

Relevant to this study, the certification efficacy debate remains largely unresolved due to the lack of research with specific populations' perceptions of counselor credibility being matched to particular credentials. To represent a current credential in the research reported here, a Certified Substance Abuse Counselor (CSAC) credential for addiction counselors was utilized. A current example is the certification available in North Carolina supported by the North Carolina Substance Abuse Board Practice Board ("NCSABPB," 2013). Given the combination of mixed findings in the credibility research and the growing prevalence of certifications, this study examined hazardous drinkers' perception of the Certified Substance Abuse Counselor (CSAC), and if that certification affects hazardous drinkers' willingness to enter treatment.

Purpose of the Study

Despite the amount of research related to problematic drinkers, there is much to discover in the area of addiction research, in particular, about the therapeutic process at the early intervention stage and also the training of the counselors who focus on addiction. Little is known about what variables are related to hazardous drinkers' willingness to enter treatment (Marlatt et al., 1997; Willenbring, 2010). For example, according to Willenbring (2010), the actual decision to enter treatment may be the crucial change point in treatment for substance abuse. Emphasis should be placed on the important goal of providing treatments that are acceptable and accessible earlier in the course of illness rather than waiting until chronicity and severe disability are present (Willenbring, 2010).

West, Mustaine, and Wyrick (2002) called for additional research comparing the training and preparation backgrounds of professional and paraprofessional counselors. Addiction counselors of varying degrees and backgrounds are now being introduced to certifications like being a Certified Substance Abuse Counselor (CSAC). Therefore, it was necessary to research the influence the certification may have on the populations it seeks to serve. The main purpose of the study was to examine whether a counselor's certification in substance abuse or the counselor's own recovery status are related to hazardous drinkers' willingness to enter counseling treatment for alcohol abuse.

As a result of these recommendations, the following research questions and hypotheses were posed. Based in the group membership similarity literature, the first question addressed whether participants who were hazardous drinkers would rate counselors who were recovering as more credible and be more likely to choose that

particular counselor as compared to counselors who did not indicate recovery status. Based on this question and the literature review presented in this chapter the following hypotheses were tested.

H1: Hazardous drinkers would rate a counselor who reports being in recovery in their professional disclosure statement as more credible than a counselor who does not report being in recovery in their professional disclosure statement.

H2: Hazardous drinkers would be more willing to choose a counselor who reports being in recovery in their professional disclosure statement than a counselor who does not report being in recovery in their professional disclosure statement.

Further, based in the certification literature, the second question addressed whether participants who are hazardous drinkers would rate counselors who reported being a Certified Substance Abuse Counselor (CSAC) in their professional disclosure statement as more credible, and be more willing to seek treatment from them, than counselors who did not indicate that they were a Certified Substance Abuse Counselor (CSAC). Based on this question and the literature review presented in this chapter the following hypotheses were tested.

H3: Hazardous drinkers would rate a counselor who reports being a Certified Substance Abuse Counselor (CSAC) in their professional disclosure statement as more credible than a counselor who does not report being a Certified Substance Abuse Counselor (CSAC) in their professional disclosure statement.

H4: Hazardous drinkers would be more willing to choose a counselor who reports being a Certified Substance Abuse Counselor (CSAC) in their professional disclosure

statement than a counselor who does not report being a Certified Substance Abuse Counselor (CSAC) in their professional disclosure statement.

In addition, because research has not yet examined the interaction effect of counselor certification and recovery status on perceptions of counselors with any group of individuals it was addressed as a research question rather than as a hypothesis. The research question was: Do counselor certification and recovery status interact to differentially affect client ratings of counselor credibility and willingness to seek treatment?

Chapter 2

Literature Review

In a landmark article advocating the application of social psychological theory to counseling research, Strong (1968) proposed that counseling be viewed as an interpersonal influence process, known as social influence theory. Strong contended that counselors enhance their perceived credibility by means of their inherent role as helpers. This study examined this assertion further by examining whether or not certain addiction counselor characteristics affect hazardous drinkers' perceptions of the credibility of the counselor and their willingness to enter treatment.

Treatment success has been significantly tied to initial perceptions of counselor credibility (Hardy, Barkham, Shapiro, & Reynolds, 1995; Kazdin, 1979); thus the need to establish credibility early on in treatment (Sue & Zane, 1987). An understanding of treatment entry, in particular, is important because only a small number of substance users enter treatment (Grant, 1997). Furthermore, limited research has been conducted on how clients' individual differences, particularly their propensity for addiction (e.g., hazardous drinkers), interact with counselors' working styles, despite evidence that clients' individual differences are the greatest source of variance in predicting therapeutic outcomes (Beutler & Crago, 1991). A review of studies most relevant to the research included material addressing the background of the problem of substance abuse, including barriers to treatment, hazardous drinkers, social influence theory and counselor credibility, recovery status, counselor training, credentialing, and analogue studies. The results can have clinical implications for counselors as they reach out to an at-risk population before their problems develop into more long-term dependence.

Background of the Problem: Substance Abuse

Substance abuse usually emerges in adolescence, and for a significant proportion of individuals, substance abuse will continue through adulthood (Sloboda, 2002). Epidemiological research has consistently identified substance abuse as one of the most prevalent mental health disorders among the general population affecting approximately 7% of the U.S. population (Grant et al., 1994). In 2003, the prevalence of alcohol use disorders was estimated at 1.7% globally, and furthermore, these disorders accounted for 1.4% of the total world disease burden (World Health Organization, 2003). Harmful consequences of alcohol dependence and other alcohol misuse include interpersonal violence (Greenfield, 1998), sexual victimization (Abbey, 2002), risky sexual behavior (Donovan & McEwan, 1995; Strunin & Hingson, 1992), and suicide (Grant & Hasin, 1999). From a health perspective, long-term alcohol abuse is known to have harmful effects on the body's liver and the immune, cardiovascular, and skeletal systems (NIH, 2000) increasing mortality risks by around 50% (Dawson, 2000). Further, in the United States, costs associated with excessive alcohol use—such as the cost of lost work productivity, health care, and mortality—amount to over $140 billion annually (Harwood, Fountain, & Livermore, 1998). Because both prevalence and alcohol dependence are highly comorbid with other psychopathologies (Driessen, Veltrup, Wetterling, John, & Billing, 1998; Tomasson & Vaglum, 1995), many clinicians find themselves treating clients with alcohol related problems (Read, Kahler, & Stevenson, 2001).

Given the prevalence of alcohol related problems, there has been extensive research to delineate the progression of this form of substance abuse and define it.

Clinically, alcohol abuse ("hazardous use") is regarded widely as an early stage of dependence (Hasin, et al., 2006). Jellinek (1960), one of the leading Post-Prohibition American authorities on alcoholism, defined alcoholism broadly as any use of alcoholic beverages that causes any damage to the individual, to society, or both. Li, Hewitt, and Grant (2007) refer to alcoholism as a common disease where approximately 4–5% of the population is affected by it at any point in time. Given the broad definitions and these approximate percentages; there is no clear distinction between heavy drinking, per se, and "addiction" (Willenbring, 2010). In fact, Willenbring (2010) further contends nonsymptomatic heavy drinking blends imperceptibly into mild, then moderate, dependence and, in a minority of those affected, severe and recurrent dependence. Albeit possibly counterintuitive, alcohol dependence is not inevitably progressive, but may have long periods of stability or alternate back and forth between heavy and lighter drinking and abstinence (Dawson et al., 2006; Vaillant, 2003). From a public health perspective, addressing the concerns of individuals at all levels of usage is important (Sobell, Cunningham, & Sobell, 1996).

Alcohol use disorders have enormous consequences not only for the health and welfare of those afflicted with the disorders but also for their families, their employers, and the larger society (Grant, Dawson, & Stinson, 2006). Approximately one in four children under 18 years of age in the United States has been exposed to alcohol abuse or alcohol dependence in the family (Grant, 2000). Furthermore, of the 11.1 million victims of violent crime each year in the U.S., almost one in four, or 2.7 million, reported that the offender had been drinking prior to the crime (Greenfield, 1998). The economic costs of alcohol abuse and dependence were $184.6 billion for 1998 (the last year for which

figures are available) or roughly $638 for every man, woman, and child living in the United States (Harwood, 2000).

A large portion of the negative effects seen these data is in part due to binge drinking. Wechsler and Nelson (2001) defined binge drinking as "consumption of a sufficiently large amount of alcohol to place the drinker at increased risk of experiencing alcohol-related problems and to place others at increased risk of experiencing secondhand effects" (p. 287). Furthermore, the NSDUH defines heavy alcohol use, often referred to as binge drinking, as five or more drinks on the same occasion on 5 or more days in the past 30 days (Office of Applied Studies, 2006). Summarized findings include the rates of alcohol use by full time college students aged 18 to 20 and found that the rates of the past month, binge, and heavy alcohol use remained steady from 2002 to 2005. Young adults aged 18 to 22 enrolled full time in college were more likely than their peers not enrolled full time (i.e., part-time college students and persons not currently enrolled in college) to use alcohol in the past month, binge drink, and drink heavily (Office of Applied Studies, 2006). In summary, substance abuse, specifically the abuse of alcohol, has dramatic implications for adults.

Hazardous Drinkers

Hazardous drinkers are a less known categorization to the general public than alcoholics but are significantly more prevalent. In 1982, the World Health Organization defined hazardous drinking as alcohol consumption which confers risk of physical or psychological harm (Edwards et al., 1982). Hazardous drinkers are defined as individuals whose quantity or pattern of alcohol consumption places them at risk for adverse health events (Reid et al., 1999). It has been estimated that the ratio of problem drinkers (i.e.,

mild alcohol dependence) to those severely dependent on alcohol is about 4:1 (Institute of Medicine, 1990). Most patients who report hazardous drinking are not alcohol dependent. There are, however, so many of these non-dependent drinkers, that they account for most of the morbidity and mortality that is attributed to drinking (Institute of Medicine, 1990). Specifically, data suggest that alcohol consumption in quantities consistent with hazardous drinking may increase the risk for adverse health events, such as hemorrhagic stroke and breast cancer (Reid et al., 1999). Furthermore, although severely dependent alcohol abusers have more serious problems, most alcohol-related costs to society stem from the large numbers of problem drinkers (e.g., drunk driving, days of missed work, domestic violence) (SAMHSA, 2005). Because meta-analytic reviews (Heppner & Claiborn, 1989; Hoyt, 1996) suggest counselor as well as client characteristics play a role in perceived credibility, particularly in early stages of treatment, this study sought to add to this literature by examining these questions with respect to the counselor credibility in a specific at-risk population defined as hazardous drinkers.

