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Authors	Coleman, Jamian
Citation	Coleman, Jamian. "Dual Diagnosis and Bias in Counselor Education and Supervision." Dissertation, Georgia State University, 2022. <a href="https://doi.org/10.57709/30435920">https://doi.org/10.57709/30435920</a>
DOI	<a href="https://doi.org/10.57709/30435920">https://doi.org/10.57709/30435920</a>
Download date	2026-05-20 04:08:48
Link to Item	<a href="https://hdl.handle.net/20.500.14694/3734">https://hdl.handle.net/20.500.14694/3734</a>

## ACCEPTANCE

This dissertation, DUAL DIAGNOSIS AND BIAS IN COUNSELOR EDUCATION AND SUPERVISION, by JAMIAN SETH COLEMAN, was prepared under the direction of the candidate's Dissertation Advisory Committee. It is accepted by the committee members in partial fulfillment of the requirements for the degree, Doctor of Philosophy, in the College of Education & Human Development, Georgia State University.

The Dissertation Advisory Committee and the student's Department Chairperson, as representatives of the faculty, certify that this dissertation has met all standards of excellence and scholarship as determined by the faculty.

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#### GRANTS:

Tarziers, K., **Coleman, J.**, Rabess, A., Ray, M., Petion, G. (2019). Evaluation of the Effectiveness of Implementing a Social Justice Advocacy Workshop for Counselors-in-Training. *Chi Sigma Iota International Statewide Networking Grant*. (Awarded: \$660)

**Coleman, J.**, Zeligman, M., (2019). The Use of Mindfulness in Relapse Prevention for Sexual and Gender Minority Persons Living with HIV. *Association for Assessment and Research in Counseling (AARC) Sponsored Scholarship Program (SSP)*. (Awarded: \$2500)

# DUAL DIAGNOSIS AND BIAS IN COUNSELOR EDUCATION AND SUPERVISION

by

JAMIAN SETH COLEMAN

Under the Direction of Franco Dispenza, Ph.D.

## ABSTRACT

Individuals living with a dual diagnosis (e.g., substance use disorder [SUD] and the co-occurrence of a psychiatric disorder) experience numerous challenges to treatment due to the complexity and overlapping nature of symptomology, psychosocial contextual factors, and limited effective evidence-based treatment options (Cochran et al., 2007; Flanagan et al., 2016). Due to the high prevalence rates of clients living with a dual diagnosis, it is likely that counselors-in-training (CITs) will work with a client dealing with a dual diagnosis as early as their practicum or internship experience (Brown et al., 2002; Salyers et al., 2006). I utilized an analogue experimental research design to create a simulated counseling experience to explore how CITs differently discriminate blame and empathy levels toward a fictitious client. The fictitious client had a dual diagnosis of SUD and PTSD, and who experienced a recent relapse to

substance use. I explored separate scores of blame and empathy in a sample of CITs (N = 138) over the age of 18, currently seeing clients in a practicum or internship experience, and enrolled in a CACREP accredited program throughout the United States in a 2 x 2 experimental analogue study. CITs were randomly assigned to one of four groups, and asked to read and respond to a short vignette of a fictitious client living with a dual diagnosis of SUD and PTSD, who had recently relapsed. The aim was to explore if and how CITs discriminate differently based on relapse determinants (i.e., intrapersonal self-medicating behavior versus interpersonal high-risk behavior) and relapse substance use type (i.e., alcohol versus crystal meth) among those living with a dual diagnosis of SUD and PTSD. Bivariate correlations and two separate two-way between group ANOVAs were utilized to analyze data. Results revealed that CITs differently discriminated blame toward the fictitious client in the vignette based on the relapse determinants and SU type. However, CITs did not discriminate empathy levels differently toward the same client based on relapse determinants and SU type. Based on the results of this study, even when attribution bias (e.g., blame) was present toward the same fictitious client, these CITs could still endorse consistent ratings of empathy toward the client.

INDEX WORDS: Counselors-in-training, dual diagnosis, substance use disorder, posttraumatic stress disorder, relapse, blame attribution, empathy

DUAL DIAGNOSIS AND BIAS IN COUNSELOR EDUCATION AND SUPERVISION

by

JAMIAN SETH COLEMAN

A Dissertation

Presented in Partial Fulfillment of Requirements for the

Degree of

Doctor of Philosophy

in

Counselor Education and Practice

in

Counseling and Psychological Services

in

the College of Education & Human Development

Georgia State University

Atlanta, GA

2022

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## **DEDICATION**

I dedicate this dissertation to all the people living with a dual diagnosis. I am forever grateful to my clients living with a dual diagnosis who have graciously shared the complex, painful, and beautiful parts of their lives with me. To my clients, you have inspired, challenged, and taught me so much through your courage to live in a world that often fails to try and understand life through your eyes. You are worthy and valuable people and bring so much splendor and uniqueness to this world beyond the stigma and stereotypes associated with your diagnosis. May the hearts and minds of people you encounter continue to awaken to see and know the fullness of your being.

## ACKNOWLEDGEMENTS

I want to acknowledge those who have supported me throughout my academic journey and helped me grow toward this accomplishment. First, I want to thank the members of my dissertation committee for your commitment to overseeing my dissertation project. Dr. Franco Dispenza, thank you for chairing my dissertation and for your patience, guidance, and mentorship throughout this project. As my advisor, you have invested so much time and energy into my growth and development, and I am thankful for the relationship we have built. I am a stronger researcher, supervisor, and educator because of you. Dr. Dennis Gilbride, I am thankful for the mentoring relationship we have shared and the wisdom, advice, and opportunity you offered me throughout my time at GSU. Thank you for your encouragement, motivation, and direction throughout this project. Your impact on me personally and professionally will last throughout my career and lifetime. Dr. Melissa Zeligman, from African buffalo to new research projects, you bring light to every situation. Thank you for believing in me to start new projects, look for unanswered questions, and pursue new academic endeavors. I am grateful for your support, feedback, and humor throughout this dissertation. Dr. Donnie Davis, thank you for your dedication and willingness to serve on my committee. You helped me learn and overcome obstacles during this process and have been instrumental in my growth as a researcher. I am grateful for the ways you challenge me to dream big and think beyond the confines of my own limitations. Dr. Moneta Sinclair, your empathy for others has inspired and affected me tremendously. Thank you for teaching and supervising me to become a counselor and supervisor who seeks to understand people and the world from a holistic lens. I am grateful for your willingness to serve on my committee and bringing your compassionate and knowledgeable expertise to this project.

I also want to acknowledge the people who believed in my potential to learn and grow throughout my life and helped get me to this point in my academic journey. To my parents, Jerry and Janet Coleman, your commitment to family provided a foundation of love, stability, and care that ground me to this day. Thank you for empowering me to seek new heights, teaching me to look for something positive in every situation, and supporting me through all of the twists and turns. You are amazing parents, and I am grateful for you. To my brother and sister-in-law, Jeremy and Leigh, thank you for all your encouragement and support along the way. To my nieces and nephews, Gracie, Wyatt, Ava, Noah, Sophia, and Asher, you bring me so much joy and remind me how to take a break and have fun. To my aunts, uncles, cousins, and family friends, thank you for all your kindness and thoughtful support through this process.

To Dan, you have been a rock of stability and dependability, cheering me on from all directions over the past four years. You are a life partner that inspires me to be a better person through your love, commitment, and humor. I am grateful for you and love you deeply. Nikki, thank you for your friendship and all the help and support with this project. Margaret, it all started at “Souper Jenny’s” over a bowl of soup. Thank you for the coffee talks, sharing your wisdom, and being a kind and caring friend. To all of my friends, both near and far, the bonds we established by living life together have strengthened me to endure throughout this process. You each mean so much to me.

To my colleagues at Positive Impact Health Centers, thank you for all your flexibility, encouragement, and support over the years. I continue to learn so much from each of you. To all of the faculty at GSU, your influence has greatly impacted me personally and professionally and has contributed to the completion of this project. Thank you to Drs. Chang and Shannonhouse and the Chi Epsilon chapter of CSI for the opportunities to serve and be part of a wonderful

community. To my cohort members, Ashlei, Kyndel, and Merideth, this has been quite a journey we have shared together, and your friendship strengthened the path. I feel so much gratitude for each of you. I also want to acknowledge my colleagues and fellow students at GSU for your generosity, kindness, and gracious, welcoming community. You have all played such a vital role in this process. To all my teachers and mentors, both past and present, your wisdom and guidance inspired, nurtured, and motivated me to keep going and trying no matter what. Thank you for awakening me with a sense of curiosity to learn and seek out new and uncovered paths in life. I commit to sharing with others what you have given to me.

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## Chapter 1

### DUAL DIAGNOSIS AND BIAS IN COUNSELOR EDUCATION AND SUPERVISION

#### Literature Review

Dual diagnosis refers to persons living with the co-occurrence of a substance use disorder (SUD) and another psychiatric disability or chronic condition (e.g., SUD and posttraumatic stress disorder (PTSD); APA, 2013). Clients living with a psychiatric disability are at a higher risk of having or developing a SUD than the general population (SAMHSA, 2020). According to the National Survey on Drug Use and Health (NSDUH; SAMHSA, 2020), an estimated 8.2 million people in the United States live with a dual diagnosis. Due to the high prevalence of dual diagnosis, counselors will undoubtedly work alongside a client with a dual diagnosis at some point in their careers. Therefore, understanding the multidimensional medical and psychosocial aspects of living with a dual diagnosis is crucial for counselors to provide competent care to this population.

High stigma and discrimination levels persist for persons living with a dual diagnosis (Francis et al., 2020). Therefore, it is vital for counselor education programs to equip counselors with the knowledge, ability, and skills to serve clients living with a dual diagnosis (Brown et al., 2002; Williams et al., 2013). Therefore, this chapter seeks to review the literature on persons living with a dual diagnosis and its implications for counselor education and supervision. More specifically, the first part of the chapter explores various treatment approaches and barriers to that treatment for persons living with a dual diagnosis, issues with bias and discrimination with dual diagnosis, and how attribution theory can be utilized as a framework to conceptualize bias and discrimination for this population. The second part of the chapter provides potential

implications in counselor education for working with persons living with dual diagnosis, including considerations for counselor educators and supervisors and counselors-in-training to assess personal bias toward persons living with dual diagnosis and pedagogical considerations utilizing the Skilled Counseling Training Model (SCTM; Smaby et al., 1999; Packman, 2009).

### **Treatment Approaches for Dual Diagnosis**

Providing counseling services to clients with a dual diagnosis can be arduous due to challenges presented by the co-occurrence of the disorders (Pinderup, 2018). Fisher et al. (2014) identified symptom severity and the overlap of symptomology between diagnoses as significant challenges counselors face when determining an accurate diagnosis. Once a dual diagnosis is determined, counselors are faced with the arduous task of determining the best treatment approach to use with these clients based on the clients' presenting symptomology and criteria for the co-occurring disorders (Fisher et al., 2014). For example, the dual diagnosis of SUD and PTSD complicates treatment due to each diagnosis's multifaceted and often overlapping symptomology (Flanagan et al., 2016). Further, dual diagnosis can present complex psychological (e.g., relapse, suicidal ideation, and homicidal ideation) and psychosocial (e.g., social and interpersonal problems, housing, and legal) concerns (Staiger et al., 2011).

Additionally, Dworkin et al. (2018) suggest that dual diagnosis is associated with poorer treatment outcomes than having just one psychiatric disorder, and limited evidence-based treatments exist for dual diagnosis. However, the same authors also propose that treatment options that include interventions focused on both the SUD and co-occurring disorder appear to be more effective than SUD treatment alone (Dworkin et al., 2018). Although it is evident that working with persons living with a dual diagnosis presents complex challenges for providing effective treatment options, evidenced-based treatment options for this population are limited

(Fisher et al., 2014). Further, counselors will likely work with persons living with a dual diagnosis and must know about and have access to effective treatment models (Fisher et al., 2014; Palmieri & Accordino, 2004).

Determining the most appropriate treatment approach for a person with a dual diagnosis can be challenging for counselors due to the multilayered considerations related to co-occurring disorders (Fisher et al., 2014). To date, three approaches to treating co-occurring disorders are commonly used in counseling to serve this population (Fisher et al., 2014; Palmieri & Accordino, 2004; Mueser et al., 2003). The first approach is *sequential treatment*, which looks at one disorder at a time. Utilizing this approach, providers first focus on treatment for the SUD as the primary concern and then consider the other diagnosis secondary to receiving treatment. This approach allows treatment to concentrate directly on SUD, which may help reduce symptoms related to substance use (SU). Still, it may omit symptomology that may overlap between diagnoses and the psychosocial implication of living with both disorders. The second approach to treating dual diagnosis is the *parallel approach*. In this approach, clients receive treatment for both disorders simultaneously, but only one counselor provides treatment without consulting other counselors. This approach is limited when considering the benefits of incorporating other counselors and helping professionals in treatment.

The third treatment approach provides an *integrative treatment* of care for someone with a dual diagnosis, which has grown in popularity as an evidence-based treatment approach to utilize with this population (Boyle & Kroon, 2006; Fisher et al., 2014; Mueser et al., 2003; Pinderup, 2018; Rogers et al., 2019). The integrative treatment approach includes a treatment team trained to provide integrative treatment to meet a client's needs living with a dual diagnosis (Boyle & Kroon, 2006). This approach incorporates a range of mental and behavioral health

needs (e.g., individual counseling, group counseling, psychiatric services, case management, certified peer specialists, and community health workers) with a care team who understands the complex and multiple needs of living with a dual diagnosis (Staiger et al., 2011). Other integrative care considerations include access to medical care, pharmacy services, housing opportunities, and legal services, which may be necessary due to the vulnerability of living with a dual diagnosis.

Taking an integrative approach with persons living with a dual diagnosis has become the favored approach over the past two decades (Pinderup, 2018). Chou et al. (2013) conducted a meta-analysis of 13 studies and found that the integrative approach offers a more promising holistic treatment approach to living with a dual diagnosis than the sequential or parallel approaches. Integrative treatment models that were developed to work with persons with severe mental illness have also been found to be effective for those living with a dual diagnosis. Three of these models include Illness Management and Recovery (IMR), Assertive Community Treatment (ACT), and Integrated Dual Disorder Treatment which can help clients gain greater access to resources and publicly funded services (Fisher et al., 2014). Although the integrated treatment approaches appear to have greater evidence for support of clients with a dual diagnosis, there are challenges that counselors face when working with this approach.

