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Sex, Romance, and Dating in Treatment Recovery: Ethical Reflections and Clinical Deliberations on Challenging Addiction Decision Making

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ABSTRACT

An engagement in sexual interactions or a romantic involvement between clients in addiction treatment settings can be high-stakes risks to the recovery and treatment process. This conventional wisdom is part of the social contract in a treatment setting that recognizes the potential harm that relationships can cause in early recovery—a message that prevails in the clinical literature. It would therefore be reasonable to assume that a non-fraternization policy is not uncommon to treatment settings. The latest (2011) data from the Substance Abuse and Mental Health Services Administration conservatively shows 126,000 clients or 7.3 % of admissions were expelled from addiction treatment. Treatment programs with non-fraternization policies most probably contribute to that statistic. Still, ethical streams of thought on clinical interventions to address therapeutically the ethical dilemma of clients who breach the treatment setting's non-fraternization policy are remarkably scarce in scientific studies and ethical precedence. This article presents two clinical approaches of "discharge" and "couples counseling and treatment planning" with an analysis of five foundational ethical principles for each. Deontological and consequentialist arguments in favour of discharge, and those opposing it, are buttressed by clinical reasoning relevant to practitioners and treatment staff. A presupposition of this article is that addiction clinicians somewhat understand ethics codes as this is a requirement of licensure and part of the (re) certification process; however, clinicians are not ethicists. Therefore, applying the five foundational ethical principles in clinical settings presents challenges for those with limited ethics preparation. Thus this article provides a framework to prepare clinicians to reason with and apply ethical codes in clinical practice, a primer to advocate support for or change to existing policies and procedures.

Keywords: *substance abuse recovery, sexual relationships, dating, ethics, non-fraternization treatment policy.*

In the addiction treatment setting, sexual and dating involvement between clients is a predictable likelihood. What do addiction professionals do when two clients are carrying on a relationship in the "shadows" in violation of the treatment setting's policy and procedures, which state that if there is a breach in the treatment agreement regarding mutually agreed upon sexual engagement or dating involvement, the result would be a clinical discharge? This situation may lead to an ethical and moral dilemma for professionals, agencies, and stakeholders. In this position, the professional may, in all probability, assume that since the treatment setting's policy is a commonly held standard and corresponds with similar agencies, adhering to it must be the right thing to do. Interpreting the agency's policy in a way that promotes its intended effect—to reduce the prospects of client relationships—raises the critical question of whether the decision making of addiction professionals who uphold such a policy is muddled by the age-old logical fallacy known as "Appeal to Tradition." Yet, when two clients are fraternizing, which is clearly against the non-fraternizing policy, can it not also be assumed that the addiction professional's decision making is a reasonable one-size-fits-all appeal to "tradition?" Not simply for the sake of tradition alone, but rather that the decision-making is deferred to from ethically sound and morally acceptable interpretations.

Alternatively, if the professional decides against discharge, concluding that it would be of little help, should this decision be afforded the same ethical and moral legitimacy as the decision of the professional in favor of discharge? This raises a number of other important questions: What are the risks to the agency, clients, and stakeholders if a non-fraternizing policy is enforced? Is a non-fraternizing policy even necessary for clients? Whether aligned or at odds with the non-fraternizing policy, the professional must perform his or her duty and act on the least harmful ethical choice.

At the same time, the professional must bear in mind that he or she stands the chance of setting an precarious precedent for future clients, with possibly even more challenging ethical implications. Here, the professional's decision must be sound in upholding the integrity of the agency and simultaneously conforming to the most effective clinical intervention in the best interest of the clients.

To this end, addiction professionals might also pause before making a final decision due to their mixed feelings and conflicting thoughts about how significant an ethical breach this infraction really is. When faced with a quandary of this nature, a moral and ethical obligation exists for professionals to guide any decision made on applied principles of justice, autonomy, fidelity, nonmaleficence, and beneficence in determining the best clinical option.

ETHICAL PRINCIPLES & ETHICAL DECISIONS

Much of the content of arguments for and against discharge comprises two ongoing streams of thought within deontology and consequentialism. Deontological ethics subscribes to the belief that decisions should be judged on good will (i.e., motive to do the right thing) and consistency (i.e., universal adherence to policy). In sharp contrast, a consequentialist perspective considers the consequences of action to be more important regardless of whether the intent of the action is "good," "right," "bad," or "wrong" (Taleff, 2010).

