Exploring the Challenges and Stressors of Working as an Addictions Counsellor

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Abstract

This qualitative study explored the challenges and stressors that are experienced by addiction counsellors in providing substance abuse treatment. In order to tap into rich and descriptive information on occupational stress in the addictions field, a modified grounded theory focused on conceptual ordering (Corbin & Strauss, 1998) was used for the research design. Participant sample consisted of 10 addiction counsellors who were recruited using purposeful selection from addiction treatment centres in Ontario, Canada. Data collection was conducted through face-to-face interviews using semi-structured, open-ended questions. Four major categories emerged from the data analysis using systematic thematic analysis: 1) Sources of Stress, 2) Signs and Consequences of Stress, 3) Stress Management and Intervention, and 4) Resiliency Against Stress. Results from this study contribute to the understanding of occupational stress in addictions counsellors. Implications for addiction organizations, educators, and counsellors are discussed.

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CHAPTER I

Introduction

Alcohol and drug abuse affect a significant number of individuals in Canada, with 13.6% of all Canadians – or 3.9 million – drinking at hazardous levels in 2004, as reported to the Canadian Addiction Survey (CAS; Adlaf, Begin, & Sawka, 2005). This means that over one in ten Canadians over the age of 15 are at a high risk for alcohol dependence. 14.4% of Canadians in the CAS study also reported using illicit drugs over the past year, with results indicating that over 4.1 million have used an injectable drug in their lifetime.

Despite the prevalence of alcohol and drug abuse, it is estimated that only 7% of those who need substance use treatment receive care for their addiction (Office of the Auditor General of Ontario, 2010). An unstable workforce among addiction workers is seen as one of the factors contributing to low treatment participation, as high turnover rates limit the ability of organizations to effectively respond to the increasing demand for services (Whitter et al., 2006). However, addiction has an impact beyond the individual needing treatment, and this cannot be overlooked.

The economic consequences of addiction to society are significant. It was estimated that healthcare, law enforcement, workplace productivity loss, premature death and disability in relation to substance abuse in Canada amounted to an overall social cost of approximately $39.8 billion in 2002 (Rehm et al., 2006). Thus, those at the frontline of addictions treatment services play a vital role in helping to reduce this social cost, as effective treatment is a necessary part of the solution. Although Canadian funding for substance abuse treatment has increased in attempt to accommodate the growing need for services (Collin, 2006), treatment agencies are still reporting a strain on staffing resources (Office of the Auditor General of Ontario, 2010). It is

essential that the workforce has the capacity to provide quality treatment, and this becomes a challenge when those within the workforce are not healthy and satisfied in their roles.

Research has shown that there is currently an issue with staff retention among addiction treatment agencies, as turnover rates for both counsellors and program directors in the addictions field have been reported to be as high as 50% (McLellan, Carise, & Kleber, 2003). Given that stress and burnout factors have been consistently associated with turnover in substance use treatment organizations (e.g. Duraisingam, Pidd, & Roche, 2009; Knudsen, Johnson, & Roman, 2003), it is important to raise awareness about the issue of occupational stress in order to promote the health and wellbeing of addiction workers.

In order to acquire a deeper understanding of work-related stress in addiction counsellors, the present study aims to address the question: "How are the challenges and stressors of working in substance use treatment defined and experienced by the addictions counsellor?" This study aimed to examine occupational stress in addictions counsellors using a modified grounded theory methodology in order to capture the details of what is experienced. More specifically, structured thematic analysis was used to uncover rich and complex information and to identify themes within the data. A secondary aim was to contribute a Canadian perspective to the empirical exploration of occupational stress in addiction counsellors, as there is limited research regarding this issue despite a large workforce of addictions treatment professionals in this country.

Further information on the difficulties encountered while delivering addictions treatment may have clinical, educational, and organizational implications that are important for the training and supervision of counsellors within this specialty. Gaining more knowledge about occupational stress in this field may be valuable towards promoting the wellbeing of addiction workers, finding coping strategies for stress, and strengthening the workforce.