The integrative treatment approach has numerous positive factors to support clients with a dual diagnosis to remain in treatment and obtain promising outcomes. However, this approach requires a myriad of demands from counselors, resulting in them feeling overwhelmed, developing negative feelings toward clients, and experiencing burnout (Francis et al., 2020; Shoptaw, 2020). Lack of interagency cooperation, case management, and detoxification facilities have been found to complicate counselors' ability to provide integrative services to this

population (Pullen & Oser, 2014). Further, clients with a dual diagnosis who experience psychosocial approaches to treatment experience numerous benefits (e.g., medication compliance, sustaining abstinence from SU, vocational rehabilitation), yet these approaches demand a team approach and are challenging to implement (Pinderup, 2018). However, counselors need to consider these types of psychosocial and agency-related approaches when working with clients living with a dual diagnosis to avoid causing harm to the client and hindering their potential for successful treatment.

### **Barriers to Treatment**

It is well-known and documented that persons living with a SUD face numerous barriers to treatment (Can & Tanriverdi, 2015; Priester et al., 2016; Taylor, 2010), which can be compounded when living with a dual diagnosis (Pinderup, 2018; Staiger et al., 2011; Subodh et al., 2018). In an integrative literature review looking at barriers to treatment for individuals living with a dual diagnosis, Priester et al. (2015) identified internal personal characteristics of the clients and external structural barriers as the two primary sets of barriers to treatment. Clients face psychosocial strains with a dual diagnosis that include vulnerabilities associated with each disorder, along with transportation, childcare, housing, medication compliance, and inappropriate referrals from primary care providers (Staiger et al., 2011; Subodh et al., 2018). In a qualitative study, Pullen and Oser (2014) interviewed counselors working with clients dealing with SU concerns. The participants in their study identified a lack of funding, transportation, housing, case management, psychiatry services, and technology resources as significant interagency barriers to accessing and receiving adequate treatment (Pullen & Oser, 2014).

One of the most challenging aspects of treatment, which can become a barrier to remaining in and returning to treatment for those living with a dual diagnosis, is relapse to SU

(Bradizza et al., 2006). Relapse to SU is common for persons living with a SUD, even more so with a dual diagnosis (Bradizza et al., 2006; Brown et al., 1989; Giordano, 2014, Miller & Rollnick, 2013). The risk of relapse to SU can decrease in intensity following both the early and middle stages of recovery yet may never fully dissipate, even in long-term recovery for clients seeking sustained abstinence (Bradizza et al., 2006; Laudet et al., 2002). In a ten-year prospective follow-up study post SUD treatment of clients living with a dual diagnosis who had attained abstinence from substance abuse, Xie et al. (2005) found that approximately one-third of the participants relapsed in the first year and two-thirds relapsed by the end of the ten-year follow-up collection point. Numerous hypotheses and theories have been proposed to explain relapse to SU, often considered intrapersonal or interpersonal contextual reasons for relapse (Donovan & Witkiewitz, 2012). One of the most researched hypotheses to explain relapse to SU for those living with a dual diagnosis is the self-medication hypothesis. The self-medication hypothesis refers to clients returning to SU as a way to cope with factors associated with the dual diagnosis (e.g., symptomology related to the dual diagnosis, inability to regulate flooding of negative emotions, boredom), as well as psychosocial life stressors (e.g., interpersonal conflict, lack of housing and employment; Khantzian, 1985). Counselors working with persons living with a dual diagnosis need to understand the high prevalence rates of relapse for those living with a dual diagnosis and why these clients may return to SU while in treatment. For example, Dawson et al. (2005) suggest as many as 65 – 70% of those attempting abstinence from alcohol dependence may experience relapse within the first year of recovery.

Priester et al. (2015) suggested in their literature review looking at barriers to treatment for the dual diagnosis that additional research is needed to understand the obstacles to treatment for clients living with a dual diagnosis. The same authors assert that counselors need to know

appropriate and beneficial treatment options for those living with a dual diagnosis to help reduce the various barriers to access and remain in treatment, including helping them navigate relapse (Priester et al., 2015). These authors also emphasize that counselors need to know appropriate and beneficial treatment options for those living with a dual diagnosis to help reduce the various barriers to access and remain in treatment, including assisting them in navigating relapse.

However, a significant concern for persons living with a dual diagnosis that also presents internal and external barriers to treatment and successful treatment outcomes for persons living with a dual diagnosis is the stigma and discrimination associated with living with a dual diagnosis.

### **Bias and Dual Diagnosis**

Francis et al. (2020) found that stigmatizing attitudes and discrimination toward persons living with a dual diagnosis persist. The stigma related to dual diagnosis is associated with negative stereotypes and labels, attitudes, and beliefs toward persons living with a dual diagnosis based on one or both diagnoses (Francis et al., 2020; Overton & Medina, 2008; Ventura et al., 2017). Stigma refers to a social process of identifying a group of people as a mark of disgrace within society (Fox et al., 2018). Stigma can arise in the form of structural stigma (Hatzenbuehler et al., 2013) or cultural manifestations of stigma (Abdullah & Brown, 2011; Yang et al., 2007) and can result in prejudices toward clients (Overton & Medina, 2008). Mental health stigma is often identified through stereotypes (i.e., cognitive beliefs), prejudice (i.e., affective experiences), and discrimination (i.e., behavioral responses) toward clients (Overton & Medina, 2008).

A stereotype refers to widely held beliefs about groups or individuals that may accurately or inaccurately represent or label that group or person (Fox et al., 2018; Overton & Medina, 2008; Tucker Edmonds, 2021). For example, persons living with a dual diagnosis of stimulant

use disorder – methamphetamine type and depression, a common co-occurring diagnosis with crystal meth use, may be stereotyped as a meth head, erratic, or dangerous due to their SUD and previous crystal meth use (Scheibe, 2017), and at the same time be labeled lazy, selfish, and ungrateful for their symptoms related to depression (Martinelli et al., 2020). Overton and Medina, (2008) asserted that in a counseling context, counselors who hold these types of assumed stereotypes could develop prejudice toward these clients, thwarting the development of a strong therapeutic alliance and hindering the counselor's ability or willingness to understand the client's experiences fully. Further, stereotypes and prejudices toward persons living with a dual diagnosis may include an overemphasis on independence through individualistic bias and assume the person living with a dual diagnosis should cope with the diagnosis on their own (Overton & Medina, 2008). Pinderup (2018) conducted a qualitative grounded theory study and found that this individualistic bias may become a covert form of discrimination, hindering counselors from offering much-needed resources (e.g., social capital for networking, case management referrals) for support. Counselors experience a wide range of emotional responses and cognitive beliefs from prejudices held toward clients, which manifest in various behavioral responses to clients or discrimination (Overton & Melinda, 2008).

Living with a dual diagnosis comes with many unique challenges in treatment, such as helping clients to identify and understand their symptomology, facing the frequency and difficulties with relapse to SU, and dealing with stigmatizing and discriminatory beliefs amongst treatment providers and staff (Back et al., 2009). In a systematic review of the literature between 2000 and 2011, van Boekel et al. (2013) identified in the literature that counselors who hold positive attitudes and optimism toward successful treatment outcomes for their clients are important for persons with a dual diagnosis to experience throughout the various aspects of the

integrated treatment approach to successfully achieve their counseling goals. However, counselors have reported experiencing negative feelings toward these clients (e.g., anger, frustration, fear) and bias toward behaviors (e.g., relapse, unwillingness or inability to participate in treatment), which can further complicate the counseling process for these clients (Martinelli et al., 2020; van Boekel et al., 2013). Although treatment approaches for those with a dual diagnosis exist in the literature for more promising and successful treatment outcomes, more research is needed related to assisting counselors in combatting feeling overwhelmed and developing negative feelings and attitudes to ensure these clients achieve successful treatment outcomes, especially due to the numerous barriers this population faces in obtaining and remaining in treatment (Coaston, 2017; Pinderup, 2018).

The fear of being discriminated against by treatment providers remains a key determinant for persons living with a dual diagnosis from seeking treatment and remaining in treatment (Francis et al., 2020). In a qualitative study seeking to understand barriers to treatment by interviewing those living with a dual diagnosis, Staiger et al. (2011) found that counselor bias, actual or perceived bias, was a key theme infused throughout the interviews. Participants in this qualitative study reported that they desired to work with counselors who would be flexible and adapt services to their individual circumstances and needs (e.g., childcare, transportation, vocational and employment obligations; Staiger et al., 2011). Further, the authors of the same qualitative study suggested that more training for providers is needed in dual diagnosis, which will challenge counselor assumptions and move towards a non-judgmental stance toward clients, especially their diagnoses.

## **Attribution Theory and Dual Diagnosis**

Attribution theory provides a framework to explain how everyday experiences and behaviors are perceived and attributed to a person as either external (i.e., situational attribution) or internal (i.e., dispositional attribution; Weiner, 1980). Situational attribution refers to recognizing and identifying factors in a person's environment to explain and interpret behavior. Dispositional attribution refers to internal characteristics or dispositions of a person to explain their behavior (Weiner, 1980). Related to clients living with a dual diagnosis, counselors make inferences and attributions to the client for the behaviors associated with acquiring their diagnoses, dealing with barriers to accessing and remaining in treatment, and risk to and reasons for relapse to SU (Lloyd, 2013). However, errors can be made in counselors' judgments and assessments about reasons for clients' behaviors related to living with a dual diagnosis, referred to as attribution bias (Araten-Bergman & Werner, 2017). According to attribution theory, the fundamental attribution error relates to making dispositional attributions toward others and not considering situational factors. For example, a drawback to making dispositional attributions toward clients with a dual diagnosis for their behaviors is negating clients' personal history, environmental, and social concerns as potential reasons and explanations for their behaviors.

Dispositional attribution bias becomes problematic when the counselor is unable or unwilling to challenge their own assumptions, and it goes unexamined. For example, attribution of blame asserts that blameworthiness and assignment of blame are socially influenced and help to explain how counselors may assign blame (Shaver, 1985). Blame attribution can negatively affect aspects of the counseling process and treatment outcomes if it goes unexamined. Clients with a dual diagnosis will likely experience a relapse to SU at some point during treatment. Counselors who attribute dispositional blame to the client (e.g., lack of motivation and

willpower, lazy, broken) without considering the situational factors (e.g., social interest, peer pressure) may have imposed bias without considering all aspects of the client's life (Williams et al., 2013).

Negative feelings toward clients with a dual diagnosis can contribute to counselors' imposing dispositional attribution bias. Anger toward clients with a SUD is a well-known response many counselors experience throughout the counseling process (Brown et al., 2002; Cornfield & Hubley, 2020). However, the more frequently counselors experience feelings of anger toward their clients, the more they hold negative attitudes toward them (Cornfield & Hubley, 2020; Donovan & Witkiewitz, 2012). These negative attitudes can compound over time, resulting in attribution biases or errors in judgment about clients and their behaviors.

Further, dispositional attribution bias toward clients living with a dual diagnosis can contribute to diagnostic bias, which occurs when a counselor inaccurately interprets information collected about a client and makes an error in judgment regarding the client's diagnosis (McLaughlin, 2002). Diagnostic bias can lead to misdiagnosis of a client's symptomology and presenting concerns, especially if there is a diagnostic sampling bias (McLaughlin, 2002).

Another aspect where attribution bias risks influencing counselors' beliefs and attitudes toward persons living with a dual diagnosis include negatively stereotyping and labeling clients based on their diagnosis, determinant behaviors associated with relapse, and lack of engagement in treatment. Attribution bias can also influence counselors' decision to choose the most appropriate treatment approach and make necessary referrals, especially in an integrated treatment approach, which can further complicate persons living with a dual diagnosis (Williams et al., 2013). Moreover, counselor educators and supervisors need to be aware of these concerns when introducing and training master-level counseling students to work with this population.

### **Implications for Counselor Education and Supervision**

It is a relatively new concept and approach to treating SUD and mental health diagnoses simultaneously (Flanagan et al., 2016; Kikkert et al., 2018), and counselors-in-training (CITs) have begun receiving preparation to work with persons living with a dual diagnosis in counselor education programs (CACREP, 2016; Lee, 2014). Over the past few decades, counselor education and supervision as a professional field have recognized the importance of considering the simultaneous treatment of dual diagnosis rather than treating SUD alone, which is evident in the inclusion of addiction courses in the current Council for Accreditation of Counseling and Related Educational Programs (CACREP) standards (CACREP, 2016). Although the field of counseling has recognized the importance of training CITs to have knowledge and skills to work with clients dealing with a SUD (Salyers et al., 2006), CACREP only implemented addictions as a required course to be taught throughout all counseling programs within the past decade (CACREP, 2016).

Further, counselor educators have an ethical responsibility to prepare CITs with the awareness, knowledge, and skills to work with clients from various cultural backgrounds and diverse experiences (ACA, 2014). This responsibility includes didactic teaching about the various medical and psychosocial aspects of dual diagnosis, including bias associated with SUD and psychiatric disabilities and how discriminatory behaviors may arise in various aspects through treatment and the counseling process. Bias in counseling is well documented in the disability and counseling literature and remains infused throughout counselor education and supervision. Counselor educators and supervisors train CITs to be multiculturally competent and compassionate to their clients, which involves recognizing and managing personal bias (CACREP, 2016).

CITs are trained to bracket or compartmentalize their biases when working with clients who hold opposing viewpoints, socio-political ideologies, and worldviews in an attempt to see the world from the client's perspective and lived experiences (ACA, 2014; CACREP, 2016; Elliot et al., 2018), as well as to avoid causing harm to the client (Dworkin et al., 2018). Counselor educators and supervisors need up-to-date and evidence-based pedagogical approaches to help CITs identify personal bias and recognize how this bias may impact the counseling process, especially if bias goes unexamined. As complex as teaching CITs about recognizing and dealing with bias can be throughout the counseling process, additional challenges to addressing bias arises when considering the complex and co-occurrence of psychiatric disabilities.