Two possible clinical options are discussed below: discharge as well as couples counseling and treatment planning. Each clinical approach is couched in five foundational ethical principles: justice, autonomy, fidelity, nonmaleficence, and beneficence. Table 1 presents an overview of each ethical principle with an overview of the role of each in guiding clinical treatment and details on how the five foundational ethics principles can be implemented clinically.

First, arguments advocating couples counseling and treatment planning are detailed. Then arguments in favor of discharge incorporating the clinical reasoning underpinned by them to support an ethical conclusion follow. Finally, the article ends with a possible clinical solution to the predicament of client relationships while in treatment.

Reasons In Favour of Couples Counseling and Treatment Planning

Ethical Principle: Justice

Justice calls for due process, which, in turn, entails the moral obligation to take a hard look into the details of the couple's relationship and avoid applying the policy in an insensitive and arbitrary manner. Not sustaining such a look would only distort and bias due process. In this stance, the non-fraternizing policy is too "black and white" and will not always fit the "offence," for it serves as too severe a "punishment" for some client relationship cases. From this perspective, any clinical intervention should take into consideration the circumstances of the relationship and the context of each client's treatment prognosis and potentially relevant factors therein (e.g., age, previous dating engagements, period of time sober) to apply fairly the policy in the name of justice. The resultant effect would mean the difference between enhancing client autonomy or not.

Autonomy

On the autonomy side of the coin, the choice of any client to get involved in a relationship—in spite of the obvious consequences that jeopardize treatment—may have a problem related to the addiction itself and thus may be a product or symptom of impulse control issues (Bickel et al., 2007; Coffey, Gudleski, Saladin, & Brady, 2003), distorted or defensive thinking patterns, habitually poor short-lived planning skills, reduced memory and impaired cognitive functions, and reduced capacity for new learning that impinges on autonomy (Fernandez-Serrano, Perez-Garcia, & Verdejo-Garcia, 2011; Rinn, Desai, Rosenblatt, & Gastfriend, 2002). Accordingly, it makes sense for any addiction agency to legislate policy that discourages sexual or dating relationships (Bissell & Royce, 1994). As Geppert & Roberts. (2008) put it, "for some clients, external consequences, which may be experienced as coercive, may be necessary 'drivers' toward motivation for recovery" (p.24).

However due to thinking patterns and personality characteristics that place limitations on internal self-control, the aim is to help clients gain greater control over their thinking, emotions, behaviors, and other capacities. This intrapersonal autonomy can, in turn, be a catalyst for an increased sense of personal efficacy and may enhance functional autonomy in both interpersonal relationships and treatment recovery.

Moreover, "choice" and decision are offshoots of education and known alternatives that, when realized, augment the capacity for free choice by creating options and informed decision making about getting into a relationship during recovery or for reason of misconceptions about the "curative" properties of sexual activity. Arguably, "choice" is a neurobiology–neurochemistry construct circumscribed in "addicts" by the brain's control circuitry—referred to as "GO!–STOP!" brain systems (Childress, 2006). The "GO!" system recruits the instinctive part of the brain involved in reward-reinforcement and primordial drive that regulates primitive survival functions. The "STOP!" circuit is the inhibitory or executive control circuit that dampens or turns off the "GO!" system. Imbalance or dysregulation in the "GO!" and "STOP!" systems may account for, as Childress argues,

> impulses toward immediate [sexual] reward,… increased risk-taking, and decision-making weighted in the moment rather than in the future. [This would] impact the ability to weigh the future consequences of our choices or processes critical to maintaining [the] commitment and motivation for abstinence (or any long-term goal) (2006, pp.47-49).

These approaches apply addiction treatment principles to understanding the brain development (e.g., stunted and altered emotional growth, delayed psychosocial development) of "addicts", and facilitating executive functioning to effect greater autonomy consistent with the very essence of fidelity.