CHAPTER II

Literature Review

Stress, the Therapeutic Alliance, and the Helping Profession

Stress is caused by exposure to external stimuli from the environment that places demands on the individual and causes a feeling of internal strain (Maslach, 1986). Helping professionals such as psychotherapists, social workers, nurses, and doctors are all exposed to many different sources of occupational stress. Providing psychotherapy can be demanding work, with the counsellor being relied on to manage crisis situations, help the client cope through difficult mental health symptoms, and facilitate progress in treatment (Neuman & Gamble, 1995). Furthermore, counsellors are regularly faced with the burdens and maladjustments of other people (Raquepaw & Miller, 1989). Suicidal statements, inability to help distressed clients, expression of anger towards the counsellor, lack of observable progress, severely depressed clients, and a lack of client motivation have been reported as sources of stressful work-related experiences for psychotherapists (Deutsch, 1984). In addition to negative client behaviours and over-involvement with clients, other factors like total hours worked, paperwork, and administrative hours were positively associated with higher level of exhaustion in mental health professionals such as psychologists (Rupert & Morgan, 2005).

The work of psychotherapy is also interpersonal in nature, and relies on the emotional and mental investment that counsellors make in building what is called the therapeutic relationship with their clients (Ducharme et al., 2008). The best practice guidelines for substance abuse treatment and rehabilitation published by the Government of Canada states that the ability to develop a therapeutic alliance with the client along with strong interpersonal skills such as empathy are associated with more positive treatment outcomes (Health Canada, 2002). Client

perceptions of the therapeutic relationship during treatment are significantly associated with meeting treatment goals for alcohol dependency, such as successfully acquiring relapse prevention skills at three months follow-up (Ritter et al., 2002). It is within the relationship between client and counsellor that much of the healing and therapeutic processes take place. The consistent emotional availability and empathy on the part of the counsellor plays a vital role in promoting a trusting and safe environment for the client to explore issues that are often painful and overwhelming (Zeddies, 1999). However, the emotional intensity that characterizes the burdens shared is often thought to contribute to the stress inherent in the role of a helping professional.

Stress and Burnout in the Addictions Helping Profession

Although there is increasing recognition of occupational stress in the addictions health care field, stress in addiction counsellors is still a highly understudied issue. Despite a common perception that it is particularly challenging to work in addictions treatment, there is little empirical evidence to support the notion that addiction counsellors experience occupational stress (Farmer, Clancy, Ayefeso, & Rassool, 2002). To address this, Farmer and his colleagues (2002) have developed an occupation-specific scale called the Addiction Employee Stress Scale (AESS), which measures levels and sources of stress in addiction workers. Using the AESS measure, these researchers have found that stressors related to providing substance abuse treatment do indeed significantly correlate with measures of burnout and lower job satisfaction.

However, a difficulty within the literature on occupational stress in addiction workers is that stress is a term used inconsistently depending on the context and perspective of the research (Farmer et al., 2002). Related terms such as *distress*, *impairment*, and *burnout* are also often used interchangeably with stress (Smith, 2009), creating some conceptual overlap. In particular,

the terms *burnout* and *stress* are used synonymously in the literature quite frequently. Thus, it should be considered that the literature reviewed in the present study may reflect this conceptual overlap. In order to capture a comprehensive picture of occupational stress in the addictions field, research on burnout as related to stress will be presented.

Burnout is defined as a negative internal response to the chronic exposure of emotional and interpersonal stressors in the workplace (Maslach, 1986) and can occur on several different levels – physical, emotional, mental, and behavioural (Elman & Dowd, 1997). Emotional exhaustion, or when one's emotional resources are depleted and overextended from interacting with clients, is seen as a central indicator of burnout (Maslach, Schaufeli, & Leiter, 2001). Experiencing work-related stress has even been found to predict increases in burnout one year later in health professionals (Peiro, Gonzalaz-Roma, Tordera, & Manas, 2001).

It should be noted that undergoing prolonged heightened stress does not necessarily result in burnout, as many professionals experience stress and still maintain a healthy wellbeing. Some research has shown that certain individual factors (such as demographic variables, personality characteristics, or job attitudes) are implicated when examining who experiences burnout – however, these relationships have not been shown to have as great of an effect on burnout as situational factors (Maslach et al., 2001). Thus, investigating occupation-specific contexts through the participants' perspective may reveal more information about the intricate ways stress is experienced by addiction counsellors, and capture more detail in what they experience within their contexts.

Although individuals can experience stress for prolonged periods and not reach burnout, occupational stress on its own can still have detrimental effects on worker wellbeing and quality of life. There are adverse psychological (e.g. depression and anxiety), physical (e.g. increased

blood pressure), and behavioural (e.g. changes in sleeping patterns, increased substance use) symptoms that are common responses to stress (Skinner, 2005; Smith & Moss, 2009). Current research may benefit from data that clarifies what occupational stress reactions might look like. An inductive, qualitative examination that allows participants to describe their own experiences and meanings may contribute to a deeper understanding of the impact of job stress.