Further, scholars (Francis et al., 2020; Rogers, 2019) have suggested that more training is needed in dual diagnosis to prepare counselors to offer evidence-based treatment services to this population and avoid causing harm by further exacerbating stigma and negative stereotypes about this population. CITs will likely work with clients living with a dual diagnosis during their practicum and internship experiences due to the high prevalence rates of co-occurring SUD and mental health disorders (Brown et al., 2002; Salyers et al., 2006), and CITs must gain experiences to assess their own personal biases toward these clients. CITs are trained to make inferences about their clients' presenting concerns and diagnoses throughout the counseling process, including case conceptualizations, behavioral health assessments, and treatment plans. However, the challenge CITs face is refraining from imposing personal bias on the clients they serve. For clients living with a dual diagnosis, CITs need to identify stereotypes and stigma often assigned to various psychiatric disorders and how their attitudes and beliefs may align with these messages.

However, before bias toward persons living with a dual diagnosis can be addressed with CITs, counselor educators and supervisors must first reflect and assess their bias toward this population. Counselor educators and supervisors are not exempt from experiencing bias toward clients, which can overflow into work with CITs (Lee, 2014). Counselor educators must take time to reflect, explore, and assess their own bias toward clients living with a dual diagnosis to recognize when this bias arises when teaching on dual diagnoses. After assessing their own bias toward clients living with a dual diagnosis, counselor educators can consider training models to assist them in helping CITs learn about dual diagnosis and recognize bias held toward this population.

### **Skilled Counseling Training Model**

Counselor bias is introduced and taught throughout counselor education programs as a key concept for CITs to reflect on and consider throughout the counseling process with clients (CACREP, 2016). As well-trained and well-intentioned as CITs may be, research suggests that bias, even examined bias, may surface during work with clients (Cornfield & Hubley, 2020; Dworking et al., 2018). This bias may arise in the form of microaggressions or other implicit or explicit discriminatory or hurtful behaviors toward the client (Cornfield & Hubley, 2020; Sue et al., 2007), which can potentially hinder clients' attainment of their treatment goals and outcomes (Chasek et al., 2017). Brown et al. (2002) suggest that counselor bias may arise through counselors perceiving themselves to be highly competent to work with particular clients due to their professional training or past life experiences, yet may lack or disregard specific factors (e.g., empathy) necessary to work with such clients. Further, without proper training and self-discipline to identify and reflect on personal bias, CITs may unintentionally impose an implicit and inferential bias on clients (Boysen, 2010; CACREP, 2016). Although some researchers have

examined CIT bias toward clients in the literature, this area of research is limited, particularly looking at CIT bias toward clients with more than one diagnosis (Driessen et al., 2008).

Therefore, additional approaches need to be considered to support counselor educators and supervisors when training CITs to work with clients living with a dual diagnosis.

To assist counselor educators and supervisors in this pedagogical pursuit, implementing the Skilled Counseling Training Model (SCTM; Packman, 2009), adapted from the Smaby et al. (1999) Skilled Group Counseling Training Model, provides a framework for teaching the multifaceted medical and psychosocial aspects of living with a dual diagnosis, assisting CITs to recognize biases, and discovering how bias can show-up throughout aspects of the counseling process when working with this population. The SCTM is a three-stage model focused on exploring, understanding, and acting through modeling, mastery, persuasion, arousal, and feedback (Packman, 2009; Smaby et al., 2009). Counselor educators can implore each stage of the model to address necessary and unique aspects of working with a client living with a dual diagnosis. A unique aspect of the SCTM is that abstract ideas related to counseling a client with a dual diagnosis (e.g., identifying symptomology, recognizing bias, determining appropriate treatment approaches) can become more accessible to CITs. For example, talking about bias toward clients is important in the classroom, but the SCTM provides CITs the opportunity to take a theoretical idea about bias and experience it in a scenario. This activity could be done in class using a role-play or more modern technological advances where the student watches a video of a client with a dual diagnosis and responds to the client while being recorded by the computer's camera. Finally, the SCTM allows CITs to receive feedback on their experiences learning about persons living with a dual diagnosis, which is necessary to facilitate learning and promote awareness.

### **Future Directions**

Although research has been conducted on counselor bias toward persons living with a SUD and other psychiatric disabilities independently, I suggest that more research is needed to understand how counselors may discriminate toward those with a dual diagnosis. More specifically, with the likelihood of CITs encountering a client living with a dual diagnosis as early as practicum and internship, it is suggested that researchers explore how CITs discriminate differently based on various aspects of living with a dual diagnosis. Important to this scholarly process would be to include aspects of attribution theory to determine if CITs make attributions toward these clients based on particular behaviors that occur during treatment. For example, relapse is common for people living with a dual diagnosis, yet research is absent in the literature on how CITs make attributions towards the determining factors associated with the relapse. Further, attitudes toward clients living with a dual diagnosis may be influenced by negative emotions (e.g., anger, fear, frustration) and negatively impact aspects of the counseling process, including empathy toward the client. It could be helpful for researchers to consider how CITs rate their degree of empathy toward clients living with a dual diagnosis and to compare the associations with their degree of attributions made toward the same client.

Most of the research that exists studying counselor and CIT bias toward clients is conducted through a self-report cross-section study design, which can be limiting when trying to understand how relationships may vary under different conditions (Boysen & Vogel, 2008). More research is needed that utilizes an experimental control means for evaluating bias toward clients (Mohr et al., 2001; Nguyen et al., 2020). Therefore, I suggest that future research utilize experimental control design studies to assess for counselor and CIT bias. One approach that may be useful for researchers to consider is an analogue experimental control design allowing the

researchers to present a simulated counseling experience in the study and manipulate the independent variables while maintaining the integrity of the stimulus (Heppner et al., 1999). Further, CITs may be influenced by a desire to conform to social norms, influencing their reporting of actual bias or discrimination toward clients. Therefore, I suggest that researchers consider participants' self-presentation concerns when designing research studies examining bias toward clients with a dual diagnosis.

Finally, it is possible that CITs with low levels of knowledge and skills to work with clients with a dual diagnosis may overestimate their ability, known as the Dunning-Kruger effect (Dunning & Kruger, 1999). Due to the complex nature and potential tendencies CITs may have to overestimate their ability to work with this challenging population, I suggest that researchers consider examining CITs' perceived abilities to work with clients living with a dual diagnosis compared to their actual abilities based on their developmental level.

### **Conclusion**

This chapter offered a literature review on various aspects of the complexity involved with living with a dual diagnosis and working with these clients. Due to the prevalence rates of persons living with a dual diagnosis, CITs will likely encounter a client with a dual diagnosis as early as their practicum or internship experience. Preparing CITs to work with this population includes training them to identify barriers that persons living with a dual diagnosis may face when seeking treatment and, once in treatment, determine appropriate treatment approaches. Further, bias and discrimination toward persons with a dual diagnosis persist, and counselor educators and supervisors need to assist CITs in assessing for personal bias toward these clients. To assist counselor educators in training CITs to work with a client living with a dual diagnosis and recognize personal biases, the Skilled Counseling Training Model (SCTM; Packman, 2009)

provides an appropriate framework to utilize with this population. Finally, more research is needed to explore various aspects of training CITs to work with persons living with a dual diagnosis, as well as helping CITs recognize personal biases toward these clients.

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## Chapter 2

### EXPLORING CIT BIAS TOWARD CLIENTS WITH SUBSTANCE USE DISORDER AND POSTTRAUMATIC STRESS DISORDER

#### Introduction

Substance use disorders (SUD) and posttraumatic stress disorder (PTSD) are chronic and debilitating conditions that can negatively affect numerous aspects of a person's life (Flanagan, 2016). SUD has been found to have a strong association with PTSD. In the United States, these two disorders have a likelihood of high co-morbidity and high prevalence as a dual diagnosis (Chilcoat & Beslau, 1998; Flanagan et al., 2016). Substance use (SU) remains a major public health concern in the United States (Substance Abuse and Mental Health Services Administration; SAMHSA, 2020) and is highly discriminated against globally (Brooks & McHenry, 2015; Luoma, 2013; SAMHSA, 2020; Yang et al., 2018). In 2019, the National Survey on Drug Use and Health (NSDUH; SAMHSA, 2020) found that approximately 165 million people over the age of 12 reported engaging in SU within a single month, and roughly 20 million people met the criteria for a SUD.

Trauma experiences amongst adults in the United States are also very prevalent and often coincide with substance use. An estimated 70% of adults will experience at least one traumatic event at some point in their lives, and up to 20% will develop a PTSD diagnosis following that event (Cabrera & Karakashian, 2021). Further, researchers have suggested that PTSD can complicate access to treatment for those with a co-occurring SUD (Giordano et al., 2016) and can negatively affect SUD treatment and outcomes (Driessen et al., 2008). Living with a dual diagnosis of SUD and PTSD presents numerous challenges for clients seeking treatment due to the complexity of the disorders, the likelihood of relapse, and stigmatizing attitudes and beliefs

that persist in society towards these disorders, which can be further exacerbated by the type of substance used and the severity of SU (Driessen et al., 2008; Kelley et al., 2009; María-Ríos & Morrow, 2020). Further, having a dual diagnosis of SUD and PTSD increases the likelihood of relapse to SU, even more so than having a dual diagnosis of SUD and another psychiatric disability (Back et al., 2009; Norman et al., 2007).

Although there has been an effort to challenge and decrease societal stigma toward PTSD and SU over the past several decades, prejudicial attitudes about and discriminatory practices against people with SUD and PTSD persist (Buchman et al., 2017; Francis et al., 2020; Kilian et al., 2021; Nieweglowski et al., 2018; Ventura et al., 2017). Considering SUD and PTSD independently, these diagnoses remain highly stigmatized within greater society, even with advancements in combatting and reducing societal stigma towards these individuals, adding to the challenges these clients face (Brooks & McHenry, 2015; Luoma, 2013; Yang et al., 2018). Considering the societal stigma that persists, along with the misunderstanding and discrimination often associated with SUD and PTSD, there is potential for clients with this dual diagnosis to experience higher levels of discrimination, even from their counselor. For example, Francis et al. (2020) examined mental health counselors' bias toward clients with a dual diagnosis and found greater stigmatizing attitudes and beliefs toward clients with a dual diagnosis than those with a single diagnosis within their sample. Further, the same authors suggest that fear of discrimination based on stigmatizing negative beliefs and attitudes that persist towards living with a SUD and PTSD diagnosis remain as barriers to seeking help and staying in treatment or recovery (Francis et al., 2020).

Research has also shown that persons living with a dual diagnosis may internalize stigmatized messages, which may compound challenges in treatment. For example, Luoma et al.

(2013) found in their sample that self-stigma and lowered self-efficacy presented obstacles for clients with a dual diagnosis of SUD and PTSD to initiate counseling and achieve their goals for treatment. The authors further suggested that clients' fear of being further stigmatized, stereotyped, or discriminated against by treatment providers based on their dual diagnosis can prevent these clients from seeking help or assistance (Luoma et al., 2013). Numerous studies have examined treatment providers' attitudes and biases towards clients living with a SUD and PTSD as independent diagnoses (Cornfield & Hubley, 2020; Maier et al., 2015; Rodgers-Bonaccorsy, 2010; Sattler et al., 2017; van Boekel et al., 2013) and few studies examining bias toward dual diagnosis (Maria Nass et al., 2019; Schulte et al., 2010). Moreover, counselors-in-training (CITs) will likely experience a client living with a dual diagnosis of SUD and PTSD during their practicum and internship experience due to the high prevalence of this diagnosis, yet CITs' bias toward dual diagnosis has yet to be explored in the literature (Lee, 2014). Therefore, it seems necessary to explore whether CITs have a bias toward a dual diagnosis of SUD and PTSD, especially with the possibility of negative bias arising toward these clients and potentially hindering their treatment and treatment outcomes.

### **Substance Use Type**

Dworkin et al. (2018) suggest that more research is needed to explore different types of substances when attempting to understand the relationship between SUD and PTSD. Specifically, CITs may have a bias toward clients with a dual diagnosis of SUD and PTSD based on the type of substance used (Can & Tanriverdi, 2015), yet this area of focus is lacking in the literature. For example, one of the generalizations made towards people with a SUD includes negative stereotypes and labels (e.g., drunk, dirty, dangerous, weakness of character, blameworthy; Corrigan et al., 2005), and research has yet to thoroughly explore these variables

and ways they could appear throughout the counseling process based on substance use type. The existing research suggests that counselors who hold these types of prejudice toward their clients' SUD can be influenced by stereotypes and labels attached to particular substances (Francis et al., 2020). These negative stereotypes and discriminatory bias toward specific substances may also overlap with PTSD symptom patterns, resulting in misdiagnosing or providing an unhelpful treatment approach. Dworkin et al. (2018) suggest that symptom cluster patterns associated with PTSD can be linked to various types of SU based on symptomology. Understanding what symptoms may arise based on which substance is related to the PTSD symptom can help counselors recognize behaviors associated with this dual diagnosis and avoid making false assumptions about SUD or PTSD symptom-related behaviors (Chilcoat & Breslau, 1998; Driessen et al., 2008; Dworkin et al., 2018). Thus, it seems vital to understand CIT bias toward persons living with a dual diagnosis of SUD and PTSD based on substance use types with different stereotypes and labels, such as alcohol use and crystal meth use.

Alcohol is a legal substance in the United States for persons aged 21 and older. It is a highly acceptable form of substance use with only mild stigma and discrimination reported toward social alcohol use (Can & Tanriverdi, 2015; Keyes et al., 2010). However, stigma and discrimination toward alcohol use can increase once alcohol use becomes problematic (Keyes et al., 2010). After receiving a diagnosis of an alcohol use disorder, negative stereotypes and labels may be placed on the client, such as SU being associated with one's inability to control their alcohol consumption (Kilian et al., 2021). However, counselors' negative attitudes and beliefs toward alcohol use may have less severity when compared to illicit substances (Keyes et al., 2010), and further investigation comparing CITs' bias toward various substances is warranted.

Highly stigmatizing beliefs toward illicit substance use are also problematic based on illicit substance type (Ventura et al., 2017). For example, crystal meth use is an illicit substance suggested to be one of society's most stigmatized and least understood substances (Sharma, 2018). Crystal meth users have been stereotyped as dangerous, violent, erratic, and beyond help, which is further supported by their depiction in movies and television programs and can cause people to fear, judge, and criticize them unfairly (Scheibe, 2017). In a qualitative study by Coleman et al. (2021) looking at the lived experiences of people in long-term recovery from crystal meth use, their participants indicated that learning to cope with the stigma and discrimination that exists toward crystal meth use above other substances was necessary to support their sustained recovery.