Table 1: Ethical principles and corresponding treatment approaches

Ethical Principle	Core Concept	Application	Treatment Approach
Justice	Entails "being honest, fair, and making judgments free from discrimination [bigotry] or duplicity" (Taleff, 2010, p.35). Due process is integral (Strike & Soltis, 1985). Ethical judgment must set a clear standard through consistency and lack of ambiguity; a concrete precedent for what is an appropriate and proportionate clinical response to the offense's severity (Strike & Soltis, 1985).	**Discharge:** No special-case exemptions required; in advance, clients made aware of cost and consequences of breaking non-fraternization policy **Couples Counseling and Treatment Planning:** Avoid one-size fits-all; differing thresholds for different "sizes" of client issues	**Discharge:** Apply policy in black and white fashion to ALL clients across treatment board **Couples Counseling and Treatment Planning:** Multidimensional biopsychosocial assessment using ASAM treatment/placement criteria across 6 dimensions: 1) acute intoxication and/or withdrawal potential, 2) biomedical conditions and complications, 3) emotional, behavioral, or cognitive conditions and complications, 4) readiness to change, 5) relapse, continued use, or continued problem potential, 6) recovery/living environment, including details of the couple's relationship.
Autonomy	Defined as "maximizing the client's experience of personal freedom" (White & Popovits, 2001, p.164). The idea is to respect autonomy vis-à-vis a client's power of choice while cultivating client empowerment and independence. This honors the client's right to self-determination (Geppert & Roberts, 2008).	**Discharge:** Allows clients to make choices and discover outcomes; conscious control/choice capacity to follow non-fraternization policy mediated by attitude toward policy, poor decisions about drug and alcohol use; ability to make decisions related to sex, dating, romantic involvement intact; deterrent effect **Couples Counseling and Treatment Planning:** Loss of control, inability to choose; self-control mechanisms diminished	**Discharge:** Rule-in factors that evidence rational cognitive function. Violating policy does not characterize degree of overall cogntive competency, e.g., attitude toward rules, ability to follow other policies and procedures, etc. Social interaction corroborated via treatment staff observations, client's treatment history and collateral contacts (probation officer, therapist, significant other, family members). **Couples Counseling and Treatment Planning:** Rule-in factors that suggest impaired/compromised decision-making ability, e.g., acute withdrawal, psychiatric symptoms (e.g., borderline personality), cognitive conditions, emotional complications (e.g., manic episode), and other interactive factors that mitigate accountablity to the point of requiring intervention to enhance intra/interpersonal function
Fidelity	Creation of an environment that is therapeutic while staying true to policies and procedures that advance and reflect the principal goals of treatment as promised (Hemphill, 2013).	Discharge: Quality of treatment milieu influenced by policy; policy's worth lies in its intent to promote recovery and enhance treatment, sends integral message about program's value system **Couples Counseling and Treatment Planning:** Quality of treatment is determined by how well policy accommodates issues/needs of clients	**Discharge:** Demonstrate utility of discharge by citing case examples from program that correlate non-discharge approaches to outcomes that are contraindicative of better or successful therapeutic gain. **Couples Counseling and Treatment Planning:** Establish needs/issues of client and problems in relationship are appropriate fit for this treatment approach
Non-maleficence	Taken from its Latin meaning to express the view of "first, do no harm." Actions deemed ethically "good" prevent harm and avoid making matters worse.	**Discharge:** Principle modalities offered to offset relationship involvement and harm; discharge no more detrimental than relationship itself **Couples Counseling and Treatment Planning:** Reduce vulnerability and poor outcomes; aims to target and resolve core issues; allows for vital monitoring and treatment retention; acknowledges that dating, sex and relationship engagment is a human desire	**Discharge:** Review principle modalities attended by client, attendance record, completion of assignments, level of engagement, staff observations related to client presentation, progress and receptivity to principle modalities, and review treatment plan goals and methods and determine if client has taken strong steps toward assuming responsibility for a positive outcome to their treatment plan **Couples Counseling and Treatment Planning:** Evaluate treatment plan goals based on assessment of needs/problems related to sex, dating; hold clients accountable by developing collaborative strategies/methods that are Specific, Measurable, Achievable, Realistic and Time limited (SMART)
Beneficence	Safeguard and promote client welfare by articulating practices that reflect what is beneficial for clients.	**Discharge:** Honesty is the cardinal principle, treatment no longer focused on individual, honors social contract between program and clients **Couples Counseling and Treatment Planning:** Allows client to experience decisions and learn based on new discoveries, psychosocial education around intimacy, expectations, boundary regulation, relationship standards	**Discharge:** Survey percentage of clients who have honored non-fraternization policy vs. those not deterred by it; tally number of clients not discharged per year **Couples Counseling and Treatment Planning:** Motivational enhancement to discover and identify relationship's connection to substance abuse/behavioral health problems; clients develop plan to track relationship progress and point at which formal treatment intervention is needed; use Feedback Informed Treatment to monitor support, trust, and safety of therapeutic alliance

Fidelity

The non-fraternization policy fails to create a therapeutic climate and may even unintentionally exaggerate the reward incentive that motivates clients to seek a sexual affair (i.e., arousal) in treatment at the potential cost of discharge. In neurobiological terms a deficiency of dopamine D2 type receptors in the striatum is correlated with increased risk-taking, arousal, and thrill-seeking pleasure (Childress, 2006). Thus the relationship may be symptomatic of a co-occurring disorder and requires counseling skills already possessed by clinicians or enhancement of therapeutic skills (Haynes, Calsyn, & Tross, 2008), which promotes improved treatment outcomes. Fidelity further necessitates clinical focus not only on issues of drug use but also to attend to other issues inherent to the relationship as a critical component of treatment, thereby maintaining the integrity of nonmaleficence.