Stress and burnout can be harmful to treatment progression and outcome. Research shows that emotional exhaustion among a treatment team has a significant negative correlation with patient satisfaction with the environment, treatment, and with preparation for autonomy after treatment (Garman, Corrigan, & Morris, 2002). Feeling a sense of personal accomplishment among staff was also found in the same study to be positively associated with higher patient satisfaction with the counsellor. Thus, the wellbeing and satisfaction of the addiction professional appears to have an important impact on the client's therapeutic experience.

Stress can create a domino effect within an organization, with burnout in one individual potentially affecting the stress level of the whole agency (Lacoursier, 2001; Knudsen, Ducharme, & Roman, 2008; Jones & Williams, 2007). Caseloads from previous or absent counsellors are divided among the remaining staff members, which in turn increases the stress levels within the organization as a collective. It is evident that the negative consequences of prolonged stress directly affect the addiction counsellor, the agency, and its clients. The degree to which burnout can be reversed is not well known, but it has been shown to be stable and long lasting (Peiro et al., 2001). Thus, an effective method for the prevention of burnout would focus on early detection of heightened stress (Sherman, 1996). However, the current studies on burnout in addiction counsellors do not account for the processes of stress that occur before burnout is reached. In order to identify an optimal point of intervention for burnout, a clarification of the

signs and experiences of stress at early onset is needed, and would be more representative coming from the addiction counsellors themselves.

Although the AESS by Farmer et al. (2002) has made significant gains to the research by creating an occupation-specific scale for addiction workers, none of the total 197 respondents from sample used to develop the scale were reported to be addiction counsellors or counsellors. A substantial number were nurses (35%), followed by social workers (7.5%), doctors (6.5%), and clinical psychologists (4%). The remaining participants were made up of other professionals (16.5% – namely, occupational counsellors, drug support workers, probation officers, general practice liason workers, outreach workers and volunteers). In the replication sample of the study, a large majority of the 120 respondents were also nurses (76%). While all frontline staff are invaluable to the total care and recovery of the substance misuser, providing psychotherapeutic treatment in particular is a qualitatively different experience for the addiction counsellor, which may require vocation-specific information. The typical role of an addiction counsellor or counsellor is to provide:

> …intensive interventions designed to support clients in changing their substance use and related behaviours…The counsellor aims to help the client understand his or her problems and develop a plan that will change the behaviour, lifestyle and/or environmental factors that contribute to these problems. Counselling may be with individuals or with groups of clients or family members (CCSA, 2007, p.4).

It is unclear whether the results from the current literature can be generalized to addiction counsellors, or whether the stress experience specific to addiction counsellors is even being captured.

Sources of Stress in the Addictions Treatment Field

Addiction treatment workers have been found to have a high risk for psychological distress. In a study of 194 substance misuse clinical staff, a prevalence rate of 82% was found for symptoms of psychological strain and 33% for emotional exhaustion related to burnout (Oyefeso, Clancy, & Farmers, 2008). One in five addiction counsellors have been reported to experience high levels of stress, and with heightened stress being significantly associated with intention to leave either their job or the field (Duraisingam et al., 2009). Though stress and burnout are not unique to addictions field, there are particular factors related to providing treatment for substance dependency that increase the exposure to stressful situations.

Challenging and stigmatized client population

Addiction is considered a chronic and relapsing condition (Annis, 1985), with treatment dropouts ranging from 30% to 60% (Wierzbicki & Pekarik, 1993). Reaching treatment goals is delayed when clients relapse, which can be frustrating for counsellors who continue to remain emotionally invested and available in the therapeutic relationship. Performance demands have been found to be a source of stress, as the addiction counsellor is seen as partly responsible for treatment progression, or a lack thereof (Ducharme et al., 2008). Given that having a sense of personal accomplishment is an important factor in preventing burnout (Maslach, 1986), a lack of therapeutic progress and a shortage in success stories would certainly affect emotional exhaustion when working with this client population (Jones & Williams, 2007; Sherman, 1996). Along with the difficulty of managing relapsing clients, denial and resistance are frequent among clients with addictions (Curtis & Eby, 2010; Elman & Dowd, 1997; Skinner, 2005), making it particularly challenging to move forward with treatment. Working with difficult clients has been

known to contribute to burnout, especially when there is a lack of available resources and staff support – an issue not uncommon within the addiction agencies (Hayes et al., 2004).