The literature suggests this population is particular about the qualities of a possible addiction counselor. When comparing non-substance abusers subjects with those with a history of substance abuse, Ritter, Bowden, and Murry (2002) found that those clients in an alcoholic outpatient dependency clinic who seemed more anxious and displayed poorer cognitive functioning appeared to perceive their counselors to have less unconditional positive regard, empathy, and congruence. Complicating matters, hazardous drinkers have so far either avoided or failed to recognize significant alcohol-related problems. According to McCusker, Basquille, Kwaja, Murray-Lyon, and Catalan

(2002), this avoidance or lack of recognition is of clinical relevance. As a result, the majority of at-risk clients do not seek help until there are established and often serious complications resulting from their drinking (Buchol, Homan, & Helzer, 1992*).*

Barriers to Treatment

Given that the estimated ratio of untreated individuals needing treatment to treated individuals ranges from 3:1 to 13:1 (Marlatt et al., 1997; Tsogia, Copello, & Orford, 2001), there exists a great need for addiction counselors to understand how to better reach this population. The availability of a wide range of treatment options is highly desirable (Epler, Sher, Loomis, & O'Malley, 2009). Research on help-seeking behaviors has primarily examined barriers to treatment. Grant (1997) determined that at the aggregate level, significant barriers to alcoholism treatment include the lack of confidence in the alcoholism treatment system and its effectiveness, stigmatization, financial concerns, and denial. In general, many respondents who expressed the need for treatment frequently did not have a conviction that treatment was really necessary or needed or would be effective (Cunningham et al., 1993; Hingson et al., 1982)**.** Factors such as lack of financial resources or facilities for childcare were found to be much less important barriers to care than were individual predisposing factors including attitudes towards alcoholism treatment. In another study, those who were younger, were married, had higher income, had higher education, and did not have an adverse general medical condition were significantly less likely to perceive a need for help or to seek help for an alcohol use disorder (Oleski, Mota, Cox, & Sareen, 2010). Hence, education about treatment seems to be related to the perception of the benefits of treatment. Even with the prospect of treatment choices, those persons who voluntarily pursue counseling must not

only be experiencing distress but must also be inclined, under these circumstances, to perceive others as potential sources of help and support (Lopez et al., 1998). Therefore, a key variable in the process of choosing help is the extent to which the user perceives the counselor conducting the treatment as a having favorable reputation (Littrell, Caffrey, & Hopper, 1987).

Influence

The current study used Strong's (1968) social influence theory to describe how the counselor is perceived by a client. The counselor builds "influence power" (p. 223) by engaging in behaviors or supplying other cues likely to enhance the client's perceptions of him or her as expert, attractive, and trustworthy—that is as a credible source of advice and help. "Credibility has been defined as the client's belief that the counselor possesses information and means of interpreting information which allows the client to make valid conclusions about and to deal effectively with his problems" (Strong & Dixon, 1971, p. 562). However, the research about the role of social influence has been critiqued due to the lack of studies delineating the connection of clients' perceptions of counselors to subsequent client behavior (Heppner & Claiborn, 1988; Strohmer et al., 1996).

Research on the client preferences and counselor credibility cues is mixed. Social influence research has consistently measured counselor credibility through three perceptions of clients: expertness, attractiveness, and trustworthiness (Heppner & Claiborn, 1988; Strohmer et al., 1996; Toriello & Strohmer, 2004). Counselors' influence potential is greater when clients perceive counselors as expert (e.g., proficient in the profession), attractive (e.g., likeable), and trustworthy (e.g., dependable/faithful) (Toriello & Strohmer, 2004). Furthermore, positive perceptions of expertness, attractiveness, and

trustworthiness may serve as relationship enhancers (Goldstein, 1986), hence increasing the potential of counselors to influence clients to willingly engage in therapy, and promote client change because it will be difficult for clients to discount counselor credibility (Strohmer et al., 1996; Toriello & Strohmer, 2004). This section of the literature review focused on the overall findings from the literature as it relates to counselor credibility and its associated influence.

The literature related to social influence and credibility is vast and spans nearly half a century. To summarize the literature for this study, two meta-analytic studies (Heppner & Claiborn, 1998; Hoyt, 1996) were reviewed. Both studies had similar findings despite different methodologies. When Hoyt (1996) reviewed Strong's (1968) social influence theory in counseling, Hoyt found that credibility cues were moderately related to credibility and that credibility was strongly related to counselor influence. Hoyt's (1996) review provided support for many of the conclusions reached by Heppner and Claiborn (1989). The main difference in how the review was conducted is that Hoyt (1996) decided not to treat dimensions of expertness, attractiveness, and trustworthiness, separately but instead as a composite score of credibility due to high inter-correlations. Hoyt (1996) concluded that his meta-analysis confirmed the key propositions of Strong's (1968) theory: counselor cues are reliably associated with credibility perceptions in these studies, and there is evidence from field studies that credibility is strongly related to influence (although the direction of causation in this relation cannot be inferred from most of these studies). Hoyt (1996) added that even if measures of satisfaction with a counselor were weak predictors of counselor influence as reported by Heppner and Claiborn (1989), they probably still target an important step in the influence process.

Hoyt (1996) maintained that client change is, at least in part, the result of an early step in the counseling process where a positive attitude about counselor helpfulness contributes to the overall development of the relationship.

Specifically relevant to this study was Hoyt's (1996) finding about reputational cues. Reputational cues, although moderately related to credibility, were only weakly related to influence. Conversely, the set of cues labeled "characteristics associated with the counselor," which were only weakly related to credibility, were moderately related to influence. The influence power of a given counselor cue was not completely mediated by its relation to credibility. Clients confronted with reputational or evidential cues, such as a diploma on the wall, likely recognize that these cues are, by definition, evidence of a counselor's credibility, and this recognition is reflected in their credibility ratings. Hoyt suggested that further research is needed related to other factors that may also influence perceptions of counselor credibility.

Counselor Recovery Status

One of the two independent variables in the study used to address the relationship between cue types and influence by exploring the perception of addiction counselor credibility literature focused on the concept of group membership similarity. The premise is that clients from special populations are thought to be likely to perceive counselors from the same special population group as more credible and attractive due to group membership similarity (Atkinson et al., 1978; Banks, et al., 1967; Sue, 1975). Counselor recovery status is a specific cue of credibility that merits further exploration of influence on the perceptions of clients (Priester et al., 2007). The actual prevalence of alcoholism among counselors is very difficult to estimate (Bissell & Haberman, 1984; Skorina,

Bissell, LeClair, & Clinton, 1990). However, given the demands on addiction counselors to establish a perception of credibility, addiction counselors have often relied on their ability to influence clients based upon their personal experience with addiction.

Addictions counselors' recovery status has been tested as a group membership similarity variable, with mixed results (Toriello & Strohmer, 2004). At the infancy of social influence theory research and addiction, Atkinson and Carskaddon (1975) attempted to distinguish how the perception of credibility varied for different client populations. For instance, not all populations were equally impressed by a prestigious introduction of the counselor. They found that mental health clients assigned high ratings to a high-prestige counselor while drug abuse inmates assigned high ratings to a low-prestige counselor, providing early evidence for the group membership similarity factor. English (1987) found that clients perceived addictions counselors with a history of recovery from addiction as more expert, attractive, and trustworthy. On the other hand, research by Creegan (1984) found no effect for the recovery status of addictions counselors.

As mentioned, an important study was Culbreath's (2000) review that researched the 16 studies available on the differences between substance abuse counselors who do and do not have a personal history of chemical addiction. Contrary to social influence theory, Culbreath (2000) maintained that clients do not perceive recovering counselors differentially from nonrecovering counselors. A major methodological limitation of the review, according to Priester et al. (2007), was the use of nonclinical samples in the studies. This created a potential concern about the level of external validity of the findings.

Toriello and Strohmer (2004) examined the impact of addictions counselors' interactional style (confrontational vs. motivational interviewing), recovery status (recovering vs. nonrecovering), and nonverbal behavior (facilitative vs. neutral) on 116 clients' perceptions of addictions counselor credibility. The results showed support for a significant relationship between perceptions of the credibility of addictions counselors and willingness to enter into a counseling relationship with them. Specifically, clients' ratings of attractiveness accounted for 29% of the variance in their willingness to choose to work with the portrayed addictions counselor. Toriello and Strohmer suggested that clients, when thinking about choosing an addictions counselor, are more concerned about addictions counselors' attractiveness and trustworthiness than addictions counselors' expertness.

In a more recent study, Priester et al. (2007) analyzed the evidential cue of counselors in recovery using a specific clinical population. Using an analogue counselor description, active Alcoholic Anonymous members (n = 116) who were in-recovery rated the varying levels of counselors' evidential cues and their credibility using the *Counselor Rating Form-Short*. There were three forms of the analogue counselor description: similarly perceived recovering, dissimilarly perceived nonrecovering, and a control. Supportive of the group membership similarity proposition and the role of evidential cues, the similarly perceived recovering counselor was viewed more positively than the control. No statistically significant differences were found between the dissimilarity and control conditions. The Priester et al. (2007) study was unusual in that it used participants with a history of addiction taking into account how their perceptions might be different from the general population without a history of addiction. The major limitations of the

study include using an analogue design, that the addiction counselors' educational backgrounds were not clarified and only the use of the term psychotherapist was used rather than distinct credentialing or educational experiences. Also, the use of participants' in recovery in AA was a step forward in the research area, yet how the participants considered themselves in a context of dissimilar individuals were assumptions that were not directly addressed. The current study addressed some of these limitations by using participants that were active users at-risk instead of recovering. Also, it specified certification status, in addition to comparing those with a history of addiction.

Recently, Soderberg and Tilly (2010) explored the significance of common experiences regarding drug abuse between clients and drug counselors during addiction treatment. A qualitative case study method was used in which four former drug users were interviewed. Soderberg and Tilly (2010) concluded that the counselors' and the drug addicts' mutual experience of drug abuse regarding drug addiction treatment was not important. These recent studies only add to the mixed findings in the literature regarding the role of addiction counselors and group membership similarity, suggesting that further research is needed in the area of group membership similarity.

Counselor Credentialing Status

Credentialing is a specific type of reputational cue that represents training in a specialty. In describing the history and future of alcohol treatment, Willenbring (2010) reported that we have a much better understanding of the course of recovery, the risk factors, and have made advances in behavioral and pharmacological treatments. One particular intervention that counselors use, to not only improve their knowledge and skills but also their recognition, are specific reputational cues, like credentials and/or

certifications. In an attempt to clarify the terminology involved, the following definition was used: certification, which is often voluntary, is established by professional groups monitoring the professional behavior of their members (Henderson, 2005). Certification is a term used to refer to the process of becoming qualified to practice and recognized by professional peers (Capuzzi & Gross, 2001; Sweeney, 1995). Generally, certification documents education, experience, and skill and can offer prestige and identification of competent counselors to promote public welfare (Davis, 1981; Jones, 1987; Vacc & Loesch, 2000). Most certifications require continuing education and higher level training, and different certification approaches may have different requirements (Pryzwansky, 1993; Sweeney, 1995; Vacc & Loesch, 2000). Therefore, certifications are designed to provide multilayered levels of protection to consumers of professional services and enforce high standards of conduct and discipline (Hall & Boucher, 2008; Skrtic, 1991). Licensure, on the other hand, means that counselors cannot practice or identify themselves professionally without having passed required exams and meeting certain other criteria (Henderson, 2005). Lastly, credentialing is a process handled at the state level (On, 2012) and has been recognized as a possible way for identifying and developing qualified service providers (Van Houtte, 2010). Credentials in counseling date back to 1973, when the Commission on Rehabilitation Counselor Certification (CRCC) was established to create accountability and consumer protection, establish criteria to attain a certification, and provide education for the public (CRCC, 2005; Saunders, Barro-Bailey, Rudman, Due, & Garcia, 2007).