Nonmaleficence

From this perspective, not therapeutically addressing client relationships in treatment, would do a disservice to both clients given the risk of harm posed would be greater if clients' personality structure, dual diagnosis, sexual problem, sexual issues, etc., went undetected and were left unaddressed through discharge. As Haynes et al. (2008) explain:

> The counselor can assist clients in identifying relapse triggers and in determining whether triggers are associated with drugs, sex, or both. Then he or she can apply those principles [relapse prevention strategies] to thoughts about sexual behavior [symptoms of psychiatric disorder or social-psychological and cognitive traits of the personality structure] and help sort out the situations, people, and feelings that lead to a desire for sex [relationship with peer client] and drugs (pp.33-34).

Addressing different etiologies of the relationship (e.g., addiction substitution, mental health issues, unhealthy self-esteem, underdeveloped self-concept, etc.) that create problems in the client's quality of life may help reduce both the severity and risk of a future recurrence of such problems, as well as safeguard client welfare by resolving said issues or etiologies. Additionally, since unresolved relationship issues between the couple could detract and divert attention away from each client's individual plan of treatment, helping both work through their relationship issues that might otherwise go unaddressed and create harm, increases the effectiveness of ongoing treatment by way of couples counseling. This presents a constructive alternative that seems more in tune with two individuals with addiction problems who are more than likely vulnerable at this point. As well, the possibility of relapse and any issues that go with it may become more probable with a discharge. Overall, this approach aims to advance clinical sensibilities about beneficence.

Beneficence

By the token of beneficence, a more instructive treatment policy is to modify the treatment plan to acknowledge that dishonesty may actually be the possibly critical response to fear, shame, and regret (among others) underlying the couple's perceived "denial" of their relationship. Hence, an informed clinical intervention recognizes that dishonesty does not, in and of itself, necessarily represent a pathological construct, but rather a natural and normative feature of human behavior in an attempt to maximize pleasure and avoid punitive costs (i.e., discharge) and pain.

Another approach to beneficence is advocating couples counseling to help the couple identify and address problems in their relationship. This might strengthen the couple's relationship or accelerate an end to it, thereby decreasing harm by helping the couple understand that their relationship is problematic. Another possible outcome is the development of higher expectations and standards for intimate relationships among the both partners to crystalize a sense of healthy, stable, and structured boundary maintenance (Roes, 2010). This may help resolve some of the factors underlying the addiction or the core issues that fed into the relationship (e.g., desire to have a baby, in need of a place to stay, terrified of being alone, low self-worth if not in a relationship, etc.), and in turn, diminish future attraction to a relationship that is not conducive to recovery and long-term abstinence.

Reasons in Favour of Discharge

Ethical Principle: Justice

The decision to discharge is presented to clients as objective, impartial, and systematic. The decision sets a predictably non-arbitrary and absolute precedent that all treatment staff can commit to as being straightforward, "to the letter," without inviting subjective, "gut feelings" and value-laden "hunches" to enter into the decision-making process. In this sense, the decision stays true to due process, which warrants consistently decisive policy application of the rules—a form of justice that promotes client autonomy.

Autonomy

Both clients signed the non-fraternizing agreement and, as free-acting adults, clearly violated it by voluntarily electing to enter into a relationship knowing the risks and consequences. The amorous involvement, judged from their own decision is not because brain functioning is impaired given that drug users can think long-term and rationally (Hart, Marvin, Silver, & Smith, 2012). Problematic substance use does not render one constitutionally incapable of operating with adequate capacity over any aspect of their life or of identifying alternative behaviors and choices in pursuing their long-term goal (e.g., a relationship) to get what they want (e.g., sexual gratification). Addiction is not a permanent state of mental impairment that disqualifies the user from logical decision making about who to get involved with in a relationship (e.g., peer client) that resulted from an earlier conscious intention. That is, sex requires clear, long-term, forward planning (i.e., "distal intentions") that involves evaluating various scenarios and making intentional pre-commitments to certain behaviors, which in turn invokes greater conscious control over future actions or behaviors (Crockett et al., 2013; Slors, 2013). Imposing couples counseling, coercing the couple's relationship into a treatment plan, or putting the couple on a treatment contract under duress as a condition of remaining in treatment is not a form of treatment support but is a set of intrusive, paternalistic measures that undermines the couple's power of choice and further constricts the couple's autonomy —

a binding feature of "criminal justice involvement" (Geppert & Roberts., 2008, p.24). Thus to preserve autonomy, discharge would be warranted, which would also uphold the principle of fidelity.