However, the challenges of and resistance towards treatment for an addiction must also be considered within its broader social context. Individuals with addictions are portrayed in society and the media as being morally weak, dangerous, immoral, blameworthy, unpleasant, violent, lacking skill (Connor & Rosen, 2008; Corrigan et al., 2005; CSAT, 2000; Keyes et al., 2010), and more responsible for their condition than other health conditions (Corrigan, Kuwabara, & O'Shaughnessy, 2009). Many health professionals also hold a negative view towards those with substance dependency, believing that the addiction is self-inflicted (Allsop & Helfgott, 2002; Skinner, Feather, Freeman, & Roche, 2007) and thus less deserving of quality care. For example, a lower willingness to provide care for those with substance abuse issues have been reported by health care providers such as general practitioners (Abouyanni et al., 2000) and nurses (Howard & Chung, 2000), creating a barrier that prevents individuals from seeking help (Skinner, Roche, Freeman, & Mikinnon, 2009). Those with an addiction who perceive stigma in the community have been shown to be significantly less likely to seek treatment services (Keyes et al., 2010). Consequently, a positive treatment outcome becomes more difficult to achieve, as the severity of their substance use has often progressed into a worsened condition by the time help is sought.

Co-morbid disorders

Addiction also comes with multiple health-related issues and a high rate of co-morbidity with other disorders. Substance use disorder (SUD) has been found to co-occur with mood disorders, anxiety disorders, and other severe mental illnesses such as schizophrenia, antisocial personality disorder, borderline personality disorder (Flynn & Brown, 2008; Saunders &

Robinson, 2002), and eating disorders (Pearlstein, 2002), adding layers of complexity to the treatment course and its outcome. Treating clients with co-morbid conditions may be stressful for counsellors who do not have enough expertise on the disorders, their presentation, and the clients' treatment needs.

Referrals for substance abuse treatment frequently come from other populations that are "doubly vulnerable" or belonging to more than one stigmatizing subgroup (Gwyn & Colin, 2010), like the criminal justice system (Broome, Knight, Edwards & Flynn, 2009) or clients with human immunodeficiency virus (HIV; Shoptaw, Stein, & Rawson, 2000). Such populations often bring specific needs to treatment, which the counsellor will have to address. Although understanding the common disorders and conditions that co-occur with addiction is an important part of a well-rounded competency in this specialization, it can also compound counsellors' experience of stress.

Trauma

Trauma is frequently present in those with addictions, as demonstrated in a study where 97% of addiction counsellors report having trauma clients in their caseload (Bride, Hatcher, & Humble, 2009). Addiction counsellors in another study reported that almost one fourth of their caseload (24%) have disclosed that they are survivors of incest (Janikowski & Glover-Graf, 2003). Since addiction counsellors may be regularly exposed to clients who use alcohol or drugs as self-medication for their traumatic experiences, vicarious or secondary trauma is thus another potential source of stress. Secondary trauma stress (STS) occurs when the counsellor becomes indirectly traumatized through the therapeutic work with trauma clients (Figley, 2002). In one study, 75% of addiction counsellors were found to have at least one symptom of STS in the previous week, and 19% reported STS symptoms in the previous week that met the diagnostic

criteria for post-traumatic stress disorder (PTSD; Bride et al., 2009). These findings demonstrate the need to prepare addiction counsellors for exposure to traumatic experiences of their clients, and to address the potential stress that counsellors undergo from these interactions. However, results from these studies are based on brief screening measures, which do not capture how the stress manifests or tap into the important details and particular context of the stress experience.

Thus, as the research shows, there are several client characteristics that may create a more stressful therapeutic interaction for the addiction counsellor. However, the ways in which working with such challenges affect the occupational experience for addiction counsellors, and how the addiction counsellor emotionally processes these experiences are not well known. There are also very few studies that examine how the counsellor copes with these potentially stressful encounters, and what helps them to manage the stress and intensity of working with complex disorders. The development of detailed knowledge on experiences with challenging cases may provide important information useful to clinicians who supervise addiction counsellors.

Job Demands and Organizational Sources of Stress

The current literature points to some organizational factors that may influence levels of stress, like ineffective supervision, a lack of professional development opportunities, lack of autonomy and control over decision-making, absence of proper performance recognition, and restricted opportunities to develop new ideas (Lacoursier, 2001). Large caseloads, too much paperwork, time pressures, stressful events, distribution of work, and unclear performance expectations are job demands that contribute to stress when working in a substance misuse treatment organization (Skinner, 2005).