Dating back over 30 years, counseling journals were alive with debate about the benefits and liabilities of certification and licensure (Cottingham, 1980; Danish & Smyer,

1981; Davis, 1981; Fretz & Mills, 1980; Gross, 1977, 1978; Hogan, 1980; Rogers, 1973; Witmer, 1978). Some authors questioned the added value of such reputational cues. The amount of education and training that a licensed counselor has already completed prior to attaining additional certification is extensive by any comparison. Even researchers within other specialties of psychology (e.g., sports psychology) have denounced the need for certification. Anshel (1992) argued against the certification of sport counselors, focusing on two issues. First, certification in sport psychology is exclusive and does not recognize the unique contributions that individuals with related skills can offer the profession. Instead, Anshel believed that the field should develop a consensus about the competencies of its practitioners, researchers, and educators. Simply, Dattilio (2002) indicated that counselors believe certification simply to be "icing on a cake that needs no further sweetening" (p. 54).

Furthermore, Miller and Brown (1997) asserted that practicing counselors with generalist training are already well qualified to treat substance abuse. They contend that effective treatment of substance abuse is not a mysterious art (noting that scientific evidence points to the efficacy of therapeutic styles and treatment approaches well within the repertoire of many, if not most counselors). These assertions reflect an even earlier claim that there are many reasons to suggest that the core training and skills of competent (Miller & Rollnick, 1991). Thomas (1993) argued that the primary purpose of professional credentialing in counseling was not to protect the weak, but rather to increase the power and authority of the professionals who stand to benefit from the legal recognition and the exclusion of competitors whom they consider to be less qualified.

Thomas' point appears to be that certification actually protects professionals and not clients.

Conversely, there are advocates for additional credentialing that support their growth. Their main point is that consumers are less likely to seek the services of professional counselors if they do not know about the competencies of the counselors, thus the public's image counselors is critical (Myers, Sweeney, & White, 2002). Despite the mixed results concerning the perception of certifications, certifications continue to develop in the field of addictions counseling, primarily supported by two separate credentialing agencies, the International Certification and Reciprocity Consortium/Alcohol and Other Abuse (IC&RC, or ICRC) and the Association for Addiction Professionals (NAADAC, originally the National Association of Alcohol and Drug Abuse Counselors). An apparent lack of standardization exists in the credentialing process. Miller et al. (2010, p. 51), described the current credentialing situation for addiction counselors in the United States as a "checkered, chaotic system." Despite the lack of standardization, this does not diminish the apparent relevance of certifications. Credentialing is important to the field of addiction counseling because (a) grassroots addiction counseling is increasingly less recognized professionally; (b) many organizations, such as funding groups, currently require counselor credentials for reimbursement of client services; (c) the credentialing process furthers the education of the addiction counselor (Miller, 2005). This still leaves the question, does possessing a certification cause those in need to be more willing to choose that particular counselor?

Previous research suggests a need for greater education for addiction counselors. There is an insufficient number of trained counselors working with alcohol use and

substance abuse and too few programs available to train them (Flynn & Brown, 2008; McLellan & Meyers, 2002; Washington, 2002). For example, in a study of six major mental health professions, from private practice to organizational settings, a significant minority of these practitioners reported having little or no training to address substance abuse, either from formal graduate education, internships, or continuing education (Harwood, Kowalski, & Ameen, 2004). Moreover, traditionally, healthcare providers are poor at identifying hazardous drinkers, and as many as 72% escape their detection (Bowen & Sammons, 1988; Conigrave, Saunders, & Reznik, 1995; Friedmann, McCullough, Chin, & Saitz, 2000). Washton (2002) indicated in a review that even few psychologists acquire the core knowledge base about substance abuse, or the clinical training/supervision in addictive disorders as part of their graduate or postgraduate education. Washton noted that there exists a well-established belief that these disorders are best treated in specialized addiction treatment programs because the type of targeted treatment these patients require is thought to lie outside the scope of what an outpatient practitioner can competently provide (Miller & Brown, 1997). Washton also noted a long-held belief by many practitioners that people with alcohol/drug problems are simply not good therapy candidates (Imhof, 1995); and finally noted that there are long-standing ideological conflicts and incompatibilities between mental health professionals on one hand and the mainstream addiction treatment system on the other (Margolis & Zweben, 1998).

There are few studies that reviewed the impact of counselors' training preparation on substance abuse treatment. Cellucci and Vik (2001) surveyed 144 professional counselors, focusing on their training and the provision of substance abuse services.

Although the great majority of respondents (89%) had had contact with clients with substance abuse problems, most rated their graduate training as inadequate preparation for such practice. This study supports an earlier study by Chiert, Gold, and Taylor (1994) that found that, although 38% of graduate programs in psychology in their survey offered at least one course on alcoholism or substance abuse, 95% of these courses were electives. Consequently, they noted that as prevalent as substance abuse is, it is surprising how little attention is given to it in graduate school training programs. These studies provide more support for adding the credentialing requirement as it fills an educational void not only for the beginner, but also for the more advanced counselor with extensive generalist training.

In a related study, Cardoso, Pruett, and Chan (2006) (reviewing education, training, and current practice) examined the preparedness of rehabilitation counselors to work with people with disabilities with primary or secondary substance-related problems. The surveyed sample included 76 participants (47 men, 29 women) from the Division 22 members of the American Psychological Association. Even though 79% of respondents reported treating individuals with alcohol and other drug issues, more than half of the sample rated their training in substance abuse treatment as inadequate. Once again, participants reported a lack of preparation in substance abuse training in their graduate program coursework, practicum, and internship. In light of these findings, the authors suggested that both continuing education courses and changes to curriculum requirements should be considered in order to close the gap between training and practice. One initiative has been designed to enhance counselors' skills in working with substance abuse clients showing mental disorders at a level below that of serious mental illness

(Hunter et al., 2005). These authors report achieving positive findings in terms of changes in knowledge and attitudes, although findings are not yet available in terms of the impact of this training initiative on client outcomes.

If counselor certification were to significantly affect hazardous drinkers' perceptions of counselor credibility and willingness to seek treatment, this would legitimize the creation of certifications for a population lacking trust in treatment. In this case, the certifications might be considered to have "worked" in terms of increasing the likelihood of getting those into treatment that otherwise would not. If the certificate does not have this effect then the existence, or at the very least, the curriculum, and/or the marketing of the certification (or similar credentialing), may need to be reassessed.

Analogue Research

This study was analogue in design. Analogue research is laboratory research that attempts to mimic real life while it controls as many extraneous variables as possible, sometimes manipulating the independent variable. As early as 1979, Gelso noted that even though they suffer from lessened generalizability to naturalistic settings analogue designs permit rigor, control, and testing of causal relationships. Therefore, despite potential threats to external validity, analogue studies have been a mainstay of the counseling research literature (Johnson, Pierce, & Baldwin, 1996). For example, Hardin and Yanico (1981) studied two years of the *Journal of Counseling Psychology* and found 41 separate studies using an analogue design. Similarly, the Johnson et al. (1996) review covered 11 years (1984-94) and three counseling journals (*Journal of Counseling Psychology*, *Journal of Counseling and Development, and Counselor Education and Supervision*) and discovered the analogue design had been used 134 times.

A few studies analyzed the effect of media presentation when measuring perceived credibility. For example, Johnson et al. (1996) analyzed how presentation format (video, audio, written transcript, or written transcript with photograph) affected participants' responses to counseling scenarios in an analogue study. In this study, participants completed three instruments, measuring counselor credibility and expectations, after watching a brief counseling session in the four formats. Results revealed significant differences among the formats on the Counselor Rating Form (CRF-S: Corrigan & Schmidt, 1983). Transcripts with pictures were rated the highest (higher than videotape and audiotape) and transcripts without pictures rated second highest (higher than video). Hence, the findings in the Johnson et al. study both corroborate and contradict those reported earlier by Hardin and Yanico (1981) and Schwab and Harris (1984). Although all three studies found no differences between audio and video; there was in fact, a major difference when written transcripts were considered. Hardin and Yanico (1981) found that counselors depicted with written transcripts were rated lower on credibility than those depicted using audio or video while Johnson et al. (1996) found that these counselors were rated higher on both credibility and trustworthiness. Due to the differences in their findings, Johnson et al. concluded that some qualities or characteristics of the specific counselor may have adversely affected the participants' ratings on the CRF-S, independent of the presentation style. In summary, Johnson et al. warned that researchers must proceed with caution when interpreting results across studies that use different presentation styles. Given that this study used a written transcript via the Internet, the limitations of this type of media were considered when interpreting the results.

Chapter 3

Methodology

The purpose of this research was to test whether recovery status and substance abuse certification status would have significant effects on perceived counselor credibility and counselor preference for hazardous drinkers. An analogue design used was to contribute to the literature to reduce barriers to treatment in the field of substance abuse. The investigation was approved by the University's Institutional Review Board.

Participants

Previous studies with significant results examining the topic had 8, 30, and 15 subjects per cell, (Paradise, Conway, & Zweig, 1986; Priester et al., 2007; Toriello & Strohmer, 2004). The average number of participants per cell (M = 30.25) was acceptable in comparison to the prior research This study also exceeded the recommended statistical minimum sample size of 88 for a 2 x 2 design with a power of .80 where α = .05 (Hinkle, Wiersa, & Jurs, 2003). A total of 186 participated in the study, over two-thirds (n = 128) identified themselves to be hazardous drinkers (7 drinks a week, 3 drinks per occasion for women and 14 drinks a week and 4 drinks per occasion for men) and at least 21 years old. Of the 128 hazardous drinkers, the majority of participants were Caucasian (n = 121), with 5 Black/African American, 1 Asian/Pacific Islander, and 1 Hispanic. To increase external validity and reduce generalizing across people in regard to cultural differences (Nisbett, 2003), only Caucasian participants (n = 121) were analyzed. All four counselor professional disclosure statements were properly represented within each cell (see Table 1).

Table 1

Method Design

	Counselor Certification Status	
Recovery Status	Certification Not Stated Yes-Recovering Alcoholic (*n* = 23)	Certified Substance Abuse Counselor (CSAC) Yes-Recovering Alcoholic (*n* = 38)
	Certification Not Stated Recovery Status Not Stated (*n* = 29)	Certified Substance Abuse Counselor (CSAC) Recovery Status-Not Stated (*n* = 31)

Of the 121 hazardous drinkers, 82 were female and 39 were male. All hazardous drinkers were at least 21 years old, with most between the ages of 35-54 (*n* = 62). The majority of hazardous drinkers had prior professional counseling experience (*n* = 75). All hazardous drinkers had at least a high school degree or equivalent, with most having a bachelor's degree (*n* = 65) with the second largest proportion having a post-graduate degree (*n* = 36).