Fidelity

To discharge is an obligation to maintain the integrity of the non-fraternization policy by honoring the agreement between the client, agency, and referral source (stakeholder). As an example, suppose that the client is also a Family Drug Court (FDC) client and, as a condition, must successfully follow through on his or her FDC service plan. However, since the "rosy"' relationship that the client is convinced is the "true working of divine intervention," he or she has consistently failed the terms of agreed service plan and is stagnant in treatment. It stands to reason that any type of solution short of discharge will merely create an enabling effect to the detriment of both clients and the support efforts of the FDC.

As DiClemente (2006) argues, "If the individual is stuck in the precontemplation stage of recovery on entry to treatment and providers are unable to move that person forward, treatment will fail because self-change is static" (p.91). In effect, change is the precinct of the client's own decision making about whether to seek a natural reward (e.g., sex) in treatment at the cost of being discharged. Thus the dishonesty and scheming that allowed the relationship to be carried out in secret, especially those that are predatory or serial in nature, are less suggestive of a dysfunctional brain circuitry than a lack of willingness (i.e., receptivity and readiness), and needlessly so, to be compliant with treatment regulations. Discharge, then, is a stage-based intervention more attuned to the client's level of readiness to engage a peer client in a relationship at the expense of treatment.

The non-fraternization policy is an acknowledgment of this reality and exists to create a safe environment that features added structure and a measure of security to physically protect the safety and well-being of clients. In line with fidelity, this discourages any attempts to initiate (serial) sexual or dating engagements, especially when initiated by predatory exploitation for a client's own aggrandizement, which would only serve to poison the therapeutic climate. To maintain fidelity requires the agency to not permit the fostering of an atmosphere and environment contradictive of treatment by strongly discouraging clients from instigating and initiating relationships with one another in the name of nonmaleficence.

Nonmaleficence

Sexual or dating involvement usually adds relationship-based pressures and stressors that damage recovery and derail clients' self-discovery efforts at self-improvement—thus muddling the therapeutic process resulting in more harm than good. This outweighs any possible benefits the clients might gain from maintaining the relationship. Yet to prevent harm, both adults were exposed to principle modalities (e.g., relapse prevention, addiction education, dialectical and cognitive behavioral interventions, etc.) that teach problem-solving skills and strategies to the cause of the relationship, negotiating problems that arise out of it and dealing with the relationship's current state. From this perspective, a clinical discharge would not do a disservice to the couple nor is it an action incongruent with nonmaleficence.

Introducing previous unhealthy relationship patterns into addiction treatment may lead to relapse, interpersonal conflict and violence, among other outcomes. Such results are arguably no more detrimental than discharge, and no more likely to produce harm than the relationship itself. Thus the policy is meant to offset relationship involvement borne and shrouded in a cloak of dishonesty. In sum, a discharge may actually prevent the creation of further harm in the long-term, reflecting the value of beneficence.

Beneficence

Relationships between clients in recovery interfere with the therapeutic process, shifting therapeutic attention away from the individual client and onto the client's relationship. The couple then is likely to define the success of the treatment by how well it has served their relationship by keeping it together and resolving their relationship issues. The result would likely cause the therapeutic lens to become out of focus with a drastic shift of the focal point moving from the individual to the couple. Previous client relationship outcomes serve as a rubric that empirically informs clinical discharge.

Accordingly, a response imbued with beneficence must send a strong message that relationships between clients in treatment are not therapeutically acceptable to maintain the integrity of the treatment setting for a safe relational environment and to promote the welfare of the majority of clients. A further instructive treatment policy is to acknowledge the value of truthfulness as a cardinal principle to the recovery and treatment process, which is not something that can be enhanced simply by modifying the treatment plan or by making it the focal point of clinical intervention. Thus to otherwise not discharge the couple is essentially an affront to beneficence and those clients who have honored the terms of their treatment policy agreements, just as it is to the agency as a whole.