Workplace support can be important in buffering the negative effects of stress that are inherent to providing treatment to addiction. For example, heavy caseloads have been found to

affect how counsellors feel they can cope with stress – as the number of clients on a caseload increases, personal coping resources decreases (Layne, Hohenshil, & Singh, 2004). Addiction counsellors with more than 30 clients were found to have significantly lower job satisfaction than their colleagues with 11 to 30 clients (Broome et al., 2009). However, results from the same study show that participants from organizations with directors rated more positively on leadership ratings were found to have lower burnout ratings and higher job satisfaction, regardless of caseload amount – demonstrating that management can play a key role in preventing burnout. Similarly, another study found that addiction workers who had lower levels of perceived workplace support also reported low levels of job satisfaction and high levels of work stress (Duraisingam et al., 2009). Detailed information about what type of support is needed may be beneficial towards employee assistance programs and prevention strategies against occupational stress.

The ability of an organization to provide effective treatment delivery involves maintaining a strong, healthy, and satisfied staff. Compounded together, stressors can have strong and negative implications toward job satisfaction and impair workforce stability by decreasing worker wellbeing. However, a limitation of these studies is that the quantitative methods used are unable to capture counsellor opinions on how an agency can help provide support against harmful factors that affect their experience with work stress. Although a significant amount of critical information has been obtained to help identify factors that predict reactions to stress, the opinions of addiction counsellors themselves on stress may be able to provide new and rich insight into strategies for retention.

Training and the Professionalization of the Addictions Field

A shift towards the professionalization of addictions treatment has occurred over the past couple of decades, and the demand for substance abuse treatment services have also been on the rise in Canada (Office of the Auditor General of Ontario, 2008). The professionalization of the addictions workforce began to occur with the adoption of evidence-based and best practices, as well as an increased use of medications for treating substance use disorders and related issues, such as concurrent mental health disorders (Whitter et al., 2006). Thus, an increase in various medical health professionals (such as physicians, nurses, and psychiatrists) and the expansion in the use of interdisciplinary teams were recruited into the workforce.

However, with the adoption of evidence-based practices, funding resources began to place higher demands on counsellors to produce successful treatment outcomes with highly complex and disordered clients (Fahy, 2007). Greater academic expectations to maintain competency and knowledge of current trends have grown, adding to the list of everyday work demands (Whitter et al., 2006). In a study of managers for addiction treatment agencies, only half of the sample believed they could effectively manage and respond to the changing trends in alcohol and drug use, such as an increase in co-occurring disorders and polydrug use (Roche, O'Neill, & Wolinski, 2004). Stress and challenges are occurring at all levels within addiction treatment organizations, and it is apparent that a substantial number of both managers and addictions counsellors are experiencing some stress due to the issues they are faced with on a daily basis. Raised expectations to provide effective quality care using limited resources sets unrealistic standards on addiction treatment providers, contributing to feelings of strain on the job (Hayes et al., 2004).

Training and the prevention of occupational stress

There is currently no uniform curriculum agreement in Canada that exists for becoming an addictions treatment professional, nor is there a regulating body overseeing standards of practice (Graves, Csiernik, Foy, & Cesar, 2008). Furthermore, only an average of 23% of Canadian addiction workers reported being certified or are working towards certification as an addictions counsellor (Ogborne & Graves, 2005). This is alarmingly low in comparison to other studies from the United States which report 50 – 84% of addiction counsellors have received certification for substance misuse counselling (Bride et al., 2009; Curtis & Eby, 2010; Rothrauff et al., 2011). This makes it difficult to determine whether trainees are receiving adequate knowledge that will allow them to provide effective service delivery upon entering the workforce.

Implementing stress prevention education during the training years helps novice practitioners to be more equipped for recognizing the warning signs of occupational distress (Sherman, 1996). Among the seven core functions of being an addictions counsellor identified by Taylor and Schiffer (1997), self-knowledge of strengths and weaknesses is suggested as one function that should be integrated into the addictions counsellor's personal and professional development. The authors emphasize that developing the awareness of one's own needs and stress levels are important to ethical practice, as feeling overstressed can hinder the counselling process. Having more information about potential sources of stress may help prepare counsellors for realistic expectations of the work and contribute to psychotherapists' confidence in their performance. However, a more active effort to begin addressing gaps in knowledge on occupational stress is needed before refining or developing new stress management guidelines.