Measures

Participants were asked to complete the following measures: Informed Consent (Appendix A), Demographic Questionnaire (Appendix B), a Counselor Preference Form

(CPF) (Appendix D), the Counselor Rating Form-Short (CRF-S) (Appendix E), the Alcohol Use Disorders Identification Test-Condensed (AUDIT-C) (Appendix F), and a Manipulation Verification (Appendix G). Time to complete all of the instruments took approximately 5 to 10 mins.

Demographic questionnaire. This form was used to gather demographic information about the participants, including gender, age, education level, race/ethnic background, and region of residence (Appendix B).

Counselor Preference Form. To measure willingness to work with the portrayed counselor, the Client Preference Form (CPF) was developed for this study using the guideline provided by Toriello and Strohmer (2004). The CPF is a one-item instrument that asked the participant to rate, on a 7-point scale with anchors 1 (not very) and 7 (very), "If you were choosing a counselor, how willing would you be to choose the counselor whose professional disclosure statement you just read?"

Counselor Rating Form–Short. (CRF-S; Corrigan & Schmidt, 1983). The CRF-S was used as a dependent variable to measure participants' perceptions of the analogue counselor. Based upon the original Counselor Rating Form (Barak & LaCrosse, 1975), the CRF-S (Corrigan & Schmidt, 1983) is a 12-item scale assessing counselor attractiveness, expertness, and trustworthiness (4 items each (e.g., *honest*), ranging from 1 = not very to 7 = very). According to Strong (1968), *expertness* is defined as the clients' beliefs that their counselor has the knowledge and skill to help them deal effectively with their problems. *Attractiveness* refers to clients' feelings of liking, admiration, and desire to be similar to their counselor. Lastly, *trustworthiness* is defined as clients' perceptions of their counselors' sincerity, openness, and absence

of motives for personal gain. The potential total score on the CRF-S ranges from 12 to 84, with higher scores denoting positive responses. Using this shortened version, Corrigan and Schmidt (1983) reported an equivalent factor structure, along with adequate levels of reliability and internal consistency estimates (above .80 for all scales), with the original measure. To determine the internal consistency of the CRF-S in this study, Cronbach's alpha (Cronbach, 1951) was calculated (Cronbach's $\alpha = .95$). A Cronbach's alpha coefficient of 0.70 is normally considered to indicate a reliable set of items (De Vaus, 2002) and supports using the CRF-S in this study as one factor. Bergin (1971) indicated, because of high intercorrelations among the subscales, researchers have suggested that this instrument measures a general "good guy" factor. Factor analytic studies (Tracey, Glidden, & Kokotovic, 1988) have supported the use of the total CRF-S score as such a generalized measure of positive perceptions. Hoyt (1996) decided to use of expertness, attractiveness, and trustworthiness, as one factor in his meta-analytic study because of consistent findings of high intercorrelations among these three dimensions among studies reporting these intercorrelations, and on the lack of significant moderator effects of credibility type on either the relation between cues and credibility or the relation between credibility and influence. Other researchers have also used the total CRF-S score as a dependent variable (Kokotovic & Tracey, 1987; Lawson & Gaushell, 1995; Morran & Kurpius, 1994). There is extensive research offering support for its validity (Ponterotto & Furlong, 1985). The higher the scores reported, the greater the perceived level of credibility. The CRF-S scores found in this study ($M = 64.23$) were consistent with the literature which

reported average scores of 57.59, 67.00, and 76.66 (Morran & Kurpius, 1994; Priester et al., 2007; Reese, Conoley, & Brossart, 2002).

Alcohol Use Disorders Identification Test-Condensed (AUDIT; Saunders et al., 1993). The AUDIT-C was used to determine whether or not a participant is a hazardous drinker. The original AUDIT was developed as a screening tool by the World Health Organization (WHO) for early identification of problem drinkers. The AUDIT-C is the condensed version which includes the following first 3 questions of the AUDIT: "How often did you have a drink containing alcohol in the past year?" "How many drinks containing alcohol did you have on a typical day when you were drinking in the past year?" "How often did you have 6 or more drinks on one occasion in the past year?" Responses were scored from 1 to 4 in the direction of problem drinking. The summary score for the total AUDIT ranges from 0, indicating no presence of problem drinking behavior, to 12, indicating marked levels of problem drinking behavior and alcohol dependence. Using cutoff points for the AUDIT-C of 4 for men and 3 women, this instrument was 99.7% as sensitive as the full AUDIT (Gordon, Maisto, & McNeil, 2001) and thus these cut-off points were used for this study. If any male or female answered less than the threshold, the participant was not considered a hazardous drinker. Bradley et al. (1998) reported test–retest reliabilities over a 3-month interval ranging from 0.65 to 0.85. Bergman and Kallmen (2002) reported a test–retest reliability of 0.98 over a 3 to 4 week interval, providing further evidence for the temporal stability of the AUDIT-C. Three studies report internal consistencies of the AUDIT-C with reliability coefficients at acceptable levels, ranging from 0.69 to 0.91 (Bergman & Kallmen, 2002; Gomez, Conde, Santana, & Jorrı´n, 2005). AUDIT-C scores for this study (n = 186) were normally

distributed, with skewness of -.071 (SE = .18) and kurtosis -.47 (SE = .35). The AUDIT-C scores ranged from 0 to 8 (M = 3.57, SD = .14). The scores for those who met the criteria for hazardous drinking (*n* = 121) were also normally distributed, with skewness of .626 (SE = .22) and kurtosis -.02 (SE = .44). The average hazardous drinker score was 4.60 (SD = .11).

Manipulation Verification. A manipulation check was included to evaluate the participants' perceived recognition of the credentials of the counselor given a choice between the four counselor descriptors. The following question was asked, "Which of the following choices best identify the qualifications of the counselor listed in the Professional Disclosure Statement?" Participants were asked to match the counselor description seen and then recall if they recognized the counselor given 4 multiple choice responses provided (see Appendix G).

Procedures

Two independent variables were examined in a 2 x 2 experimental, randomized, analogue research design: certification status and recovery status (certified and not stated to be in-recovery, not stated to be certified and in-recovery, both in-recovery and certified, and lastly, not stated to be certified and not stated to be in-recovery). Consistent with literature in this field (Creegan 1984; English, 1987; Priester et al., 2007; Toriello & Strohmer, 2004) when a counselor cue was not presented in the counselor description, the phrase "not stated" was not included in the description (in the current study the professional disclosure statement). This absence indicated that the counselor was either not in recovery, did not possess a certification or both.

Excerpts from the template provided by the North Carolina Board of Licensed Professional Counselors were used to format the counselor description ("Template," 2013). No information about gender was provided to avoid any potential gender bias. To allow for increased generalizations to the real world of substance abuse clinical practice and to reduce the elevation of the CRF-S scores, licensure of the counselor was not included in the disclosure statement. Some substance abuse professionals may only have graduated from high school, whereas others may hold undergraduate or graduate degrees (Mustaine, West, & Wyrick, 2003).

Participants were recruited through the use of email notification, social media, and direct solicitation. Specifically, emails concerning the study were sent to professional colleagues who shared the study with unknown participants. A link for the online survey was distributed via twitter to random accounts. Lastly, with the use of the approved survey notification handout, participants were solicited in airports in order to achieve a more diverse sample. No incentives for participation were provided. The participants were included in the study regardless of race or gender. All participants were provided with an informed consent form prior to completing any of the instruments. The data was collected using a web-based survey design, via www.surveygizmo.com. Participants were given the following directions: (a) read the informed consent (to assure anonymity, participation served as consent), (b) complete demographic information and population screening assessments (c) were randomly assigned to read one of the four descriptions of an analogue counselor (see below), (d) complete the subsequent dependent measures, and (f) read the disclaimer. Photos of the counselor or other extraneous information were

excluded to keep the focus on the primary variables of interest, which was the perception of the recovery status and the counselor credentials.

As mentioned, a description of a counselor was presented in a professional disclosure statement. The first component of the description was a complete professional disclosure statement including information on confidentiality. Listed below the disclosure statements were the bullet point descriptions used to differentiate each professional disclosure statement. Bold bullet points were selected for clear distinction between each of the four scenarios. For a list of the four counselor descriptions, see Appendix C.

Carefully read this description and imagine that you will be working with this particular counselor at a counseling center:

Professional Disclosure Statement

Introduction:

This Disclosure Statement is a part of the Standards of Practice. Here is some important information about the counseling process and my services. As you may already know, therapy is an engaging process. During counseling, I will do my best to honor your personal experiences and perspective. You can count on me to provide you with honest feedback, and to offer suggestions based on my clinical training and life experiences. I encourage your active participation and collaboration as we develop our therapeutic relationship and work to meet your chosen goals.

Confidentiality:

All of our communication becomes part of the clinical record, which is accessible to you upon request. I will keep confidential anything you say as part of our counseling relationship, with the following exceptions: (a) you direct me in writing to disclose information to someone else, (b) it is determined you are a danger to yourself or others (including child or elder abuse), or (c) I am ordered by a court to disclose information.

Counseling Background:

- Five years of counseling experience
- Recovering Alcoholic
- Volunteer at a local community recreational center
- Client-centered counseling approach

I look forward to the opportunity to work with you. Thank you.

A second description will identify the counselor with a certification by the deletion of the phrase, "recovering alcoholic" and inserting the phrase, "Certified Substance Abuse Counselor (CSAC)."

Counseling Background:

- Five years of counseling experience
- Certified Substance Abuse Counselor (CSAC)
- Volunteer at a local community recreational center
- Client-centered counseling approach

The third form of counselor description will be a counselor with both a history of being in-recovery and with a certification.

Counseling Background:

- Five years of counseling experience
- Recovering Alcoholic
- Certified Substance Abuse Counselor (CSAC)
- Volunteer at a local community recreational center
- Client-centered counseling approach

The final statement describers a counselor with neither a history of recovery nor a certification and is just described as a counselor.

Counseling Background:

- Five years of counseling experience
- Volunteer at a local community recreational center
- Client-centered counseling approach

Following the completion of the survey, information regarding hazardous drinking and a list of help-seeking professional resources was provided. Also, a professional disclaimer also included the following statement derived from a national alcohol screening program supported by Boston University School of Public Health ("Alcohol Screening," 2013): "This survey does not provide a diagnosis of alcohol dependence or any other medical condition. The information provided here cannot substitute for a full

evaluation by a health professional, and should only be used as a guide to understanding your alcohol use and the potential health issues involved with it." Participants were informed that 7 drinks a week, 3 drinks per occasion for women or 14 drinks a week and 4 drinks per occasion for men, suggests the need for further evaluation from a professional. An explanation was provided stating that the greater the quantity, the more likely it was that the patient's drinking was affecting his or her health. A disclaimer about resources about how to seek help was provided including informational websites and additional screening options (Appendix H).