CONCLUSION

It is common for clients to develop feelings that qualify one another as "fictive kin." However, when this phenomenon extends beyond the bonds of extended kin, and takes on feelings that meld to "romantic" sentiment, it can problematize the non-fraternization policy.

Romantic liaisons involve the expression of love or affection outside the boundaries networked into peer fellowship that either intends or culminates in sex or dating. The spirit of this social interaction manifest in the proverbial "love" letter, holding hands, kissing, a coquettish grin or glance, ogling or touching private parts, an implicit verbal or non-verbal remark of sexual nature or social overtures with tone of reference to dating or sexual engagement. All are behaviours or actions that constitute a violation of the non-fraternization policy, albeit to a lesser degree than dating or sex. In this case, treatment staff might first intervene with a treatment contract that establishes very clear parameters considered for a second time infraction resulting in clinical discharge.

Treatment staff might also settle the second 'romantic' liaison infraction by electing to transfer one client to a different treatment

setting in order to disrupt the relationship and obviate the need for discharge. As an alternative approach such an intervention could also be used for any violation of the non-fraternization policy. This would call for extra variables to the decision-making process in determining which particular client would be selected for transfer to another treatment setting. Treatment staff might decide that age, period of sobriety, prior treatment episodes, readiness for change, previous romantic engagements, diagnosis and symptoms, medication compliance, current treatment prognosis and trajectory, along with current level of care (to name a few) are the cluster of variables to be absorbed into their decision process.

The phenomenon of dating, romantic and sexual relationships between clients in addiction treatment is not an unusual event. Yet, these kinds of cases represent an ethics subtopic that presents a rather unique clinical challenge to ethical addiction decision making. There is clear lack of supporting, published evidence about the relative treatment merits of couples counseling and treatment planning (and other treatment approaches) for clients in the context of substance abuse treatment to support claims stated for either treatment approach outlined in this article. As such, this ethics subtopic is a "grey" area of clinical reasoning and decision-making that lends itself least to empirical studies, allowing for greater latitude in making ethically nuanced arguments. Because of this, the addiction clinician's ethical principles is a general strategy clinicians are inclined to fall back on in nominating a set of ethical values or principles that are taken to be relevant to such cases. The application of these principles (or concepts) to the clinicians own empirical experiences in dealing with clients engaged in a romantic, sexual, or dating engagement in treatment takes standing in whether a client should be discharged or retained in treatment.

Here, whether for or against treatment settings reinforcing the expulsion of clients for dating, sexual or romantic involvement between one another in treatment, deontological and consequentialist arguments are essentially based on the same conceptual foundation: that relationship involvement between clients is not therapeutically acceptable and merits some sort of clinical intervention. The addiction clinician's ethical principles are meant to challenge moral philosophical and clinical worldviews about the advantages and disadvantages of discharge. That is of course part of the challenging ethical addiction decision-making process.

The common denominator in both clinical interventions proposed is that no one really knows what the outcome of any couple's relationship will be—for good or for bad. Nonetheless, relationship involvement between two clients generally does little, if anything, to support the maximum benefit of treatment processes, especially without therapeutic guidance. On the other hand, discharge may merely encourage clients to develop greater proficiency in keeping the relationship under the veil of secrecy via dishonesty and manipulative behaviors to obviate treatment intervention. Thus couples counseling and treatment planning aims to manipulate the clinical environment and craft interventions intended to shape and reinforce in successive approximations *lasting* behavioral change. This is accomplished via the internalization of clinical interventions that echo a sense of rhyme and reason from the perspective of clients.

For any ethical judgment to do the least amount of harm in deciding the best interest of client, stakeholder, and agency, clinicians must scrutinize the institutional setting and context in which they work. Institutional setting is a question of whether treatment takes place in residential, outpatient, private, or non-profit facility. In treatment contexts characterized by (a) a high degree of internal staff inconsistency, (b) low human capital, (c) ineffective addiction counselors, (d) under-utilization of adjunct support referral services, (e) systemic failure to collaborate with stakeholders in treatment planning, (f) voluminous client caseloads, and (g) substandard treatment planning, the treatment environment would seem less suitable for the delivery of treatment planning and couples counseling, and instead favor a clinical transfer or discharge approach. The sum of these explanatory factors has a primacy effect on determining the merits of a discharge decision—or one incompatible with it. This appeal to contextualize decision making is a pragmatic approach that properly takes stock of the quality of treatment as a necessary motivational factor that matters to addiction ethics (Berton, 2014).

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