Although both of these examples of types of substances can lead to a SUD diagnosis, crystal meth use remains highly stigmatized and under-researched. In contrast, alcohol use has a more acceptable public view and has had a greater focus in the literature. Thus, for clients dealing with a dual diagnosis of SUD and PTSD in counseling, bias may arise based on negative stereotypes and labels associated with various substance types that could worsen PTSD symptoms (e.g., negative emotions, avoidance) and intensify the risk of relapse to SU (Chilcoat & Breslau, 1998; Read et al., 2004). Still, more research is needed to understand the complexity of how someone living with a dual diagnosis of SUD and PTSD is discriminated against based on the type of substance used. One important factor that needs consideration is the high probability these clients will experience relapse to SU during treatment, adding to the need to understand how CITs may discriminate based on the details of the relapse, which has yet to be explored in the literature.

## Relapse Determinants

Individuals living with a dual diagnosis of SUD and PTSD also face a high occurrence of relapse to SU and the stigma associated with relapse (Kelley et al., 2021; Read et al., 2004).

Negative views toward relapse to SU include weakness of willpower, broken personal disposition or character within the person, or immoral choice (Witte et al., 2019). One way relapse has been classified is through Cummings et al. (1980) taxonomy of relapse. This classification system is based on two domains that consider situational factors and emotional states a client may experience before a relapse occurs. The first domain in the taxonomy of relapse is *intrapersonal determinants*, which includes ways a person could relapse to SU during a relapse to self-medicate or cope with negative emotions (e.g., anger, depression), negative physical issues (e.g., chronic pain), or temptations (e.g., cravings, urges; Cummings et al., 1980; Donovan & Witkiewitz, 2012).

The second domain is categorized as *interpersonal determinants*, which refers to relapsing to SU in social or interpersonal situations, such as feeling peer pressure to use or as a way to improve or increase positive emotions in social situations (Cummings et al., 1980; Donovan & Witkiewitz, 2012). These two domains of relapse determinants provide a viewpoint of understanding relapse to SU, yet there has been little evidence to support how these relapse determinants may be viewed and discriminated against by treatment providers. Few studies have examined relapse to SU among those dealing with the co-occurrence of SUD and PTSD. However, the existing literature suggests that the presence of PTSD is associated with worse treatment outcomes and a heightened risk of relapse amongst those with a SUD (Bradizza et al., 2006; Gielen et al., 2016). Further, treatment providers can discriminate toward these clients who relapse to SU based on prejudices toward the determining factor or cause of the relapse (Pickard,

2017). Therefore, more research is needed to understand CIT bias toward clients with a dual diagnosis of SUD and PTSD who experience relapse. Specifically, researchers should explore how CIT bias may differ based on the type of substance used, the relapse determinant, and the degree to which CITs may attribute blame to clients for relapse.

### **CIT Bias**

Limited studies have examined bias toward clients living with a dual diagnosis of SUD and PTSD from the point of view of CITs, even though CITs will likely encounter a client dealing with SUD or PTSD independently or as a dual diagnosis as early as their practicum and internship experiences in various counseling settings (Brown et al., 2002; Salyers et al., 2006). In a study examining counselor attitudes, Cornfield and Hudley (2020) found that nearly 69% of their sample of CITs worked in settings that did not specialize in SUD treatment. Yet, over 89% of their sample reported experiences working with clients with SUD, suggesting it is common for clients to present to counseling with SU concerns, either for themselves or someone close to them, in various settings (Cornfield & Hudley, 2020).

CIT bias toward clients can positively and negatively influence various aspects of the counseling process and treatment outcomes for clients with SUD and PTSD (Brown et al., 2002; Fisher et al., 2014; Francis et al., 2020; van Boekel et al., 2013). Negative bias toward clients can lead to a substandard level of counseling care (Francis et al., 2020; van Boekel et al., 2013). However, positive attitudes toward these clients, including hopeful and optimistic views toward treatment and outcomes, have been found to help clients motivate change and better achieve their goals for treatment (Miller & Rollnick, 2013). In a quantitative study by Chasek et al. (2012), the researchers found in their sample of CITs that non-biased and positive attitudes predicted around 13% of the variance in optimism toward treatment outcomes for SUD. Negative attitudes toward

persons with a PTSD diagnosis can lead CITs to hinder the therapeutic alliance and counseling-related outcomes. They can contribute to CITs' risk of experiencing vicarious trauma, compassion fatigue, and burnout (Trippany et al., 2004). However, despite the evidence suggesting that CIT bias can negatively impact work with clients living with a dual diagnosis, research has yet to consider how CITs discriminate differently toward clients with a dual diagnosis of SUD and PTSD.

An important aspect to consider for those living with a dual diagnosis is how blame is attributed to various factors. Much debate has occurred in the literature regarding the question, “Who is to blame for SUD or PTSD diagnoses?” based on the contributing factors associated with the events preceding or during the diagnosis (Williams et al., 2013). Attribution theory (Weiner, 1980) would suggest that CITs first observe people’s problems and then determine the cause of the problem to be based on either a situation (i.e., external factor) beyond the client’s control or caused by a disposition (i.e., internal factor) within the client (Lloyd, 2013). Bias toward clients with SUD and PTSD has also been associated with how counselors attribute blame to the client for the behaviors related to acquiring their diagnoses. For example, if a client discloses that they started using substances as "party drugs" while attending circuit parties and then engaging in risky sexual behaviors, counselors may blame the client for developing a SUD due to engaging in these acts (Chilcoat & Breslau, 1998). For clients with a PTSD diagnosis, disclosing information about the traumatic event that led up to the PTSD (e.g., rape occurring with SU involved) may lead a CIT to blame the trauma survivor for the diagnosis (Stewart & Jacquin, 2010).

Several hypotheses exist regarding how blame may be attributed to clients living with a dual diagnosis of SUD and PTSD who relapse to SU (Dworkin et al., 2018). The first hypothesis

to be considered with this population is the high-risk hypothesis, which refers to behaviors often associated with relapse to SU that someone may engage in to deal with PTSD symptoms (e.g., engaging in social activities to manage PTSD avoidance or isolation symptomology) or general life stressors (e.g., financial, housing, or employment concerns) (Chilcoat & Beslau, 1998). These high-risk SU behaviors include drug-dealing-related crimes or risky sexual behaviors (Ahuja et al., 2021; Dworkin et al., 2018). Another hypothesis of importance for this topic when considering blame attributions with a dual diagnosis of SUD and PTSD is the self-medication hypothesis. The self-medication hypothesis refers to a person with a SUD using substances to cope and manage PTSD symptoms, emotional distress, situational concerns, and psychosocial concerns (Henwood & Padgett, 2007; Khantzian, 1985). Both of these hypotheses could have implications on how CITs attribute blame to clients with a dual diagnosis of SUD and PTSD who relapse to SU; however, research has yet to consider how CITs attribute blame to these clients based on the type of substance used during a relapse.

As mentioned previously, relapse is common in persons living with a dual diagnosis of SUD and PTSD. We live in an era of accountability, and the temptation for CITs working with these clients may be to attribute and assign blame to the client based on the factors for the relapse to SU (Pickard, 2017). For example, a client who relapses to SU as a way to cope with unpleasant emotions due to PTSD symptomology (i.e., intrapersonal determinant) may be blamed at lower levels than someone who relapses to SU due to peer pressure to use (i.e., interpersonal determinant) while engaged in a social interaction to manage isolation (Donovan & Witkiewitz, 2012). Further, CITs may tend to attribute blame to these clients who experience a relapse to SU based on bias toward the type of substance used during the relapse. For example, clients with a dual diagnosis of SUD and PTSD who relapse to alcohol use may be attributed

blame differently by CITs than an illicit substance (e.g., stimulants) due to stereotypes and labels attached to the substances, as well as society's accepting nature of alcohol use versus negative attitudes and beliefs toward certain illicit substances (Francis et al., 2020). At this time, we do not know how CITs attribute blame to clients with a dual diagnosis of SUD and PTSD following a relapse, and further research is needed to look at the attribution of blame toward relapse determinants and SU type. However, Francis et al. (2020) researched clinicians' attitudes toward persons living with a dual diagnosis based on alcohol and crystal meth use and found significantly more negative attitudes toward the person using crystal meth. These researchers recommended that more research be conducted on treatment providers' attitudes (e.g., blame) toward clients living with a dual diagnosis to understand how these clients are discriminated against based on SU type. To that end, empathy is an additional factor that has the potential to influence CIT bias but has yet to be explored in the literature for persons living with a dual diagnosis of SUD and PTSD following relapse to SU.

### **Empathy**

Another important aspect to consider related to CIT bias and how CITs attribute blame toward clients dealing with a dual diagnosis of SUD and PTSD is empathy. Empathy refers to counselors' attempt to understand and relate to clients and their experiences with a compassionate and benevolent attitude (Elliott et al., 2018). Empathy is one of the core ingredients in Carl Rogers' (1957) explanation of how change occurs through the therapeutic alliance between counselor and client. In previous studies, counselors' empathy levels have positively influenced the therapeutic relationship and client outcomes (Elliot et al., 2018). In a quantitative study by Litam (2019), the author explored how labels influence counselor attitudes and predict empathy and found that labels and demographics of the counselor correlated and

predicted empathy and myth acceptance toward their sample's diagnosis (Litam, 2019). Prior literature indicates empathy is related to counselor attitudes and bias toward persons living with disabilities and chronic illness (Webb et al., 2016). Further, Wei-Mo Tu et al. (2019) suggest that empathy can help reduce stigma towards persons with a SUD. However, Levitt-Jones et al. (2017) suggest that more research is needed utilizing simulation through situations that replicate actual counseling situations to understand better how helpers' empathy levels impact persons living with disabilities in the counseling process.

Considering the context of a client living with a dual diagnosis of SUD and PTSD and who experienced a relapse to SU, empathy can play a vital role in clients returning to treatment and achieving successful treatment outcomes (Elliot et al., 2018). CITs may experience and express empathy differently based on their intrapersonal reactions to and biases toward aspects of the relapse. For example, a CIT may experience different levels of empathy toward a client living with a dual diagnosis of SUD and PTSD who relapses to SU as a way to self-medicate and cope with distressing emotions and PTSD symptoms (i.e., intrapersonal determinant) versus a client who relapses due to experiencing social pressure to use from their recovery network (i.e., interpersonal determinant). Further, CITs' emotional responses to clients living with a dual diagnosis of SUD and PTSD who relapse to SU may also be influenced by the type of substance used by the client during the relapse (Wei-Mo Tu et al., 2019). However, researchers have yet to thoroughly investigate CIT empathy levels towards clients living with a dual diagnosis of SUD and PTSD who relapse to SU based on relapse determinants and substance use type. Moreover, it seems important to consider how CIT empathy levels may differ toward clients living with a dual diagnosis of SUD and PTSD who relapse to SU based on how they attribute blame for the relapse. Therefore, research that explores CITs' empathy levels and their associations with blame

attribution toward persons with a dual diagnosis of SUD and PTSD is needed for CITs to reduce imposing personal bias and better support these clients.

### **The Present Study**

Previous research indicates that CITs will likely work with clients presenting to counseling with SUD or PTSD independently and as a dual diagnosis. Further, CITs will possibly witness a client living with a dual diagnosis of SUD and PTSD experiencing the aftermath of relapse to SU during their practicum and internship experience. These clients need their CIT to avoid imposing a personal bias toward them following a relapse and, instead, to provide an empathetic understanding of their relapse experience. Thus, more research is needed to understand CIT bias by exploring how CITs differ in blame attribution and empathy levels based on relapse determinants and the type of substance used for clients living with a dual diagnosis of SUD and PTSD following a relapse, which has great potential to inform counselor educators and supervisors on how to prepare CITs to better serve this population.

The need for research exploring CIT bias toward clients with a dual diagnosis of SUD and PTSD is further underscored by the fact that many of the previous studies have relied on self-report cross-sectional study design data (Boysen & Vogel, 2008), and studies are needed that utilize an experimental means of evaluating CIT bias (Mohr et al., 2001; Nguyen et al., 2020). Self-report cross-sectional study designs may not fully capture the accurate responses from participants since the surveys are designed in a general participants' response. When measuring CITs' bias toward clients from self-report, the researchers risk having participants select answers based on what they perceive as the most socially acceptable response instead of their actual thoughts and feelings related to the survey (Heppner et al., 2015). Thus, it is important to create a

counseling situation close to real-life for CITs to encounter when exploring CITs' bias (Cook & Rumrill, 2005).

Specific to this study, an analogue experimental control design, which is discussed in more detail in the next section, was implemented to allow participants to experience a fictitious counseling situation close to real-life (Cook & Rumrill, 2005). The CIT participants read information about a client living with a dual diagnosis of SUD and PTSD with a recent relapse experience in a short vignette (Shown in Appendix A) and then responded to the surveys. Having CITs observe a real-life situation with a client with a dual diagnosis would present practical benefits (e.g., availability of clients or client actors, cost, time) and ethical implications (e.g., restricting intervention, confidentiality); which is further support to utilize the analogue design for observation (Cook & Rumrill, 2005). This analogue design allowed all participants to be randomly assigned to read one of four controlled vignettes. The vignettes contained the same information about the client, except I changed the substance use type (i.e., alcohol use and crystal meth use) and relapse determinants (i.e., intrapersonal self-medicating behavior, interpersonal high-risk behavior) within each of the four vignettes to control for the information participants receive about the client before responding to the surveys.

In addition to creating a simulated experience for the study, I also wanted to consider the possibility of CIT's self-presentational bias. CITs may have an unconscious inclination to rate their scores toward a client living with a dual diagnosis of SUD and PTSD based on a tendency to conform to social norms, which is consistent with other research studies examining CIT bias (e.g., Mohr et al., 2001). To achieve this, I introduced a measure assessing for CITs' awareness of socially appropriate behavioral norms and their desire to conform to those norms (Lennox & Wolfe, 1984). I planned to use these social presentation concerns as a control function in our

analysis when looking at the associations of blame attribution and empathy levels based on relapse determinants and substance use for a client with a dual diagnosis of SUD and PTSD.