Data Analysis

The design of the study was a 2 (recovery status at two levels: recovering or not recovering) x 2 (certification status at two levels: certified or not certified) factorial. Data was analyzed using a 2 x 2 multivariate analysis of variance (MANOVA) examining two main effects with two dependent variables (counselor credibility and willingness to seek treatment) and an interaction effect. An interaction effect was examined to assess the combination of both a recovering counselor and a Certified Substance Abuse Counselor.

Chapter 4

Results

This study examined the perceptions of hazardous drinkers about counselor recovery and certification status. Two hypotheses and one research question were addressed using these two independent variables and two dependent variables, participants' perceptions of counselor credibility and counselor preferences. Means and standard deviations were examined for all primary variables (see Table 2).

Table 2

Recovery & Certification Status, Means, and Standard Deviations of Dependent Variables

Measure/Recovery Status	M	SD
CRF-S		
None	62.59[a]	11.93[a]
Recovery	67.09[b]	11.88[b]
Certified	61.68[c]	14.10[c]
Recovery & Certified	65.84[d]	11.06[d]
Total	64.23[e]	12.30[e]
CPF		
None	5.31[a]	1.41[a]
Recovery	4.70[b]*	1.66[b]
Certified	5.29[c]	1.18[c]
Recovery & Certified	4.74[d]	1.78[d]
Total	5.01[e]	1.55[e]

Note: CRF-S = Counselor Rating Form-Short. CPF = Counselor Preference Form.
[a] n = 29. [b] n = 23. [c] n = 31. [d] n = 38. [e] n = 121. *$p < .05$.

Prior to conducting the 2 x 2 multivariate analysis of variance (MANOVA), a Pearson correlation was performed between the dependent variables in order to test the MANOVA assumption that the dependent variables would be correlated with each other in the moderate range (Meyer, Gamst, & Guarino, 2006). Hazardous drinkers' ratings of credibility and counselor preference were significantly correlated, $r = .36$, $p < .01$. A meaningful correlation pattern was observed among the dependent variables, suggesting the appropriateness of a MANOVA. Additionally, a the Boxes M value of 9.62 was associated with a *p* value of .409, which was interpreted as non-significant based on Huberty and Petoskey's (2000) guideline (i.e., $p < .005$). Thus, the covariance matrices between the groups were assumed to be equal for the purposes of the MANOVA.

Main Effect of Recovery

Main effects were calculated for recovery status and certification status and an interaction effect was tested for both recovery and certification status together. The first hypothesis tested was that hazardous drinkers would rate recovering counselors as more credible than counselors without a recovery history. Counselor recovery status, as presented in the professional disclosure statement, was the independent variable and the CRF-S scores was the dependent variable. A statistically significant MANOVA effect was obtained for the counselor recovery status, Wilks' Lambda = .898, $F(2, 116) = 6.58$, $p = .002$ (see Table 3).

Table 3

MANOVA Main Effects Analysis

Effect	Λ	*F*	*p*	η^2
Recovery	.898	6.58	.002*	.102
CSAC	.998	.144	.866	.002
Recovery x CSAC	1.00	.014	.986	.000

Note: *$p < .05$.

Prior to conducting a follow-up univariate analysis for the recovery status variable, the homogeneity of variance assumption was tested for both hazardous drinkers' ratings subscales (credibility and counselor preference). Based on a series of Levene's *F* tests, the homogeneity of variance assumption was considered satisfied. The test for homogeneity of variance was not significant for the Counselor Rating Form-Short (CRF-S), (Levene $F(1,117) = .932$, $p > .05$, indicating that this assumption underlying the application of ANOVA was met. Also, a test for homogeneity of variance was not significant on the Counselor Preference Form (CPF) (Levene $F(1,117) = 2.579$, $p > .05$), indicating that this assumption underlying the application of ANOVA was also met.

It is worth noting that the scores for the recovering counselor ($M = 67.09$) were higher than the non-recovering counselor ($M = 62.59$) and approached statistical significance, $F(1,117) = 3.660$, $p = .058$. Therefore, hazardous drinkers did not rate recovering counselors as significantly more credible than counselors without a recovery

history. Although, the first hypothesis was not supported it did approach significance. A brief discussion will be presented in Chapter 5 to address potential clinical implications.

The second hypothesis was that hazardous drinkers would be more willing to select a counselor in recovery than a counselor not in recovery. Counselor recovery status in the professional disclosure statement was the independent variable and the CPF scale was the dependent variable. As stated earlier, hazardous drinkers' ratings of counselor preference did differ significantly indicating an effect for counselor recovering status, $F(1,117) = 4.22$, $p = .042$. However, instead of the predicted direction of the hypothesis (that hazardous drinkers would be more willing to select a counselor in recovery than when recovery status was not stated), the opposite effect occurred. Hazardous drinkers' were significantly less likely to prefer the counselor in recovery ($M = 4.70$) than the counselor not in recovery ($M = 5.31$).

Main Effect of Certification

The third hypothesis was that hazardous drinkers would rate a Certified Substance Abuse Counselor (CSAC) as more credible than a counselor who was not certified as a Certified Substance Abuse Counselor (CSAC). Counselor certification status, as presented in the professional disclosure statement, was the independent variable and the CRF-S was the dependent variable. There was not a statistically significant main effect for the Certification in Substance Abuse (CSAC), Wilks' Lambda = .998, $F(2,116) = .144$, $p > .05$. Based on non-significance between the two groups, hazardous drinkers were not significantly more likely to rate a certified counselor as more credible ($M = 61.68$) compared to a counselor not listing a certification ($M = 62.59$).

Likewise, the fourth hypothesis was that hazardous drinkers' would be more willing choose a counselor with the CSAC certification than without the (CSAC) certification. There was not a statistically significant difference in scores for certification status between the certified and the non-certified counselor, $F(1,117) = .00$, $p > .05$. The ratings for the Certified Substance Abuse Counselor (CSAC) ($M = 5.29$) as compared to the counselor who was not certified ($M = 5.31$) were very similar. Based on the lack of a difference between the two groups, hypothesis four was not supported.

Interaction Effect

The interaction effect of counselor certification and recovery status among hazardous drinkers was addressed as a research question rather than as a hypothesis. The research question was: Would counselor certification and recovery status interact to differentially affect client ratings of counselor credibility and willingness to seek treatment? There was not a significant difference for the interaction effect of the combination of recovery and certification counselor, Wilks' Lambda = 1.00, $F(1, 117) = .014$, $p > .05$. Based on the non-significant interaction effect, counselor certification and recovery status did not interact to differentially affect hazardous drinkers' ratings of credibility and counselor preference.

Manipulation Verification Effect

Lastly, a manipulation verification check was included to assess the accuracy of participants' recall of the actual counselor description they viewed. The manipulation verification results were troubling. Only 16.12% accurately verified the certified counselor seen in the counselor description along with a mere 8.70% of participants who

properly matched the recovery status of the counselor viewed. As a result, extreme caution should be taken when making any conclusions from the current study.

Chapter 5

Discussion

In this study hazardous drinkers' perceptions of the counselors' variables, recovery and certification status, were examined. A multivariate analysis of variance (MANOVA) failed to support any of the four hypotheses and no interaction effect was found. However, a significant opposite effect did occur with one hypothesis. These chapters reviews the test of the hypotheses, limitations of the study, and implications for theory, future research, training, and practice, including aspects specific to the field of counseling psychology.

Test of Hypotheses and the Interaction

The first two hypotheses assessed hazardous drinkers' perception of credibility and counselor preference using the evidential cue of counselor recovery status. The first hypothesis was that hazardous drinkers would rate recovering counselors as more credible than counselors without a recovery history. Although this hypothesis approached statistical significance (p = .058) hazardous drinkers did not rate recovering counselors as more credible than non-recovering counselors. Thus hypothesis 1 was not supported.

The second hypothesis further assessed the evidential cue of counselor recovery status by testing whether hazardous drinkers' would be more willing to choose a recovering counselor than a counselor not in recovery. Although there was a significance difference between the two groups, the hypothesis that hazardous drinkers would prefer the recovering counselor was not supported. Contrary to the group membership similarity argument used to develop this hypothesis; hazardous drinkers were significantly less

willing to choose a counselor in-recovery than a counselor without mention of the counselor's recovery status in the professional disclosure statement. A possible explanation for this finding is that hazardous drinkers' may not identify as a person with a substance abuse problem. If this were the case, the premise of a group membership effect would not be applicable, thus leading to the clinical implications discussed later in this chapter.

The last two hypotheses assessed the role of the reputational cue certification status in the perceptions and choices of hazardous drinkers. The third hypothesis was that hazardous drinkers would rate a Certified Substance Abuse Counselor (CSAC) as more credible than a counselor who was not certified as a Certified Substance Abuse Counselor (CSAC). Hazardous drinkers did not rate the counselor with the designation Certified Substance Abuse Counselor (CSAC) as more credible than one who did not have that designation. Thus hypothesis 3 was not supported.

The fourth hypothesis using certification status as a reputational cue was that hazardous drinkers would be more willing to choose a Certified Substance Abuse Counselor (CSAC) than a counselor who was not certified. Hazardous drinkers were not more willing to choose the counselor with the designation Certified Substance Abuse Counselor (CSAC) than one that did not have that designation. Based on lack of significance between the two groups, hypothesis 4 was not supported.

Finally, an interaction effect was analyzed to examine hazardous drinkers' perceptions of the substance abuse counselors with respect to the combination of recovery and certification status. While there has been considerable research in this area with respect to counselor recovery status, few studies have explored the relationship

between recovery and certification status. The research question asked, "Do counselor certification and recovery status interact to differentially effect client ratings of counselor credibility and willingness to seek treatment?" The addition of certification in substance abuse counseling for a recovering counselor seemed likely to be rated more favorably their non-recovering, non-certified counterparts. Despite including both a reputational and an evidential cue to describe the counselor, the results indicated there was no interaction between the cues and the hazardous drinkers' perception or choices.

Limitations

The present study had several limitations. The primary limitation was the concerning result from the Manipulation Verification. There was a very low percentage of participants who accurately matched the counselor viewed in professional disclosure statement to the Manipulation Verification. The lack of awareness for the counselor and/or recall prevented definitive implications regarding hazardous drinkers' perceptions of the different counselor's described.

A possible explanation for the result were related to the limitations of Internet research. Participants may not have been focused enough on the questions due to the size of the device utilized (e.g., smartphone, tablet, personal computer), the location surveyed, or the amount of text seen at any one time. Related to limitations of the Internet research, other limitations were associated with the sample criteria. Initially, participants with prior counseling experience were to be excluded. Given that the participants consisted of 67% with prior professional counseling, this exclusionary criteria was not utilized. The hazardous drinkers' previous counseling experience may have affected their perceptions based upon the counselor they had previously seen, and the outcome of that counseling,

to name a few confounding variables. Also, the participants consisted of predominantly of highly educated, female Caucasian Americans. Thus, this sample did not represent a diverse population. However, this type of sample is consistent with Internet research (Gosling, Vazire, Srivastava, & John 2004; Mitchell & Jolley, 2012) and in support of the sample, 100% of the participants were hazardous drinkers. Even given these limitations, this Internet based study was in line with past research that applied social psychological research to counseling (Strong et al., 1992), was consistent with the value placed on experimental rigor (Hill & Corbett, 1993), and allowed comparisons with other findings in this body of research.