Therefore, this study sought to examine how CITs may discriminate differently between relapse determinants (i.e., intrapersonal self-medicating behavior versus interpersonal high-risk behavior) and substance use type (i.e., alcohol use versus crystal meth use) among those living with a dual diagnosis of SUD and PTSD by examining the relationships between blame and empathy levels, while controlling for social desirability, in an experimental control research design. To explore these relationships, I specifically planned to answer the following research question and hypotheses:

**Research Question 1:** What are the relationships between blame, empathy, and concern for appropriateness for CITs after being assigned to read one of four vignettes related to SUD and PTSD?

**H1:** I hypothesize that blame scores will be significantly negatively associated with empathy levels based on previous studies exploring blame and empathy levels in samples of those in the helping field (e.g., Araten-Bergman & Werner, 2017).

**H2:** I hypothesize that concern for appropriateness scores will be significantly negatively correlated with blame scores and significantly positively correlated with empathy levels.

**Research Question 2a:** When encountering a fictitious client living with a dual diagnosis of SUD and PTSD, will CITs differently discriminate on ratings of blame as a function of the client's reason for relapse and SU type?

**H1:** I hypothesize that CITs will attribute higher levels of blame to the fictitious client whose relapse determinant was linked to interpersonal high-risk behavior when compared to

blame scores toward the client whose relapse determinant was based on an intrapersonal self-medicating type behavior.

*H2:* I hypothesize that CITs will attribute lower levels of blame to the fictitious client who used alcohol during relapse when compared to blame scores toward the client who used crystal meth.

*H3:* I hypothesize that a significant interaction between relapse determinants and SU type will occur based on CIT blame scores.

**Research Question 2b:** When encountering a fictitious client living with a dual diagnosis of SUD and PTSD, will CITs differently discriminate on ratings of empathy as a function of the client's reason for relapse or SU type?

*H1:* I hypothesize that CITs will report lower levels of empathy toward the client whose relapse determinant was linked to interpersonal high-risk behavior when compared to empathy scores toward the client whose relapse determinant was based on an intrapersonal self-medicating type behavior.

*H2:* I hypothesize that CITs will report higher levels of empathy toward the client who used alcohol during relapse when compared to empathy levels toward the client who used crystal meth.

*H3:* I hypothesize that a significant interaction between relapse determinant and SU type will occur based on CIT empathy levels.

## **Method**

### **Sample**

The original sample of participants consisted of 150 CITs from CACREP accredited master's counseling programs throughout the United States. The CIT participants were recruited

by emailing and asking local and regional counselor educators and supervisors from 157 CACREP programs throughout the United States (e.g., clinical rehabilitation counseling, clinical mental health counseling, school counseling) to share the recruitment posting with their students.

An a priori power analysis using G\*Power (version 3.1; Faul et al., 2009), with a medium effect size, a significance level of .05, a power of .80, two groups with two levels in each group, and one covariate to determine a total sample size of at least 128 participants would be necessary to detect a significant effect. To ensure the minimum sample size was met, I recruited a total of 150 subjects to allow for the removal of cases with empty or incomplete questionnaires and those cases where participants failed to respond to attention checks (Silber et al., 2018) accurately. To participate in this study, participants had to be over the age of 18, in practicum or internship experience, and currently seeing clients in a counseling setting. All participants in the sample were over the age of 18. However, two participants were removed from the sample after indicating they were not enrolled in a practicum or internship experience and currently seeing clients. During the assessment and cleaning process of the data, five participants were removed for failing to complete all parts of the survey from the dataset, and an additional five participants were deleted for failing to appropriately select three of the four (75%) attention checks were removed during the cleaning process (Silber et al., 2018). This process resulted in a final sample size of 138 cases used for data analysis, and participants' demographic characteristics are presented in Table 1.

Table 1

*Demographic Data for Participants*

Variable	<i>M</i>	<i>SD</i>	<i>Range</i>	<i>%</i>	<i>n</i>
Age (years)	29	8.14	21-58		138

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Gender		
Cisgender men	13%	18
Cisgender women	84.8%	117
Transgender	.7%	1
Gender non-binary	.7%	1
Non-binary woman	.7%	1
Race/Ethnicity		
Asian	4.3%	6
Biracial/Multiracial	2.9%	4
Black/African Descent	11.6%	16
Hispanic or Latino	5.8%	8
Indigenous/ Native American	.7%	1
Middle Eastern	.7%	1
White/European Descent	79%	109
Other	1.4%	2
Sexual Orientation		
Bisexual	18.1%	25
Gay	.7%	1
Heterosexual	74.6%	103
Queer/Pansexual	3.6%	5
Other	2.9%	4
Religious or Spiritual Affiliation		
Agnostic	15.2%	21

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Atheist	9.4%	13
Buddhist/Taoist	4.3%	6
Christian/Catholic	46.4%	64
Hindu	.7%	1
Jewish	1.4%	2
Muslim/Islam	1.4%	2
Spiritual (but not religious)	21.7%	30
Wiccan/Pagan/Neo-Pagan	2.2%	3
Other	4.3%	6
Counseling Program Type (CACREP Accredited)		
College Counseling and Student Affairs	.7%	1
Clinical Mental Health Counseling	70%	98
Clinical Rehabilitation Counseling	1.4%	2
Marriage, Couple, and Family Counseling	4.3%	6
Rehabilitation Counseling	1.4%	2
School Counseling	21%	29
Practicum or Internship Site Setting		
College or University	21.7%	30
Crisis Setting	2.2%	3
Detox Center	.7%	1
Hospital	5.1%	7
Non-profit/Community Health Setting	23.9%	33
Private Practice Clinical Setting	25.4%	35

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P-12 Schools	25.4%	35
State or Local Government Setting	3.6%	5
Other	5.1%	7
Taken an Addictions Course		
Yes	60.1%	83
No	39.9%	55
Taken a Trauma Course		
Yes	49.3%	68
No	50.7%	70
Participant Region (ACES)		
NCACES	10.1%	14
NARACES	18.1%	25
SACES	55.1%	76
RMACES	11.6%	16
WACES	5.1%	7

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### **Stimulus Material**

To explore how CITs discriminate differently on relapse determinants (i.e., intrapersonal self-medicating behavior versus interpersonal high-risk behavior) and relapse substance use type (i.e., alcohol versus crystal meth) among those living with a dual diagnosis of SUD and PTSD, I utilized an analogue study design. Utilizing an analogue study design to assess CIT bias is consistent with other research studies that used analogue design when looking at counselor and CIT attitudes and perceptions toward clients (e.g., Mohr et al., 2001). Analogue research is

designed to investigate a condition that emulates a real situation that one would encounter in a counseling situation but without breaching ethical concerns related to an actual client interaction (e.g., confidentiality; Cook & Rumrill, 2005). The analogue design allows the researchers to manipulate the independent variables while maintaining the integrity of the stimulus (Cook & Rumrill, 2005; Heppner et al., 1999). For this particular study, the manipulated independent variables were SU type (i.e., crystal meth use and alcohol use) and the relapse determinant (i.e., intrapersonal self-medicating behavior, interpersonal high-risk behavior). Therefore, four conditions were utilized for comparison in this study's design, which consist of (a) crystal meth use and relapse due to intrapersonal self-medicating behavior, (b) alcohol use and relapse due to intrapersonal self-medicating behavior, (c) crystal meth use and relapse due to interpersonal high-risk behavior, and (d) alcohol use and relapse due to interpersonal high-risk behavior.

After giving consent to participate in the study, participants were randomly assigned to one of the four groups. The stimulus featured a short vignette (Shown in Appendix A) of a fictional scenario summarizing psychosocial information about a 32-year-old male client with a previous diagnosis of PTSD following a traumatic event that led the client to use substances to help cope with his PTSD symptoms. Each of the four written scenarios was identical except for manipulating substance use type and relapse determinant. These fictitious scenarios were utilized as the stimulus material to assess how CITs discriminate their attributions of blame and empathy levels toward a client with a dual diagnosis of SUD and PTSD based on substance use type (i.e., alcohol use, crystal meth use) and relapse determinant (i.e., intrapersonal self-medicating behavior, interpersonal high-risk behavior).

The content developed for the vignettes in this study was adapted from previous studies (Crabb & Linton, 2007; Maier et al., 2015) that explored counselor attitudes toward clients with

SUD and PTSD independently. First, I adapted the SUD portion of the vignette for this present study from a study by Crabb and Linton (2007), which explored counselor beliefs toward SUD. The PTSD portion of the vignette for this study was adapted from Maier et al. (2015), one of the few studies looking at counselors' attitudes toward working with clients with PTSD. Further, I utilized these scholars mentioned above who used a short vignette of a client whose presenting concerns directly align with symptomology and criteria for a PTSD diagnosis outlined in the *Diagnostic and Statistical Manual of Mental Disorders-5<sup>th</sup> Edition (DSM-5; American Psychiatric Association, 2013)*.

To assess the validity of the stimulus and verify that the scenarios were believable, a group of five practicing counselors who work in addiction and trauma read the vignettes and rated them for clarity, believability, and importance. Following the approach utilized in an analogue study by Mohr et al. (2001), I asked practicing counselors to read the vignettes and then rate eight prompts on a 5-point Likert-type scale, ranging from 1 (*Very Unclear, Completely Unimportant*) to 3 (*moderately*) to 5 (*Very Clear, Very Important*). The practicing counselors responded to the following questions and statements. Their mean scores along with standard deviation are provided: (a) *How well do you understand the relapse concern of the client?* ( $M = 5.0$ ,  $SD = 0$ ), (b) *The vignette is realistic and clear to the reader* ( $M = 5.0$ ,  $SD = 0$ ), (c) *The reason for this client's relapse was very clear* ( $M = 4.6$ ,  $SD = .49$ ), (d) *It is clear this client has a SUD* ( $M = 5.0$ ,  $SD = 0$ ), (e) *It is clear this client has PTSD* ( $M = 4.8$ ,  $SD = .40$ ), (f) *How likely is it that a CIT would encounter this scenario during practicum or internship?* ( $M = 4.6$ ,  $SD = .49$ ), (g) *How important would empathy be for a CIT working with this client?* ( $M = 5.0$ ,  $SD = 0$ ), and (h) *How important would attributing blame to this client for their relapse be for a CIT working with this client?* ( $M = 4.6$ ,  $SD = .49$ ). Based on the feedback and ratings from the practicing

counselors' assessment, I decided to proceed with the vignette as sufficient for the stimulus material for this study.

### **Ethical considerations**

This study was reviewed and approved by the GSU IRB. The primary ethical risks involved issues of informed consent and confidentiality. All data gathered from participants was stored in password-protected computers and in a locked office, only to be viewed by members of the research team. In addition, data was not paired with identifying information of participants; therefore, I utilized participant codes assigned to each participant for this study. Further, I will seek to reduce any breach of confidentiality by not sharing any specific information about the participants when results are presented and published that could potentially be linked to the participants. Participants were made aware that I would seek to maintain confidentiality, but the research that occurs online may not be secure due to the online format of the study. The risk of the research was deemed to be low, and participants were informed that they could quit the research at any time or skip questions without penalty.

Participants were invited to take part in this research study voluntarily. It was up to the participants to decide if they would like to participate in the study. If they decided to participate, they agreed to the informed consent and were assigned randomly to one of four conditions through Qualtrics. The participants were then presented with a vignette of a client based on their assigned condition, followed by a series of online surveys surrounding self-presentation concerns, attribution of blame, empathy levels, and demographics. Participation included a one-time, 10-20-minute time commitment that occurred at the time and location of their choosing. This study was confidential and did not ask for their name during the research study. While the

research team made plans to maintain confidentiality, participants were made aware that the information may not be secure if they completed the research online.

Participants had the option to receive a \$5.00 Amazon e-gift card for participation if they met the inclusion criteria or donate that \$5.00 to Positive Impact Health Centers to support counseling and SU treatment for clients living with a dual diagnosis. Participants who chose to receive the \$5.00 e-gift card were asked to submit an email address to receive the compensation. To avoid breach of confidentiality, participants were asked to use an email address that did not contain their name or any identifying information (for example, panther01@email.com). A total of 85 participants received a \$5.00 Amazon e-gift card, and 65 donated their \$5.00 to Positive Impact Health Centers.

Participants had the choice to participate in this study and were made aware in the informed consent that they did not have to partake in this study. If participants decided to be in the study and change their minds, they had the right to drop out at any time. Participants could skip questions or stop participating at any time and would not lose any benefits to which they were otherwise entitled. Participating in this study did not expose participants to any more risks than they would experience on a typical day. Should participants have experienced any distress triggered by the questions asked in this study, they were encouraged to contact the National Suicide Prevention Lifeline at 1-800-273-TALK (8255), their local crisis center, or emergency room.

## **Measures**

### ***Demographic and Background Questionnaire***

To understand our participants' personal demographics and experiences, I gathered the following information in a demographic questionnaire. CITs were asked about their gender,

sexual orientation, intimate relationship status, age, race/ethnicity, religious and spiritual affiliation, the highest level of education, financial earnings, and region of the country where they currently reside.

Following the personal demographic questions, participants were asked to provide information about their program of study in a CACREP accredited master's level counseling program. The participants were first asked to indicate their specialty program (e.g., Addiction Counseling, Clinical Mental Health Counseling, Clinical Rehabilitation Counseling, School Counseling, Addictions Counseling) as outlined by the CACREP (2016) standards. Participants were asked to confirm whether or not their master's level counseling program is CACREP accredited in a yes or no response. Further, two additional questions in this section asked the participants to indicate if they had taken an addiction and trauma-related course during their master's program with a yes or no response. Demographic responses from CITs are provided in Table 1.

### ***Attribution Questionnaire – Blame Attribution Subscale***

To assess how CITs attribute blame to clients living with a dual diagnosis of SUD and PTSD following a relapse, I utilized the *blame* subscale from the Attribution Questionnaire 27 (AQ-27, Corrigan et al., 2003). The AQ-27 was designed to assess for stigma, stereotypes, and negative emotional responses toward psychiatric disabilities based on attribution theory (Corrigan et al., 2003). The AQ-27 has nine subscales that include: (a) blame, (b) anger, (c) pity, (d) help, (e) dangerousness, (f) fear, (g) avoidance, (h) segregation, and (i) coercion (Corrigan et al., 2003). For the purpose of this study, I utilized the *blame* subscale to assess the degree to which CITs attribute blame differently to a client living with a dual diagnosis of SUD and PTSD who experienced a relapse, on the relapse determinant and substance use type. The AQ-27 *blame*

subscale contains three items focused on the degree to which people have control over and are responsible for their psychiatric disability and symptoms related to their diagnosis (Corrigan et al., 2003). A sample item from the blame subscale includes, “I would think that it was this client’s own fault that he is in the present condition.” Scoring of the AQ-27 is based on a nine-point Likert-type scale, ranging from 1 (*not at all*) to 9 (*very much*). Scores for the *blame* subscale range from 3 to 27, and higher scores indicate more blame attributed to the client.