The other limitations were associated with the traditional issues of laboratory research described by Kazdin (1986) and Kerlinger (1986) having to do with the study's analogue nature and the caution of generalizing results to actual counseling sessions (Toriello & Strohmer, 2004). Strohmer, Leierer, Cochran, and Arokiasamy (1996) discussed that while analogue designs allow more rigor, a limitation is that they may not represent a realistic counseling environment. For example this study only examined the first step in the counseling process. As noted by Strong and Dixon (1971), social influence has five boundary conditions: (a) the fact that counseling is a conversation, (b) the clearly defined roles of the client and the counselor, (c) the varying (usually extended) duration of counseling, (d) the extent of client motivation, and (e) the level of client distress. The analogue format used in this study met two of the boundary conditions established by Strong and Dixon (1971). This study emphasized clearly defining the role of the counselor (the professional disclosure statement) and the client's level of distress identified (being a hazardous drinker). Although a limitation, this design

is prevalent in the literature. In support of the design of this study, Priester (2003) presented meta-analytic findings comparing analogue studies that did not meet the boundary conditions to studies that did and found equivalent effect sizes between the two methods. Therefore, the analogue design in this study was consistent with much of the research in this area.

Other limitations were a result of the study attempting to focus on specific elements of the substance abuse treatment process. This study relied on participant's initial reaction to a counselor, which represented the beginning of the help-seeking process. This focus has been criticized by some reviewers (Watkins, 1990) as only representing a portion of the treatment process. Related, because denial is one of the major barriers to treatment, participants may have been reluctant to share their personal drinking histories. An alternative method could have used the perspective of asking participants to deflect attention away from personal responses and instead direct the focus to rating "your friend" and his or her drinking history to possibly produce more valid results. However, focusing on the very initial phase of treatment was supported by the need to help determine how to reduce barriers of entry to treatment and the importance of the client-counselor match (Project MATCH, 2008).

Lastly, a limitation related to the substance abuse literature, although consistent with the role of the paraprofessional in substance abuse counseling, was the counselor descriptions in the professional disclosure statements. The counselor preference scores may have been lower than expected because participants were not able to gather information needed to form an opinion of the counselor. Comparisons of average scores using the CPF were limited (with only a regression analysis data reported; Toriello &

Strohmer, 2004) and more importantly, the current study used a unique description. A more thorough description of the qualifications required for a Certified Substance Abuse Counselor (CSAC) that included coursework requirements may have led to a greater influence and higher scores. The counselors were intentionally not identified to have a license or specific educational requirements (e.g., master's degree in counseling).

Implications for the Treatment of Hazardous Drinkers

The purpose of the study was to assess whether or not certain counselor cues would influence hazardous drinkers' help-seeking behaviors. Treatment success has been significantly tied to initial perceptions of counselor credibility (Hardy et al., 1995; Kazdin, 1979); thus making it important to establish credibility early on in treatment (Sue & Zane, 1987). An understanding of treatment entry, in particular, is important because only a small number of substance users enter treatment (Grant, 1997). The professional disclosure statement is arguably the first intervention in the treatment process.

The findings reported here indicate that the counselor cues used as interventions made no difference and actually made the participant less likely to choose the recovering counselor. This reverse effect may be because the hazardous drinkers had not yet identified themselves as having a substance abuse problem. Hence, they did not consider themselves to be in a similar to the recovering counselor. Taking it a step further, it is possible that the hazardous drinkers' were still in the denial phase of their problem, which resulted in their perceiving the recovering counselor as potentially (finding very near significance) more credible, but being less likely to choose them for counseling. It made no difference at all whether a counselor was certified or not. Therefore, neither the

evidential nor reputational counselor cue increased the likelihood of hazardous drinkers seeking help. The clinical implications of these findings discussed in the next sections.

Theory and Research

Strong (1968) proposed that counseling could be viewed as a social influence process. The results of this study suggest that Strong's social influence theory was likely not applicable as used in this study. When proposing that group membership similarity would affect the perception of hazardous drinkers, an assumption was made about this group that appeared to be incorrect. Because participants were not notified of their hazardous drinking status after taking the alcohol use identification test, it is not clear that they identified themselves to be in the hazardous drinkers' category. More or less, "it takes two to tango" to test group membership similarity. In this case, we had one member asking the other to dance but in this case, the other did not even know they had been invited to the party. Or if they did recognize the invitation, perhaps they refused to dance.

The negative effect in choosing a recovering counselor could be explained by the lack of identity development of the hazardous drinker, which is evident in previous research with participants who clearly identified as having a "disability" (Priester et al., 2007). Or conversely, it is possible hazardous drinkers have become aware of their drinking propensity yet are still unwilling to identify themselves in a similar group with a person in recovery. As mentioned, the concept of denial has been a major barrier to treatment for substance abusers. As a result, this might explain how hazardous drinkers were actually less willing to choose a counselor in-recovery as compared to a counselor without any indication of recovery status.

The finding in this study that credibility was not influenced by counselor recovery status in the professional disclosure statement contributes to the mixed literature. Some researchers used participants who were actively in treatment or actively in recovery resulting in the potential for help-seeking identity development and found similar results. For example, Culbreath (2000) asserted that clients do not perceive recovering counselors differentially from nonrecovering counselors. In a more recent study using a national survey, similar findings revealed that therapists' recovery status was not related significantly to clients' perceptions of therapist empathy, the working alliance, session depth, and therapist credibility (Wolff & Hayes, 2009). In support of group membership similarity, Priester et al. (2007) found that recovering alcoholics viewed recovering counselors more positively than they did nonrecovering counselors. Also, these results vary from prior research where support was shown for a significant relationship between cues of the credibility of addictions counselors and willingness to enter into a counseling relationship with them (Toriello & Strohmer, 2004). The results of this study revealed hazardous drinkers' were less willing to enter into a counseling relationship with a recovering counselor than one who did not list a recovery history in their professional disclosure statement. The main difference in the current study compared to prior research was this study's examination of pretreatment, hazardous drinkers. Therefore, the self-identity awareness of the participants has potential implications when applying social influence theory to the counseling relationship.

The Certified Substance Abuse Counselor (CSAC) was the other counselor cue explored. The lack of an effect for counselor certification status potentially adds to the mixed findings of prior research regarding the influence of certain reputational cues. The

lack of perceived differences for Certified Substance Abuse Counselors (CSAC) as measured by both credibility and willingness to choose a counselor support aspects of prior literature. For example, Thomas (1993) argued that that certification actually protects professionals and not clients. On the other hand, there is considerable literature where reputational cues have had a reliable effect on clients' perceptions (Corrigan et al., 1980; Gade & Wilkins, 2012; Goates-Jones & Hill, 2008; Humeidan, 2011; Leierer et al., 1996, 1998; Siegel & Sell, 1978; Townes et al., 2009).

The lack of significance in this study does not necessarily indicate that certification or a similar type of credential would be an inappropriate cue with other populations, e.g., recovering individuals. However, the Certification in Substance Abuse (CSAC) clearly did not resonate with hazardous drinkers from this study, but this study was narrow in terms of the scope of participants who could benefit from a certified counselor. The Certification in Substance Abuse (CSAC) was not created to resolve a barrier to treatment, but rather to provide counselors with varying experiences, education and more training tools and resources in working with those in treatment.

Implications for Counselor Training

The results of this study add to the discussion in the literature between the recovering paraprofessionals and non-recovering professionals and the training of addiction counselors (West et al., 2002; Yalisove, 1998). It has been well-established that there are an insufficient number of trained counselors working with alcohol use and substance abuse and too few programs available to train them (Flynn & Brown, 2008; McLellan & Meyers, 2002; Washington, 2002). The majority of surveyed counselors rated their graduate training as providing inadequate preparation for practice with

substance abuse clients (Cardoso et al., 2006; Cellucci & Vik, 2001). Meanwhile Miller and Brown (1997) asserted that practicing counselors with generalist training are already well qualified to treat substance abuse. In an empirical review of clinician's impact on the quality of substance abuse treatment, Najavits, Crits-Christoph, and Deirberger (2000) contended that one of the most important findings from several decades of research on substance abuse treatment was that "clinicians are a key factor influencing treatment outcome and retention" (p. 2163). This study supported the important role of counselor characteristics, whether they were positive or negative.

Substance abuse counselors often have varied clinical outcomes with some having greater success than others (Luborsky et al., 1985; McClellan & Meyers, 2004; Najavits & Weiss, 1994; Project MATCH, 1998). Historically, there has been a strong preference historically in favor of recovering counselors, based on the assumption that chemically dependent clients will only listen to recovering counselors who have had experience overcoming an addiction (Culbreath, 2000). This study did not support this preference with respect to hazardous drinkers and recovering counselors suggesting that it could be a potential poor client-counselor match. A similar effect likely occurred with the lack of counselor influence with the Certification in Substance Abuse (CSAC). This particular type of certification simply may not seem relevant to hazardous drinkers because of their lack of their identity development as someone who needed professional help for their drinking habits.

Counselor training should include a better understanding of the clients they are trying to reach. Developing an awareness of the identity development of hazardous drinkers or other at-risk populations may serve as a means to work towards a better

client-counselor match. There is a need to identify and respond appropriately. As previously noted, healthcare providers are poor at identifying hazardous drinkers, and as many as 72% escape their detection (Bowen & Sammons, 1988; Conigrave et al., 1995; Friedmann et al., 2000). Counselors could benefit from preliminary substance abuse screens for clients to create client and counselor awareness about their problems. Then clients and counselors could be better matched to focus on the recognized problem areas. If the client develops an identity as a problematic drinker (or not), then the counselor is better equipped to address the issue. This increased knowledge about substance abuse by both the client and counselor may serve as a relationship enhancer. In turn, counselors need to be further educated on the stages of substance abusers from denial to being actively in recovery. An understanding by the counselor of what the stage the client is in needs to be a key element for counselors trying to reach substance abusers.

The results of this study fall in line with the research that reports that clients have little regard for theory or technique, but do recognize the importance of the person who is the counselor (Elliot & Williams, 2003). Obviously hazardous drinkers noticed the recovering counselor's drinking history and were less likely to choose that counselor as a result. With respect to the certified counselor, although not necessarily a technique, the Certification in Substance Abuse (CSAC) did represent possession of a particular knowledge base for hazardous drinkers.

As a result, counselors obtaining a certification in substance abuse need to understand its limitations as a means of outreach. Reasons for the lack of influence of the certification go beyond the hazardous drinkers' awareness or denial of their own status. Hazardous drinkers may not have perceived the Certification in Substance Abuse

(CSAC) to be enough of an advanced training criterion. Or simply, the certification was not well known enough to produce an effect on credibility or increase the likelihood of choosing that particular counselor. Only one type of certification was described in this study. Given that substance abuse certifications are relatively new, an understanding and appreciation of the certification may be lacking. Its effect could be reanalyzed in the future once the certification becomes more established. Furthering skill development in the substance abuse field may not have an immediate impact in terms reducing a treatment barrier for hazardous drinkers. This does not preclude the possibility though of an enhanced therapeutic relationship due to the increase in the counselor's confidence based upon the additional experience gained through certification.