The AQ-27 is a widely used measure and has been extensively used in research on various populations and age groups and in evaluating public stigma toward mental illness among students and workers in the helping professions. The AQ-27 includes a wide range of stereotypes and stigmatizing behaviors and has been shown to have excellent content validity, indicating the scale measures what it is intended to measure. Further, in a study by Brown (2008), a factor analysis of the scale found strong factor loadings of .50 and higher. Moderate correlations between the *blame* subscale and other stigma measures (e.g., Social Distance Scale, Affect Scale), indicating the AQ-27 *blame* subscale has been shown to have good construct validity (Brown, 2008). Corrigan et al. (2004) identified significant convergent correlations between money donated to a mental illness advocacy group and scores on the *blame* subscale ( $r = -.27$ ). The AQ-27 has revealed adequate to strong internal consistency for the nine subscales, with alpha values ranging from .60 to .93 (Brown, 2008). The *blame* subscale has reported acceptable reliability (Cronbach’s alpha = .78; Corrigan et al., 2003). In the current study, the Cronbach’s Alpha for the items on the *blame* subscale was .72, indicating sufficient reliability.

### ***Comprehensive State Empathy Scale***

CIT empathy levels were assessed with the Comprehensive State Empathy Scale (CSES; Everson et al., 2017), which measures state empathy (i.e., empathy levels one may experience at

a specific time) rather than other scales that measure trait empathy, or a general psychological disposition. The CSES is a 30-item self-report scale measuring the participants' state empathy after reading one of four fictitious client vignettes based on the manipulation of SU type and the presence of PTSD. The first 12 items are a list of feelings and ask the participants to rate the extent they experienced each feeling in response to the client (e.g., "compassionate," "tender," "distress"). Items 13- 30 are a list of statements that ask the participants to rate the extent to which each state is true for them concerning the client's story (e.g., "I found that the scenario affected my mood.").

The CSES is based on a five-point Likert scale ranging from 1 (*completely untrue*) to 5 (*completely true*), with higher scores equating to higher empathy levels. The CSES includes six subscales and each subscale has shown adequate to strong reliability: (a) shared affect (Cronbach's alpha = .86), (b) distress (Cronbach's alpha = .93), empathetic concern (Cronbach's alpha = .87), helping motivation (Cronbach's alpha = .84), empathic imagination (Cronbach's alpha = .86), and cognitive empathy (Cronbach's alpha = .86) (Levett-Jones et al., 2017). Confirmatory factor analysis identified six factors, each with high loadings. Levett-Jones et al. (2017) examined state empathy toward a patient using the CSES and found the scale revealed strong internal consistency for the total score with a Cronbach's alpha of .95 (e.g., Levett-Jones et al., 2017). In the current study, the Cronbach alpha coefficient was .89, indicating good reliability for the CSES with this sample.

### ***Concern for Appropriateness Scale***

I utilized the Concern for Appropriateness Scale (CFA; Lennox & Wolfe, 1984) to investigate CITs' tendencies to conform to group conformity pressures and social norms that could influence their ratings of attribution of blame and empathy levels toward the fictitious

client scenario. Wolfe et al. (1985) suggested that the CFA is designed to examine a protective style of self-presentation to shield oneself against social disappointment. Further, Johnson (1989) investigated the validity of the CFA on undergraduate students' tendencies to conform and provided further evidence that the scale predicts conformity to peer pressure and social norms. In a study utilizing the CFA to measure young adults' concern levels, Wolfe et al. (1985) found that concern scores positively corresponded to conformity to peers' attitudes and beliefs toward the type of substances and the environments where substance use occurs (Wolfe et al., 1986). I selected the CFA as a reliable and valid measure to investigate and control for the possibility that CITs' scores of attribution of blame and empathy levels toward a fictitious client scenario may be persuaded by their desire to conform to social norms.

The CFA is a 20-item measure based on a five-point Likert scale ranging from 1 (strongly disagree) to 5 (strongly agree). It assesses participants' tendencies to conform to group pressures or norms when considering their responses. The CFA has two subscales, *cross-situational variability* (7 items; Cronbach's alpha = .82) and *attention to social comparison information* (13 items; Cronbach's alpha = .82; Lennox & Wolfe, 1984). For the purposes of this study, I used the 13-item subscale *attention to social comparison* to assess for CITs' levels of conformity since it aligns with the purpose of this study. A sample item from the CFA *attention to social comparison* subscale is, "It's important to me to fit into the group that I'm with." Scores range from 13 to 65, with higher scores indicating greater tendencies to conform to group pressures or norms. The CFA *attention to social comparison* subscale has shown good validity and internal consistency reliability for samples in previous studies (e.g., Mohr et al., 2001; Cronbach's alpha = .83) and has shown useful as a measure to examine participants' tendencies for self-presentation bias and conforming to group norms (Johnson, 1989). Lennox and Wolfe

(1984) reported that the CFA had shown a relationship with one's ability to modify self-presentation and social anxiety. The Cronbach alpha coefficient for the present study was .86, indicating good reliability for this scale.

### **Procedure**

Before the recruitment of participants began, I received approval from the university's Institutional Review Board. To meet the criteria and be included in the study, participants had to be over 18 years old, in a CACREP accredited graduate counseling program, and currently seeing clients in a practicum or internship experience. Participants were recruited through postings in professional organization listservs that went to practicum and internship students in CACREP accredited programs. As a secondary method of recruitment, I utilized snowball sampling by asking participants to share the study announcement with other potential subjects.

The recruitment script sent to participants included the rationale for the study, informed consent, and a link to the Qualtrics study. In considering the potential consequence of participants' responses being influenced by their awareness of the research study's focus (CIT bias and dual diagnosis of SUD and PTSD) and the potential risk of participants providing socially acceptable or desirable responses, I utilized a mild form of deception in the study's recruitment script and order of instruments, as outlined in Mohr et al. (2001), to reduce response bias from participants. The recruitment script provided participants with an overview of what to expect in the study, which indicated that the study explores CITs' assessment of clients with multiple presenting concerns (Mohr et al., 2001). The participants first consented to participate in the study and then were randomly assigned to one of four conditions for participation in the study. Once randomly assigned to one of the four conditions, the order of vignette and instruments was: (a) partial demographic questionnaire, (b) vignette that corresponds to the

assigned condition, (c) Attribution Questionnaire – blame subscale (Corrigan et al., 2003), (d) Concern for Appropriateness Scale (Lennox & Wolfe, 1984), (e) Comprehensive State Empathy Scale (Everson et al., 2017), and (f) remaining demographic questions.

I utilized a 2 X 2 between-subject design for this study for group comparison. The two manipulated independent variables were SUD type (i.e., Alcohol, Crystal Meth) and relapse determinant (i.e., relapse due to intrapersonal self-medicating behavior, relapse due to interpersonal high-risk behavior). After agreeing to participate in the study, participants were randomly assigned to read the case study that reflected one of the four conditions for this study. The participants were asked to complete each portion of the study in the order outlined in the directions so that they would not encounter questions related to SUD or relapse determinants that could potentially influence their responses.

All participants completed the study in an online format through Qualtrics. The researchers did not collect any self-identifying information from the participants to ensure confidentiality. However, participants had the option to receive a \$5 e-gift Amazon card or donate their earned \$5 to Positive Impact Health Centers to support persons with co-occurring diagnoses. If participants decided to receive the \$5 e-gift card, they were asked at the end of the survey to provide a non-identifying email address where the e-gift card was distributed through the Amazon website. A total of 85 participants received a \$5.00 Amazon e-gift card, and 65 donated their \$5.00 to Positive Impact Health Centers.

### **Data Diagnostics and Analytic Strategy**

To begin the preliminary analysis, I assessed all completed surveys ( $n = 150$ ) to determine the total number of cases for data analysis ( $n = 138$ ). The data cleaning process first involved screening data for missing cases. I removed five participants who failed to complete all

parts of the survey from the dataset. Next, I assessed the four attention checks (Silber et al., 2018) strategically inserted throughout the surveys to gauge whether participants were attentively responding to the items on the survey. A sample attentional check in the study included, "Please select 'Somewhat' for this response." A total of five participants who failed to appropriately select three of the four (75%) attention checks were removed during the cleaning process. I then reviewed data to ensure all participants were currently enrolled in a Practicum or Internship experience and seeing clients in a clinical setting, leading me to remove two participant cases for indicating they were not enrolled in a Practicum or Internship experience or seeing clients.

Next, data were screened for errors, including frequencies for each variable, to ensure scores for each variable were within range to avoid distorting statistical analysis. This process included examining each variable's mean, standard deviation, and distribution (i.e., skewness, kurtosis, and outliers). Originally, I planned to perform a two-way multivariate analysis of covariance (MANCOVA) to investigate the interaction effect between SU type and PTSD group differences in attribution of blame and empathy levels while controlling for self-presentation concerns. However, the correlational analysis of the dependent variables (i.e., blame and empathy) revealed a non-significant bivariate relationship ( $r = -.14$ ). Similarly, the covariate (self-presentation concerns) also revealed a non-significant association with blame ( $r = -.06$ ) and empathy ( $r = .11$ ). Therefore, it was necessary to switch to a two-way analysis of variance (ANOVA) for statistical analysis. To consider the two additional questions from the demographic questionnaire that asked participants to indicate whether or not they had taken an addictions course and trauma-related course during their master's program, I conducted a point-biserial correlation coefficient (Gupta, 1960) to understand the relationship between the

continuous (i.e., blame and empathy) and dichotomous (i.e., addictions course and trauma-related course) variables. There was a non-significant association between blame and the addictions course ( $r_{pb} = .03$ ) and the trauma course ( $r_{pb} = -.04$ ). Similarly, there was a non-significant association between empathy and the addictions course ( $r_{pb} = .05$ ) and the trauma course ( $r_{pb} = -.03$ ). Therefore, participants' responses to the questions about taking an addictions course and trauma course were not included in my model for statistical analysis.

Assumptions for a two-way ANOVA were examined prior to statistical analysis, which included: (a) *level of measurement*; I ensured our independent variables were categorical, dependent variables were continuous, and the covariate was continuous, (b) *independence of observations*; I utilized a random assignment method to ensure that observations were independent of all other observations (c) *normal distribution*; I ensured that each condition had a minimum sample size of at least 20 cases in each condition (Tabachnick & Fidell, 2013) to ensure robustness, Mahalanobis distance test (Field, 2015), and probability-probability (P-P) plot were utilized through SPSS to confirm that the dependent variables were normally distributed within each group, and the Shapiro-Wilk results did not show evidence of non-normality in each condition (Shapiro-Wilk Results Shown in Table 2) (d) *outliers*; during the assessment for normal distribution, I observed the output from Boxplot for each condition to ensure no cases were present with scores entirely different from the remainder of the sample; further, I calculated the Mahalanobis distance for each observation to assess and identify any significant cases that lie at an abnormal distance from others values in the dataset and found the maximum value for the two dependent variables was less than the critical value of 13.82 indicating this assumption was met, (e) *homogeneity of variance*; to ensure that the variability of scores for each of the groups was similar, I performed Levene's Test for Equality of Variances, which were non-significant

for blame ( $F(3, 134) = .31, p = .82$ ) and empathy levels ( $F(3, 134) = 1.14, p = .33$ ), indicating the variances in the different groups are similar between dependent variables and equal for all levels of the independent variables.

Table 2

*Shapiro Wilk Test of Normality*

Dependent Variables	Blame			Empathy	
	<i>n</i>	<i>W</i>	<i>p</i>	<i>W</i>	<i>p</i>
Independent Variables					
Crystal Meth & Self-Medicating	34	.96	.28	.98	.89
Crystal Meth & High-Risk Behavior	36	.96	.29	.97	.37
Alcohol & Self-Medicating	33	.96	.33	.98	.7
Alcohol & High-Risk Behavior	35	.97	.61	.98	.73

For this study, SPSS statistics version 27 was used for all statistical analysis. Descriptive statistics, including means and standard deviations, and Pearson's bivariate correlational analyses were used to determine the relationships between blame and empathy levels. Two separate two-way between groups ANOVAs were performed to investigate the interaction effect between the independent variables (relapse determinant and SU type) on blame and empathy levels. After considering the interaction effect of the independent variables, each factorial ANOVA was used

to explore how CITs discriminated blame and empathy levels differently within each independent variable.

### Results

To address Research Question 1, I conducted bivariate correlations to determine if blame was significantly negatively associated with empathy levels for my sample. Pearson's correlation coefficients were calculated excluding cases pairwise for our study participants, and it was determined that blame attribution was negatively associated with empathy levels ( $r = -.14$ ) but was not found to be significant using an alpha level at .05. Concern for appropriateness had a non-significant negative correlation to blame ( $r = -.06$ ) and a non-significant positive correlation to empathy ( $r = .11$ ) using an alpha level at .05. Thus, these associations did not show support for either of my hypotheses for Research Question 1, and concern for appropriateness was not included as a covariate in the model (Descriptive statistics and bivariate correlations are shown in Table 3).

Table 3

*Descriptive Statistics and Correlations for Study Variables*

Variable	<i>N</i>	<i>M</i>	<i>SD</i>	1	2	3
1. Blame	138	11.68	3.39	—	—	—
2. Empathy	138	123.49	16.57	-.14	—	—
3. Concern for Appropriateness	137	45.27	10.54	-.06	.11	—

\* $p = .05$

To begin addressing Research Questions 2a and 2b, two separate two-way ANOVAs were conducted to investigate how CITs differentially discriminate blame and empathy levels toward a fictitious client living with SUD and PTSD following a relapse to SU based on SU type

and relapse determinant. The means, standard deviations, and sample sizes for blame and empathy levels for each condition can be found in Table 4.

Table 4

*Means and Standard Deviations for Blame and Empathy*

Dependent Variables	Blame			Empathy	
	<i>n</i>	<i>M</i>	<i>SD</i>	<i>M</i>	<i>SD</i>
Independent Variables					
Crystal Meth Use	70	12.31	3.3	124.47	16.97
Alcohol Use	68	11.03	3.37	122.49	16.22
Relapse: Self-Medicating	67	10.91	3.56	124.96	14.98
Relapse: High-Risk Behavior	71	12.41	3.06	122.11	17.94
Crystal Meth & Self-Medicating	34	11.59	3.53	124.82	16.35
Crystal Meth & High-Risk Behavior	36	13.0	2.96	124.14	17.75
Alcohol & Self-Medicating	33	10.21	3.51	125.09	13.67
Alcohol & High-Risk Behavior	34	11.8	3.09	119.62	18.26

## Blame

To address Research Question 2a, I interpreted the results in the first two-way ANOVA to explore how CITs attribute blame scores differently toward a fictitious client living with a dual diagnosis of SUD and PTSD follow a relapse based on the relapse determinant and SU type used during the relapse (shown in table 5). The main effects analysis showed a statistically significant difference at  $p < .05$  level in blame scores between the two relapse determinants:  $F(1,134) = 7.24, p = .01$ . As hypothesized, mean scores indicated that CITs in our sample attributed higher levels of blame to the client whose relapse determinant was linked to interpersonal high-risk behavior ( $M = 12.41, SD = 3.06$ ) when compared to mean scores to the client whose relapse determinant was linked to intrapersonal self-medicating behavior ( $M = 10.91, SD = 3.56$ ). Considering the second hypothesis for Research Question 2a, a statistically significant difference at  $p < .05$  level in blame scores between the two SU types:  $F(1,134) = 5.34, p = .02$ . was found. As expected, the mean scores indicated that CITs in this sample attributed higher levels of blame to the client whose SU type was linked to crystal meth use ( $M = 12.31, SD = 3.31$ ) when compared to mean scores to the client whose SU type was alcohol ( $M = 11.03, SD = 3.37$ ). Finally, the two-way ANOVA revealed that there was not a statistically significant interaction between the effects of relapse determinant and SU type on levels of blame,  $F(1, 134) = .03, p = .86$ , and partial  $\eta^2 = .00$ . This finding did not support my third hypothesis for Research Question 2a since there was no significant difference between the effect of SU type on levels of blame for the relapse determinants.

Table 5

*Two-Way ANOVA Statistics for Blame Scores on Relapse Determinant and SU Type*

Source	Type III Sum of Squares	Mean Square	$F(1, 134)$	$p$	$\eta_p^2$
Relapse Determinant	77.53	77.53	7.24	.01*	.05
SU Type	57.18	57.18	5.34	.02*	.04
Relapse Determinant x SU Type	.27	.27	.03	.88	.00

Note. \* $p < .05$

### **Empathy**

To address Research Question 2b, I interpreted the results in the second two-way ANOVA to explore how CITs attributed empathy scores differently toward a fictitious client living with a dual diagnosis of SUD and PTSD follow a relapse based on the relapse determinant and SU type used during the relapse (shown in Table 6). The main effects analysis revealed a non-significant difference at  $p < .05$  level in empathy scores between the two relapse determinants:  $F(1,134) = 1.03, p = .31$ , which did not support my first hypothesis for Research Question 2a. Considering the second hypothesis for Research Question 2b, I found a non-significant difference at  $p < .05$  level in empathy levels between the two SU types:  $F(1,133) = .46, p = .49$ . This non-significant finding indicates that CITs in my sample did not differentially discriminate empathy levels based on the SU type used by the fictitious client and did not support my hypothesis for Research Question 2b. Finally, the interaction between the effects of relapse determinant and SU type was not statistically significant on levels of empathy,  $F(1, 134) = .59, p = .44$ , and partial  $\eta^2 = .004$ . This finding did not support my hypothesis for Research

Question 2b since there was no significant difference in the effect of SU type on levels of empathy for the relapse determinants.

Table 6

*Two-Way ANOVA Statistics for Empathy Levels on Relapse Determinant and SU Type*

Source	Type III Sum of Squares	Mean Square	F (1, 134)	p	$\eta_p^2$
Relapse Determinant	284.57	284.57	1.03	.31	.01
SU Type	127.24	127.24	.46	.49	.00
Relapse Determinant x SU Type	165.12	165.12	.59	.44	.00

*Note.* \* $p < .05$

### Discussion

This study aimed to examine if and under which circumstances CITs may discriminate differently between relapse determinants (i.e., intrapersonal self-medicating behavior versus high-risk interpersonal behavior) and substance use type (i.e., alcohol use versus crystal meth use) toward a fictitious client living with a dual diagnosis of SUD and PTSD following relapse to SU. To attempt to understand CITs' discriminatory responses based on these variables, I explored separate scores of blame and empathy in a sample of CITs (N = 138) over the age of 18, currently seeing clients in a practicum or internship experience, and enrolled in a CACREP accredited program in various parts of the United States in a 2 x 2 experimental analogue study. The results of this study expand the current understanding of how CITs discriminate differently toward clients living with a dual diagnosis of SUD and PTSD following relapse to SU based on the type of substance used during the relapse and the relapse determinant.

In this study, I hypothesized that as CITs attributed higher levels of blame to the fictitious client in the vignette, there would be a strong connection to how CITs reported lower state empathy levels toward the same client. The results of the bivariate correlation revealed a negative but non-statistically significant association between blame and empathy levels, rendering me to reject my first hypothesis in Research Question 1. This finding counters previous research findings that suggest higher levels of blame could be significantly and negatively associated with empathy levels (Araten-Bergman & Werner, 2017; Elliot et al., 2018). Instead, findings indicated that blame attributed to the fictitious client had no bearing on their state empathy scores. The non-significant association contradicts Weiner's (1980) model of motivated behavior within attribution theory. This model suggests that making attributions (e.g., blame) to a client can evoke negative emotions toward the client that can hinder a helper's feelings of empathy. Therefore, CITs in this sample may have discriminated blame differently based on their assignment to one of the four conditions. However, their empathy levels remained consistent between conditions.

I also considered CIT self-presentation bias in the correlation analysis by examining the relationship between the concern for appropriateness scores and considering my second hypothesis for Research Question 1. Concern for appropriateness scores also revealed a non-significant correlation with blame and empathy levels and opposed my second hypothesis for Research Question 1. Based on previous research studying concern for appropriateness variables associated with CIT bias (e.g., Mohr et al., 2001), I expected a significant association with my dependent variables. However, this non-significant association suggests that CITs' presentation concern did not influence the attribution of blame or empathy level scores for CITs within my sample.

The two two-way ANOVAs revealed several findings that partially support my hypotheses for Research Question 2a. First, I explored the main effects of SU type and relapse determinants on attributions of blame scores among CITs' responses toward the fictitious client. The fictitious client in the vignette remained consistent in details across four conditions except for manipulating the relapse determinant and SU type used in the scenario. As expected, CITs attributed significantly higher blame scores to the client who relapsed because of high-risk interpersonal behavior and involved crystal meth as the SU type. Living with a dual diagnosis of SUD and PTSD comes with many complex challenges for clients seeking recovery and dealing with the high likelihood of relapse, particularly when considering how much control a client living with this dual diagnosis has over managing the risk of relapse based on symptomology related to living with the dual diagnosis. Attribution theory (Weiner, 1980) suggests that counselors may make errors in making attributions without considering all factors involved with the client leading to attribution bias (Araten-Bergman & Werner, 2017).

Further, attribution theory suggests an observer may attribute blame to someone based on the perceived controllability of the problem (Weiner, 1980). Related to the findings of this study, higher levels of blame may be attributed to the fictitious client when his situation was perceived within his control based on the contexts involved in the scenario related to the details of the relapse. This study's higher blame scores suggest that CITs revealed bias by attributing more blame for the high-risk behavior based on the context of the scenario read in the stimulus material. High-risk behaviors associated with relapse may have been perceived by CITs in this study as more controllable by the fictitious client based on negative stereotypes, labels, and stigma associated with the behaviors (Ahuja et al., 2021; Dworkin et al., 2018). However, the CITs excused self-medicating behavior related to the relapse by the fictitious client, revealing

their bias toward relapse determinants. Thus, these findings indicate that CITs in this sample did not discriminate based on the fictitious client's dual diagnosis but rather on the context where the diagnosis manifests itself. Counselor educators and supervisors should consider this finding when teaching CITs on the topic of dual diagnosis of SUD and PTSD to help CITs recognize how biased assumptions can arise based on the context of their client's situation or problem, even when behaviors may be out of the client's control due to aspects related the diagnosis.

Next, I considered the main effects for my second hypothesis of Research Question 2a. As predicted, there were significant differences in blame scores toward the fictitious client based on SU type, which supports previous research that suggested CTs may have a bias toward clients with a dual diagnosis of SUD and PTSD based on the type of substance used (Can & Tanriverdi, 2015). Previous research suggests that the negative stereotypes, labels, and perceived dangerousness associated with crystal meth may increase bias in treatment providers toward clients who use crystal meth (Corrigan et al., 2005; Sharma, 2018). Similarly, Francis et al. (2020) explored stigmatizing attitudes among clinicians toward clients living with a dual diagnosis based on substance use type, specifically alcohol and crystal meth. They found greater stigmatizing attitudes toward clients using crystal meth could lead to attribution bias, providing additional support for my findings.

The CITs in this study showed bias based on the type of substance used by the fictitious client in their assigned condition. Attribution bias can lead counselors to make errors in their decision-making process to help clients living with a dual diagnosis achieve their goals for treatment. One particular area that needs consideration related to this study's findings is how attribution bias could lead CITs to make a diagnostic bias (McLaughlin, 2002). The attribution bias CITs in the study revealed based on the situation and context of the fictitious client could

lead the CIT to misdiagnose the client with an appropriate diagnosis. Suppose CITs perceive a client who uses crystal meth as more to blame for his situation based on the context of the relapse. In that case, counselor educators and supervisors need to consider how this bias could lead CITs to overlook additional presenting concerns and overlapping symptomology and select a misdiagnosis. Lastly, this finding supports other scholars who suggest persons in the helping professions may make more dispositional attributions (e.g., blame) to a client who relapses from crystal meth use than other substances (Scheibe, 2017), and counselor educators and supervisors need to consider incorporating attribution bias into CITs' coursework and assignment to assist them from making errors of judgment and potentially causing harm to clients living with a dual diagnosis.

The third hypothesis for Research Question 2a was surprisingly not supported in this study. Based on CIT blame scores, the findings revealed a non-significant interaction between relapse determinants and SU type. Attribution of blame was measured by asking CITs to rate how much the fictitious client was to blame for his current situation based on the relapse determinant and SU type included in their assigned vignette. Although CITs reported significant differences in their blame scores based on relapse determinant and SU type independently, there was no indication that blame scores on relapse determinant differed when SU type overlapped in each of these conditions. This finding suggests that the intersection of relapse determinants and SU type may not play an essential role in CITs' attribution bias, yet CIT bias may still be present based on each of the variables independently.

Considering the main effects from the second two-way ANOVA, all of my hypotheses for Research Question 2b were not supported in this study. Although non-significant findings were revealed for each hypothesis, these non-significant findings may shed some important

insights into CITs' ability to experience state empathy toward a client with a dual diagnosis in various contexts. CITs were randomly assigned to read one of four vignettes about a fictitious client, yet CITs in this sample did not differ on ratings of state empathy levels regardless of the reason for relapse or SU type included in the case vignette they received. This finding suggests that CITs may experience consistent empathy toward a client with a dual diagnosis who experiences a relapse based on varying situational contexts.

Further, even when attribution bias (e.g., blame) was present toward the same fictitious client, these CITs could still endorse consistent ratings of empathy toward the client. CITs' reporting non-significant differences in empathy toward the fictitious client based on the relapse determinant included in the four conditions of this study contradict other scholars who have suggested that treatment providers may report altered levels of empathy due to changing contexts related to clients who experience a relapse to SU (Pickard, 2017). However, CITs begin hearing counselor educators and supervisors stressing the importance of offering empathy to their future clients as soon as they begin their counselor training, no matter the theoretical orientation or treatment modality, psychosocial considerations of the clients, or diagnosis assigned to the presenting concerns (Clark & Butler, 2020; Giordano et al., 2020). Thus, the findings of this study suggest that CITs in CACREP programs report state empathy toward a client living with a dual diagnosis who experiences a relapse to SU without discriminating empathy levels based on the context related to the relapse.

Considering empathy levels and SU type, CITs did not report a significant difference in their empathy levels toward the fictitious client living with a dual diagnosis of SUD and PTSD based on the type of substance used. This finding was surprising based on prior research (Wei-Mo Tu et al., 2019) that helping professionals' empathy levels toward clients may be hindered

based on the perceived dangerousness and behaviors associated with different substances. Moreover, CITs in this study reported significantly higher levels of blame toward the fictitious client who used crystal meth over alcohol in the vignette. However, scores did not significantly differ in their empathy levels to the same client compared to their scores toward the client who used alcohol.

### **Implications for Counselor Education and Supervision**

This study revealed several important findings for counselor educators and supervisors to consider for training CITs to work with a client living with a dual diagnosis of SUD and PTSD. It is well-documented that clients living with a dual diagnosis are highly stigmatized (Buchman et al., 2017; Francis et al., 2020; Kilian et al., 2021; Nieweglowski et al., 2018; Ventura et al., 2017). Clients living with the co-occurrence of SUD and PTSD are at a high risk of experiencing a relapse to SU and face stigma and bias associated with the relapse (Kelley et al., 2021; Read et al., 2004). CITs will likely see a client living with a dual diagnosis of SUD and PTSD as early as their practicum or internship experience (Lee, 2014). Therefore, CITs need to recognize personal bias toward these clients that may hinder the therapeutic relationship, client retention to treatment, and treatment goals and outcomes (Kelley et al., 2009; María-Ríos & Morrow, 2020). The CITs in this sample reported higher blame to the client they read about in the vignette that experienced a relapse based on SU type and relapse determinant. Specifically, CITs attributed more blame to the client who used crystal meth and the client who engaged in high-risk behavior during the relapse. Counselor education programs train CITs to care for their clients and help them improve and achieve their goals for counseling. Assisting CITs in recognizing personal bias toward these clients includes showing them how bias (e.g., blame) could be attributed based on varying contexts related to clients' relapse. Blame can advance stigmatizing beliefs toward

clients, hinder the therapeutic relationship, create barriers to clients achieving their goals in treatment, and contribute to compassion fatigue and counselor burnout (Trippany et al., 2004).