For decades recovering counselors have been more willing to pursue drug and alcohol certification (state or national) than their non-recovering counterparts (McGovern & Armstrong, 1987). Given the influence of paraprofessionals in the field of substance abuse counseling and their propensity to acquire certifications, the counselor professional disclosure statements were a realistic representation of the training options available to all (degree or non-degree) substance abuse counselors in the field. Despite the depiction of these credentials, hazardous drinkers did not perceive the certified counselors to be more credible or willing to choose such a counselor. This study offers caution to those recovering counselors interested in acquiring a certification in substance abuse in an attempt to increase credibility. In fact, recovery status alone, without additional certification, resulted in higher ratings of credibility compared to both a counselor with both cues of recovery and certification.

Practice

Limited research has been conducted on how clients' individual differences, particularly their propensity for addiction (e.g., hazardous drinkers), interact with counselors' working styles (Beutler & Crago, 1991). An implication for practice that can be drawn from this study is that counselors should focus on the level and timing of counselor self-disclosure. In particular, recovering counselors may consider not revealing their recovery status in the very early stages of treatment. This would contradict the traditional model of paraprofessional counselors in which being in-recovery is often disclosed very early in treatment as a compensatory quality. In substance abuse training environments, counselors are often encouraged to be directive and confrontational given the complex array of client defenses such as denial, resistance, and minimization that often accompany substance abuse disorders (Miller et al., 1993). The results of this study may suggest that this particular type of self-disclosure may actually have a negative effect on the likelihood of a hazardous drinker choosing a counselor who self-discloses their recovery status too early.

Despite hazardous drinkers not initially choosing the recovering counselor, the higher ratings of credibility for recovering counselors might present an opportunity. Once in treatment, the recovering counselor could gain credibility by then disclosing their recovery status. Therefore, if the counselor waited until the hazardous drinkers actively committed to treatment and then shared his or her recovery status, this could enhance the treatment process. This timing could lead to more hazardous drinkers in need of treatment seeking help because many hazardous drinkers may not consider themselves to have a problem. Clients may be reluctant to see a counselor in recovery because they are either

still in denial or do not want to address their substance abuse. Once in treatment and after the client has developed an identity of being a hazardous drinker, the counselor could self-disclose. By self-disclosing at an appropriate time, an enhanced therapeutic relationship could ensue, leading to a reduction in early dropout rates

The initial influence of the Certified Substance Abuse Counselor (CSAC) to either increase credibility or the likelihood of choosing the counselor was not supported. However, an inference to the overall benefits of the certification cannot be made. The hazardous drinkers' responses were very similar when comparing certified versus non-certified counselors. Even still a counselor with the certification may be more qualified and competent as a result of the additional training. Ultimately, the more clinicians feel competent in accessing the variety of empirically supported means of help available for substance abusers, the more flexible and comprehensive they can be in their offering of treatment options (Read et al, 2001). Although, given the lack of initial influence with hazardous drinkers, the results do pose further questions for the increasing popularity of substance abuse certifications. The certifications may very well provide more trained substance abuse counselors, yet as an intervention to reduce barriers to treatment, the results were inconclusive at best.

Recommendations for Future Research

Future research recommendations include exploring the relationship of the role of client identity development to specific counselor characteristics. Despite the large amount of literature on the factors that influence the extent to which clients' perceive counselors as credible, no known research had specifically addressed the issues of hazardous drinkers' perceptions of recovering counselors or counselors' training in substance abuse

until this study. A priority for future research should be to further study the importance of patient, therapist, procedural, and relationship factors (Beutler et al., 2004). The "factors" in this study were hazardous drinkers and counselors that were either in-recovery or were Certified Substance Abuse Counselors (CSAC).

Understanding the clients' identity development as a hazardous drinker would provide more insight into how to intervene at a very early stage in substance abuse process. For example, because the group membership similarity appeared not to be applicable due to the lack of identity development by the hazardous drinkers, future research could explore what would reach this population more effectively. The first step in providing appropriate assistance to people with substance abuse is accurate identification of the problem (Read et al., 2001). The challenge with hazardous drinkers is their potential lack of awareness (or denial) that a problem exists. In comparing the perceived credibility of addiction counselors using hazardous drinkers, clients' readiness-to-change level could be assessed with established instruments (e.g., The Stages of Change Readiness and Treatment Eagerness Scale; Miller & Tonigan, 1996). Future research could explore what particular counselor interventions are most effective with populations in the "pre-contemplative" stage. It is very possible that not all hazardous drinkers view their own drinking habits the same, their readiness for treatment, or the type of counselor preferred. Better understanding of the perceptions of hazardous drinkers' willingness to seek help would contribute to the literature in addiction field and alcohol abuse.

Similarly, the identity development as it relates to the age of the alcohol abuser is also an area to be explored further. For example, underage drinkers tend to consume more

alcohol per occasion than those over the legal minimum drinking age of 21 (Institute of Medicine, 2004). A younger population would represent those greater in need, but perhaps less aware of their hazardous drinker propensity compared to the older adults predominantly represented in this study. Future research with a greater representation of underage hazardous drinkers would allow for increased external validity.

Another research recommendation would be to assess the role of self-disclosure of recovery status once in treatment as opposed to during the introduction of the counselor. The timing of when and how much to self-disclose to substance abusers may serve as a relationship enhancer. Ultimately, an evaluation of self-disclosure and drop-out rates could be conducted.

The other construct to explore further is the role of counselor certifications. Given that specific therapist attributes are predictive of client outcomes (Project Match, 2008; Wampold, 2013), the counselor training literature would benefit from further examination of certifications. Insufficient knowledge exists about which specific aspects of professional training and professional experience that most effectively contribute to the clinical efficacy (Beutler & Kendall, 1995).

As a result, the Certification in Substance Abuse (CSAC), and other credentials like it, are worth further examination. Greater explanation of the details of the certification may have altered hazardous drinkers' perceptions. For example, a counselor seeking to increase credibility or the likelihood of being chosen for treatment might explore communicating the type of coursework taken to further emphasize the level of expertise in the area. Because the certification is relatively new to the field, explaining what the requirements are to become certified might help to educate potential clients and

increase their likelihood of seeking help. Future research could also extend the certification to measure clinical outcomes of certified counselors as compared to non-certified in a real life therapeutic environment. A randomized comparison of clinical outcomes of counselors with and without certification would provide additional insight into the validity of the certification. Lastly, exploring the ability to match certain populations to counselors with specific certifications would provide insight into the need for increased specialization or lend itself to support more generalized training.

Implications for Counseling Psychology

This study has clinical implications for the field of Counseling Psychology. An important aspect of Counseling Psychology is "…guided by a philosophy that values individual differences and diversity and a focus on prevention, development, and adjustment across the life-span." (Society of Counseling Psychology, 2014). Due to the lack of diversity in this sample, further exploration with a more multi-cultural population of hazardous drinkers would be supported.

Future research could examine the adequacy of trained counseling psychologists in providing substance abuse treatment. Cardoso et al. (2006) found that even though 79% of rehabilitation counselors reported treating individuals with alcohol and other drug issues, more than half of the sample rated their training in substance abuse treatment as inadequate. Pertaining to the benefits of substance abuse training, the teaching of specific skills is a common component of many effective treatments for problem drinking (Monti, Gulliver, & Meyers, 1994; Monti, Kadden, Rohsenow, Cooney, & Abrams, 2002; O'Malley, 1996). The opportunity to specifically address a population that is often underserved, misunderstood, and whose drinking behavior affects every demographic is

seemingly a natural fit for the field. Although, justification to acquire a specialty certification in substance abuse in addition to a doctorate remains unsupported.

Lastly, exploring whether it was the role of recovery status or simply revealing any personal characteristic prior to forming a relationship would add to the counseling psychology literature. The results of this study should offer caution to counseling psychologists when marketing their services. Counseling psychologists may consider not relying solely on the attainment of a doctorate degree to increase credibility or the likelihood of being selected for treatment compared to other counselors who also serve hazardous drinkers. Lastly, similar to the role of certification, future counseling psychology research could explore the profession's perceived level of credibility compared to other counseling professions by specific populations.

Conclusion

This study investigated the role of counselor influence in substance abuse counseling. Hazardous drinkers' perception of a counselor's recovery and certification status were examined to determine if these counselor characteristics increased credibility or counselor preference. An unexpected finding occurred for the hazardous drinkers' ratings of the recovering counselor. Hazardous drinkers were actually less willing to choose a recovering counselor than a non-recovering counselor. There were no differences between certified and non-certified counselors on any dependent variables despite the growing popularity in the field of addiction counseling. This study did not find an interaction effect between the counselor status of both recovery and substance abuse certification. These results may not be applicable to the group membership similarity literature in regard to the perception of counselor recovery status due to the

possible lack of identity development of the hazardous drinkers who participated in this study. Future research should continue to explore special populations and their perceptions of counselors with identifiable training and experience to reduce potential barriers to treatment.

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Appendix A

Informed Consent

Dear Research Participant:

Thank you for taking the time to read about our research study. This study is only open to participants who are 21 or older. Why do we need your help? We are interested in understanding attitudes and behaviors in the counseling process. This information can be used to improve counselor related services. Your responses can help us do that. We would greatly appreciate your taking time from your busy schedule to participate in this study.

Participation in the research project involves completion of the on-line survey, which should take approximately 10 minutes. The survey is hosted on the SurveyGizmo site, which uses current security standards for data storage and transmission.

To ensure confidentiality, no personally identifying information will be associated with the responses. All analyses will be performed on group data only and confidentiality of data will be maintained within the limits allowed by law. The results of this research may be published. However, no participant will be identified by specific description in any such publication. Your participation in this research study is voluntary and you may withdraw from participation at any time without consequence. As you answer questions about your behaviors, you may become aware of some things you hadn't thought about before. It is not expected that you will experience any discomfort as a result of answering these questions. There is no compensation for participating in this study. The University of Memphis does not have any funds budgeted for compensation for injury, damages, or other expenses.

If you have any questions about this study, please contact the principle investigator: Robert W. Adams, M.S., M.B.A., rwadams@memphis.edu, under the supervision of Douglas C. Strohmer, Ph.D., chair of the department of Counseling Education Psychology and Research. If you have additional questions regarding research rights, Jacqueline Y. Reid, Administrator for the Institutional Review Board for the Protection of Human Subjects may be contacted at (901) 678-2533.

Your completion and submission of the questionnaire indicates that you have read this informed consent page, that you have been informed that your data will remain confidential within limits allowed by law, that you will allow the researchers to include your data in the aggregate data set, and that you understand you may withdraw from the study at any time without consequence. Please read the questions carefully as the response options for the questions do change depending on the question. Thank you for your time.