Further, attribution bias and attribution of blame can lead to diagnostic bias and potentially hinder clients living with a dual diagnosis of PTSD from receiving appropriate treatment interventions and care (McLaughlin, 2002). Therefore, CITs need to consider how blaming clients who relapse to SU based on the reason for the relapse, and the type of substance used during the relapse could hinder change and disempower these clients and potentially further promote relapse to SU (Pickard, 2017). Counselor educators and supervisors want to consider pedagogical opportunities for CITs to recognize and examine personal bias toward clients living with a dual diagnosis of SUD and PTSD, such as incorporating experiential activities in the classroom and supervision. Giordano et al. (2015) recommended incorporating creative and experiential activities in classes, such as an addictions course, that may evoke CIT bias, followed by the opportunity to process the findings to receive constructive feedback from counselor educators and supervisors, and student colleagues.

While the results on blame attribution were consistent with prior research, the findings concerning empathy levels toward a client living with a dual diagnosis of SUD and PTSD following a relapse were novel. The non-significant findings on empathy levels based on the relapse determinant and SU type may provide counselor educators and supervisors some helpful and encouraging understandings about CITs who may work with clients with a dual diagnosis of SUD and PTSD who experience a relapse. CITs showed consistent empathy level scores toward the fictitious client regardless of relapse determinants and SU type. A CIT may be able to demonstrate empathy toward a client living with a dual diagnosis of SUD and PTSD following a relapse but still possess some level of differential blame around the context of the relapse.

Empathy toward clients living with a dual diagnosis of SUD and PTSD has been shown to influence clients' retention in treatment and promising treatment outcomes (Elliot et al., 2018). Therefore, counselor educators should continue to promote empathy as an important factor for CITs to be aware of to support clients living with a dual diagnosis of SUD and PTSD and avoid imposing personal bias and potentially causing harm. Further, the findings of this study suggest that CITs from CACREP programs across the United States may exhibit high levels of state empathy, which may speak to the CITs themselves and the counselor educators' role in modeling and teaching the importance of empathy toward clients.

### **Limitations and Future Research**

This study had several limitations that should be considered when interpreting the results. First, the results were limited to the conditions utilized in this study. For the present study, I utilized alcohol due to the familiarity and legality of its societal use, less severe stigmatizing messages, and the high amounts of research compared to crystal meth, an illicit substance, highly stigmatized and limited in research. Future research should consider additional substances (e.g., marijuana, opioids) to understand further how CITs may discriminate differently based on SU type.

Attribution theory was the primary theoretical framework utilized for this study to explore the explicit bias of CITs toward clients living with a dual diagnosis of SUD and PTSD. Attribution theory might also be used as a strategy to identify implicit bias toward clients living with a dual diagnosis who also hold marginalized identities (e.g., racial and ethnic minorities); however, researchers may hypothesize more negative dispositional attributions toward such populations (Fassinger & Morrow, 2013). For example, the client in the vignette for this study identified as White. Other studies should consider additional racial and ethnic identities of the

client to include in the study to understand how CITs discriminate differently toward a client based on the client's racial and ethnic identity. This research should consider CITs' implicit bias, and researchers need to consider frameworks that provide appropriate and best research practices for assessing implicit bias and avoiding racial injustices (Fassinger & Morrow, 2013).

I utilized an analogue approach for this study in an attempt to create a condition closely related to a real-life scenario (Cook & Rumrill, 2005). However, analogue research design has limitations to external validity based on how information is presented. I utilized a vignette of a fictitious client separated into four conditions based on relapse determinant and SU type via Qualtrics. CITs might have responded differently based on a different format of presenting the client information. Since participation occurred online, CITs could have experienced screen fatigue or lack of motivation to respond with accurate and honest answers. Future research studies should consider client videos or even real-life or real-time scenarios as the stimulus format to increase the generalizability of these results.

Finally, I explored blame and empathy levels to explore how CITs discriminate toward a client living with a dual diagnosis of SUD and PTSD following relapse to SU. This study relied on CITs' self-reports for state empathy levels rather than measured empathy. Future research should consider opportunities that will allow observation to measure and notice CITs' empathy levels toward clients. Further, the findings from this study are based on CITs and may not reflect the empathy levels of seasoned counselors later in their careers. Researchers should consider how empathy levels and discriminatory factors are maintained by counselors later in their careers. Future research should consider how other groups (e.g., professional counselors, SU treatment staff, and administrators) who likely encounter persons living with a dual diagnosis of SUD and PTSD discriminate differently toward these clients following a relapse. Future research

could also compare results between groups to understand further bias toward persons living with a dual diagnosis of SUD and PTSD.

### **Conclusion**

The dual diagnosis of SUD and PTSD presents numerous challenges for counseling. It is likely CITs will work with a client dealing with the co-occurrence of SUD and PTSD as early as their practicum and internship experience. This dual diagnosis is highly stigmatized and discriminated against in our society, and relapse to SU is highly probable for this population. Thus, it is important to understand how CITs may discriminate toward clients living with a dual diagnosis of SUD and PTSD. This study explored CITs' levels of blame and empathy toward a client living with a dual diagnosis of SUD and PTSD following relapse to SU based on SU type and relapse determinants. The results of this study indicated that CITs discriminate blame differently toward a client living with this dual diagnosis based on relapse determinants and SU type. However, CITs did not discriminate empathy levels differently toward the same client based on relapse determinants and SU type. CITs need appropriate training to assess for and manage personal bias toward clients living with a dual diagnosis of SUD and PTSD. Based on the results of this study, it is important for counselor educators and supervisors to incorporate discussions about blame as a potential contributor to bias in counselor education and supervision curriculum and training programs.

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## APPENDICES

### Appendix A

#### Vignette

(Instructions): Below is a client case that one of your fellow supervisees presents during their case presentation in group supervision. Please read the case carefully and fully before proceeding to the next page.

John is a 32-year-old White male who received a PTSD diagnosis at the age of 22 after witnessing the violent murder of his nephew. Three months following the traumatic event, John reported suffering from increased nervousness and difficulties concentrating. His friends noted a change in his behavior following the event and described him as “extraordinarily jumpy and irritable.” Over and over, thoughts about the distressing incident intruded into his mind. He reported feeling numb and barely able to participate in the normal activities of daily life following the traumatic event. Other than that, he had the feeling of a limited future and, at night, he would wake up because of nightmares and would struggle to fall back to sleep again.

John started using *crystal meth (alcohol)* when he was 24-years-old as a way to cope with his intense PTSD symptoms. After 8-years of intense *crystal meth (alcohol)* use, John sought treatment and entered an integrated treatment program to address his co-occurring substance use disorder and PTSD diagnoses. After 2-months in the treatment program, John experienced a relapse and dropped out of treatment. John stated, “*I relapsed on crystal meth (alcohol) because I felt so overwhelmed by all the emotions and intrusive memories related to my nephew’s death and wanted to escape*” (“*I relapsed on crystal meth (alcohol) while I was having sex with friends in my support network and they pressured me to use*”).

## Appendix B

### Demographic and Background. Questionnaire

#### **Demographics:**

**1. Please select your gender:**

- Male
- Female
- Intergender
- Transgender
- I identify as \_\_\_\_\_

**2. Please select your sexual orientation:**

- Bisexual
- Heterosexual
- Gay
- Lesbian
- Queer/Pansexual
- Asexual
- I identify as \_\_\_\_\_

**3. Current Age:** \_\_\_\_\_

**4. Please select the racial/ethnic group with which you identify:**

- African American or Black
- American Indian or Alaska Native
- Asian
- Caucasian American (non-Hispanic)
- Hispanic or Latino
- Middle Eastern
- Native Hawaiian or Pacific Islander
- Biracial/Multiracial
- I identify as \_\_\_\_\_

**5. Please select your spiritual/religious affiliation (if applicable):**

- Agnostic
- Atheist
- Buddhist/Taoist
- Christian/Catholic
- Hindu
- Jewish
- Muslim/Islam
- Spiritual but not religious
- Wiccan/Pagan/Neo-Pagan
- I identify as \_\_\_\_\_

**6. Please indicate your yearly combined financial support (e.g., wages, family, public assistance):**

- Less than \$9,999
- \$10,000-\$19,999
- \$20,000-\$49,999
- \$50,000-\$99,999
- \$100,000 or above

**7. In what region of the United States do you currently reside? (Based on the Bureau of Economic Analysis)**

- New England:** Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island and Vermont
- Mideast:** Delaware, District of Columbia, Maryland, New Jersey, New York, Pennsylvania
- Great Lakes:** Illinois, Indiana, Michigan, Ohio, and Wisconsin
- Plains:** Iowa, Kansas, Minnesota, Missouri, Nebraska, North Dakota, and South Dakota
- Southeast:** Alabama, Arkansas, Florida, Georgia, Kentucky, Louisiana, Mississippi, North Carolina, South Carolina, Tennessee, Virginia, and West Virginia
- Southwest:** Arizona, New Mexico, Oklahoma, and Texas
- Rocky Mountain:** Colorado, Idaho, Montana, Utah, and Wyoming
- Far West:** Alaska, California, Hawaii, Nevada, Oregon, and Washington

**Program of Study:**

**8. What is your current program of study?**

- Addiction Counseling
- Career Counseling
- College Counseling and Student Affairs
- Marriage, Couple, and Family Counseling
- Clinical Mental Health Counseling
- Clinical Rehabilitation Counseling
- Rehabilitation Counseling
- School Counseling
- Other, please specify \_\_\_\_\_

**9. Is your program CACREP Accredited?**

- Yes
- No

**10. Have you taken an Addictions course during your program?**

- Yes
- No

**11. Have you taken a Traumatology or Trauma related course during your program?**

- Yes
- No

### **Practicum/Internship Work Setting Questionnaire**

**12. Are you currently engaged in seeing clients at a Practicum or Internship site?**

- Yes
- No

**13. Please identify the type of setting of your Practicum or Internship site:**

- Non-profit/ Community Health Setting
- Hospital
- Detox Center
- Crisis Setting
- Private Practice Clinical Setting
- State or Local Government Setting
- P-12 Schools
- Other, please specify \_\_\_\_\_

**14. How long have you been at your current Practicum or Internship site? Please specify total number of months:**

- Months: \_\_\_\_\_

**15. Does your current Practicum or Internship site specialize in the treatment of clients with substance use disorders?**

- Yes
- No

**16. How often do you work with clients with substance use disorders?**

- Never     Almost Never     A Few Times a Year     Monthly     Weekly     Daily
- 0            1                    2                    3                    4                    5

**17. Please select all categories of substances below that your clients have discussed current or past use with you during their intake or in session:**

- Alcohol**
- Cannabis** (e.g., Marijuana, Hashish, Edibles)
- Psychedelics** (e.g., LSD, Magic Mushrooms, Mescaline)
- Party/rave Drugs** (e.g., MDMA, GHB, Ketaime)
- Hard Drugs** (e.g., Cocaine, Crack, Heroin, Prescription Stimulants/Opioids, Methamphetamine)
- Any Other Substances**, please specify: \_\_\_\_\_

**Appendix C:****Attribution Questionnaire – 27 – *Blame* Subscale**

Please read the following statement about John, the client you read about in the vignette and provide the response between 1 (not at all) to 9 (very much) to each statement or question:

1 2 3 4 5 6 7 8 9  
not at all - very much

1. I would think that it was John's own fault that he is in the present condition.
2. How controllable, do you think, is the cause of John's present condition?
3. How responsible, do you think, is John for his present condition?

## Appendix D:

### Comprehensive State Empathy Scale

On the next pages, you will find a series of statements and questions. Please read and respond to each one, even if it seems very similar to another. Answer each question quickly, without spending too much time on any particular one.

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Below is a list of feelings. On a scale of 1-5, please rate the extent to which you experienced each of these feelings in response to the client, John, from the video you watched and with the information read about John in the vignette.

1 = indicates you experienced this feeling *not at all*

5 = indicates that you experienced this feeling *very much*

1. Compassionate
2. Moved
3. Soft-hearted
4. Sympathetic
5. Tender
6. Warm
7. Distressed
8. Disturbed
9. Grieved
10. Troubled
11. Upset
12. Afraid

Below is a list of statements. On a scale of 1-5, please rate the extent to which each statement is true for you in relation to John's story.

1 = indicates that is *completely untrue for you*

5 = indicates that this is *completely true for you*

13. I found that the scenario affected my mood
14. I was very affected by the emotions in this story
15. I actually felt John's distress
16. I experienced John's feelings as if they were my own
17. I found myself imagining how I would feel in John's situation
18. I found myself imagining myself in John's shoes
19. I found myself trying to imagine how things looked to John
20. I found myself trying to imagine what John was experiencing
21. I would really focus on John's emotions if I was caring for him
22. I experienced a strong urge to help John
23. I would get really involved in trying to help John
24. I found myself thinking about what could be done to help John
25. I feel confident that I could accurately describe John's experience from his point of view
26. I found it easy to understand John's reactions
27. I found it easy to see how the situation looked from John's point of view.
28. Even though John's life experiences are different to mine, I can really see things from his perspective
29. I am sure that I know how John was feeling
30. I feel confident that I could accurately describe how John felt

## Appendix E:

### Concern for Appropriateness Scale

Please consider each of the following statements in your everyday life and respond to how true these relate to you between 0 (certainly, always false) to 5 (certainly, always true).

1. It is my feeling that if everyone else in a group is behaving in a certain manner, this must be the proper way to behave.
2. I actively avoid wearing clothes that are not in style.
3. At parties I usually try to behave in a manner that makes me fit in.
4. When I am uncertain how to act in a social situation, I look to the behavior of others for cues.
5. I try to pay attention to the reactions of others to my behavior in order to avoid being out of place.
6. I find that I tend to pick up slang expressions from others and use them as part of my own vocabulary.
7. I tend to pay attention to what others are wearing.
8. The slightest look of disapproval in the eyes of a person with whom I am interacting is enough to make me change my approach.
9. It's important to me to fit in to the group I'm with.
10. My behavior often depends on how I feel others wish me to behave
11. If I am the least bit uncertain as to how to act in a social situation, I look to the behavior of others for cues.
12. I usually keep up with clothing style changes by watching what others wear.
13. When in a social situation, I tend not to follow the crowd, but instead behave in a manner that suits my particular mood at the time.