Sincerely,
Robert W. Adams, M.S., M.B.A.
Douglas C. Strohmer, Ph.D.
Department of Counseling, Educational Psychology and Research
College of Education, Health and Human Sciences
The University of Memphis

Appendix B

Demographic Questionnaire

I meet the criteria for this study (21 years or older) and have read the informed consent. I agree to take this survey. Yes No

1. I am: Male / Female

2. What is your current age?

___ 21-24
___ 25-35
___ 35-54
___ 55+

3. Which of the following describes your highest level of education?

12^{th} grade or less
Graduated high school or equivalent
Some college, no degree
Associate degree
Bachelor's degree
Post-graduate degree

4. Which of the following best describes your ethnicity?

Asian/Pacific Islander
Black/African-American
Caucasian
Hispanic
Native American/Alaska Native
Other/Multi-Racial
Decline to Respond

5. Have you ever received professional counseling before?

Yes No

Appendix C

Professional Disclosure Statements

1. Recovering Alcoholic

Carefully read this description and imagine that you will be working with this particular counselor at a counseling center:

Professional Disclosure Statement

Introduction:

This Disclosure Statement is a part of the Standards of Practice. Here is some important information about the counseling process and my services. As you may already know, therapy is an engaging process. During counseling, I will do my best to honor your personal experiences and perspective. You can count on me to provide you with honest feedback, and to offer suggestions based on my clinical training and life experiences. I encourage your active participation and collaboration as we develop our therapeutic relationship and work to meet your chosen goals.

Confidentiality:

All of our communication becomes part of the clinical record, which is accessible to you upon request. I will keep confidential anything you say as part of our counseling relationship, with the following exceptions: (a) you direct me in writing to disclose information to someone else, (b) it is determined you are a danger to yourself or others (including child or elder abuse), or (c) I am ordered by a court to disclose information.

Counseling Background:

- Five years of counseling experience
- Recovering Alcoholic
- Volunteer at a local community recreational center
- Client-centered counseling approach

I look forward to the opportunity to work with you. Thank you.

2. Certification

Carefully read this description and imagine that you will be working with this particular counselor at a counseling center:

Professional Disclosure Statement

Introduction:

This Disclosure Statement is a part of the Standards of Practice. Here is some important information about the counseling process and my services. As you may already know, therapy is an engaging process. During counseling, I will do my best to honor your personal experiences and perspective. You can count on me to provide you with honest feedback, and to offer suggestions based on my clinical training and life experiences. I encourage your active participation and collaboration as we develop our therapeutic relationship and work to meet your chosen goals.

Confidentiality:

All of our communication becomes part of the clinical record, which is accessible to you upon request. I will keep confidential anything you say as part of our counseling relationship, with the following exceptions: (a) you direct me in writing to disclose information to someone else, (b) it is determined you are a danger to yourself or others (including child or elder abuse), or (c) I am ordered by a court to disclose information.

Counseling Background:

- Five years of counseling experience
- Certified Substance Abuse Counselor (CSAC)
- Volunteer at a local community recreational center
- Client-centered counseling approach

I look forward to the opportunity to work with you. Thank you.

3. Recovering Alcoholic and Certification

Carefully read this description and imagine that you will be working with this particular counselor at a counseling center:

Professional Disclosure Statement

Introduction:

This Disclosure Statement is a part of the Standards of Practice. Here is some important information about the counseling process and my services. As you may already know, therapy is an engaging process. During counseling, I will do my best to honor your personal experiences and perspective. You can count on me to provide you with honest feedback, and to offer suggestions based on my clinical training and life experiences. I encourage your active participation and collaboration as we develop our therapeutic relationship and work to meet your chosen goals.

Confidentiality:

All of our communication becomes part of the clinical record, which is accessible to you upon request. I will keep confidential anything you say as part of our counseling relationship, with the following exceptions: (a) you direct me in writing to disclose information to someone else, (b) it is determined you are a danger to yourself or others (including child or elder abuse), or (c) I am ordered by a court to disclose information.

Counseling Background:

- Five years of counseling experience
- Recovering Alcoholic
- Certified Substance Abuse Counselor (CSAC)
- Volunteer at a local community recreational center
- Client-centered counseling approach

I look forward to the opportunity to work with you. Thank you.

4. Neither Recovering Alcoholic nor Certification

Carefully read this description and imagine that you will be working with this particular counselor at a counseling center:

Professional Disclosure Statement

Introduction:

This Disclosure Statement is a part of the Standards of Practice. Here is some important information about the counseling process and my services. As you may already know, therapy is an engaging process. During counseling, I will do my best to honor your personal experiences and perspective. You can count on me to provide you with honest feedback, and to offer suggestions based on my clinical training and life experiences. I encourage your active participation and collaboration as we develop our therapeutic relationship and work to meet your chosen goals.

Confidentiality:

All of our communication becomes part of the clinical record, which is accessible to you upon request. I will keep confidential anything you say as part of our counseling relationship, with the following exceptions: (a) you direct me in writing to disclose information to someone else, (b) it is determined you are a danger to yourself or others (including child or elder abuse), or (c) I am ordered by a court to disclose information.

Counseling Background:

- Five years of counseling experience
- Volunteer at a local community recreational center
- Client-centered counseling approach

I look forward to the opportunity to work with you. Thank you.

Appendix D

Counselor Preference Form (CPF)

Use the following scale to select your answer.

"If you were choosing a counselor, how willing would you be to choose the counselor whose professional disclosure statement you just read?"

1 2 3 4 5 6 7

not very very

Appendix E

Counselor Rating Form-Short (CRF-S)

Each characteristic is followed by a seven-point scale that ranges from "not very" to "very". Please mark at the point on the scale that best represents how you viewed the counselor.

For example:

FUNNY

not very X : : : : : : very

WELL DRESSED

not very : : : : : X : very

These ratings might show that the therapist did not joke around much, but was dressed well. Though all of the following characteristics we ask you to rate are desirable, therapists may differ in their strengths. We are interested in knowing how you view these differences. This form is confidential and will not be shown to your counselor.

1. SINCERE

not very : : : : : : very

2. SKILLFUL

not very : : : : : : very

3. HONEST

not very : : : : : : very

4. EXPERT

not very : : : : : : very

5. LIKABLE

not very : : : : : : very

6. **SOCIABLE**

not very _____:_____:_____:_____:_____:_____:_____ very

7. **WARM**

not very _____:_____:_____:_____:_____:_____:_____ very

8. **TRUSTWORTHY**

not very _____:_____:_____:_____:_____:_____:_____ very

9. **EXPERIENCED**

not very _____:_____:_____:_____:_____:_____:_____ very

10. **RELIABLE**

not very _____:_____:_____:_____:_____:_____:_____ very

11. **PREPARED**

not very _____:_____:_____:_____:_____:_____:_____ very

12. **FRIENDLY**

not very _____:_____:_____:_____:_____:_____:_____ very

Appendix F

Alcohol Use Disorders Identification Test-Condensed (AUDIT-C)

Please mark the answer that is correct for you**.**

1. How often did you have a drink containing alcohol in the past year?

   Never
   Monthly or less
   Two to four times a month
   Two to four times a week
   Four or more times a week

2. How many drinks containing alcohol did you have on a typical day when you were drinking in the past year?

   Never
   1 or 2
   3 or 4
   5 or 6
   7 to 9
   10 or more

3. How often did you have 6 or more drinks on one occasion in the past year?

   Never
   Less than monthly
   Monthly
   Weekly
   Daily or almost daily

Appendix G

Manipulation Verification

Which of the following choices best identify the qualifications of the counselor listed in the Professional Disclosure Statement? Please select only **one** of the four choices.

1. Certified Substance Abuse Counselor (CSAC) and a Recovering Alcoholic

OR

2. Certified Substance Abuse Counselor (CSAC) and no mention of recovery status

OR

3. Recovering Alcoholic

OR

4. None of the above

Appendix H

Disclaimer

Disclaimer
This survey does not provide a diagnosis of alcohol dependence or any other medical condition. The information provided here cannot substitute for a full evaluation by a health professional, and should only be used as a guide to understanding your alcohol use and the potential health issues involved with it.

Alcohol Relation Education:
Researchers use the term "alcohol problems" to refer to any type of condition caused by drinking which harms the drinker directly, jeopardizes the drinker's well-being, or places others at risk. Depending on the circumstances, alcohol problems can result from even moderate drinking, for example when driving, during pregnancy, or when taking certain medicines. Alcohol problems exist on a continuum of severity ranging from occasional binge drinking to alcohol abuse or dependence (alcoholism).

A response of 7 drinks a week, 3 drinks per occasion for women or 14 drinks a week and 4 drinks per occasion for men, suggests the need for further evaluation from a professional. The following counts as a drink:

- 12 ounces of regular beer (150 calories)
- 5 ounces of wine (100 calories)
- 1.5 ounces of 80-proof distilled spirits (100 calories)

The greater the quantity, the more likely it is that this behavior is affecting your health and safety. If you drink more than the limits described, we recommend that you talk to your doctor or counselor about how alcohol may be affecting you. In addition, a list of available resources is indicated below:

Resources:
The University of Memphis Counseling Center http://www.memphis.edu/ctt/
National Institute on Alcohol Abuse and Alcoholism http://www.niaaa.nih.gov/
Substance Abuse and Mental Health Services Administration
http://www.samhsa.gov/
Alcoholics Anonymous www.aa.org
Alcohol Screening http://www.alcoholscreening.org/

Thank you

Appendix I

Internal Review Board Approval

The University of Memphis Institutional Review Board, FWA00006815, has reviewed and approved your submission in accordance with all applicable statuses and regulations as well as ethical principles.

PI NAME: Robert Adams
CO-PI:
PROJECT TITLE: Counselor Recovery Status and Substance Abuse Certification: A Relationship to Perceived Credibility and Willingness to Seek Treatment with Hazardous Drinkers
FACULTY ADVISOR NAME (if applicable): Douglas Strohmer

IRB ID: #2903
APPROVAL DATE: 10/31/2013
EXPIRATION DATE:
LEVEL OF REVIEW: Exempt

Please Note: Modifications do not extend the expiration of the original approval

Approval of this project is given with the following obligations:

1. If this IRB approval has an expiration date, an approved renewal must be in effect to continue the project prior to that date. If approval is not obtained, the human consent form(s) and recruiting material(s) are no longer valid and any research activities involving human subjects must stop.

2. When the project is finished or terminated, a completion form must be completed and sent to the board.

3. No change may be made in the approved protocol without prior board approval, whether the approved protocol was reviewed at the Exempt, Exedited or Full Board level.

4. Exempt approval are considered to have no expiration date and no further review is necessary unless the protocol needs modification.

Approval of this project is given with the following special obligations:

Thank you,
Ronnie Priest, PhD
Institutional Review Board Chair
The University of Memphis.

Note: Review outcomes will be communicated to the email address on file. This email should be considered an official communication from the UM IRB. Consent Forms are no longer being stamped as well. Please contact the IRB at IRB@memphis.edu if a letter on IRB letterhead is required.