Given that stress is a result of believing that external demands exceed one's capacity to respond (Maslach, 1986), having an expectation of the potential stressors can help increase one's

perceived ability to cope. Clanton and colleagues (1992) suggest that those who are entering the field may benefit from information about the work in order to help them anticipate the type of stress that they will experience. Both the employee and the organization can find ways to develop coping strategies for the stress if they are better able to anticipate what the stressors are. Prevention education helps to reduce the duration of the distress experienced, and reduces risk for impairment of professional functioning (Sherman, 1996). To assist in preparing for work-related challenges, educators and human resource departments can provide detailed accounts describing occupational stress to those entering the workforce.

Research has shown that those with longer years of experience as rehabilitation counsellors were found to have significantly higher learned resourcefulness towards coping with stress and higher levels of personal accomplishment (Clanton, Rude, & Taylor, 1992). Another study found that greater confidence towards handling everyday work stressors was significantly associated with less burnout in rehabilitation nurses (Elliott, Shewchuk, Hagglund, Rybarczyk, & Harkins, 1996). These researchers contend that the perceived ability to tolerate stress is important in protecting individuals from negative effects of occupational stress. However, because these studies were examining health professionals for physical disability rehabilitation, it is not certain whether these results can be generalized to addiction counsellors.

What is known is that the sources of stress encountered by an addictions counsellor are many – challenging population with high co-morbidity, risk of secondary trauma, excessive job demands, low resources and salary, increasing performance expectations, and inconsistent retention and recruitment of staff members. The studies reviewed demonstrate multiple aspects that contribute to an explanation as to why addiction workers may experience occupational stress. These studies also point to a lack of formal training and education for a professionally

evolving health care field – limiting access to fundamental information important to stress management upon workforce entry, such as knowledge of challenges in the field. However, there are few studies that thoroughly examine addiction counsellor's opinions on the occupational stress that they experience, which may be important in informing the development of strategies for stress prevention and management – both of which play key roles in worker retention.

Impact of Stress on the Addiction Field

Effects of Turnover on Workforce Instability

Being a consistent and dependable figure in the life of someone with an addiction is therapeutically important for a disorder that is characterized by instability and recurrence (Newman, 1997). To help promote an optimal therapeutic alliance, the environment of the organization would ideally emulate a sense of consistency and safety that these clients so often do not experience in other areas of their life. Thus, turnover within a substance abuse treatment agency can have damaging effects on the outcome of treatment. A growing concern for the addiction workforce, however, is that occupational stress and burnout have been consistently found to be associated with both turnover intention and actual turnover (Duraisingam et al., 2009; Knudsen et al., 2003). For this reason, examining the impact of stress on addiction counsellors before burnout is reached is a necessary step toward preventing burnout.

Research has shown that there is high workforce instability in the addictions services field, Turnover in SUD treatment organizations have been found to range from around 19% to 33% (Eby, Burk, & Mahr, 2010; Gallon, Gabriel, & Knudsen, 2003; Johnson, Knudsen, & Roman, 2002), with one widely cited study reporting a 50% turnover for both counsellors and program directors within the past 16 months (McLellan et al., 2003). However, more recent research on

turnover intention and actual turnover have yielded mixed results. Research on turnover intention has important implications for retention strategies, as turnover intention has been found to be the best predictor of actual turnover (Griffeth, Hom, & Gaertner, 2000). In a study of 929 addiction counsellors in the United States, the researchers found low intentions to leave the SUD treatment field, with less than 8% indicating *definitely* intending to leave the field (Rothrauff et al., 2011). On the other hand, a study that systematically tracked 245 addiction counsellors and 44 clinical supervisors working in substance abuse treatment centres found that over a one year period, 33.2% of counsellors and 23.4% of supervisors had left their organization, with 75% of counsellors and 64% of supervisors leaving their organization voluntarily (Eby et al., 2010). Thus, although addiction counsellors are not reporting intentions to leave the substance abuse treatment field, actual turnover rates across organizations are showing high instability, with approximately one in three leaving their jobs over a one-year period.

In comparison to lay-offs due to insufficient funding or performance issues, voluntary resignation was the most common source of turnover in substance abuse treatment agencies (Gallon et al., 2003). Turnover in an organization can be costly, at an estimated cost to rehabilitation facilities of almost $165,000 USD per year (Barrett, Riggar, Flowers, Crimando, & Bailey, 1997). Given the many damaging effects occupational stress can have on the addictions treatment field, it is no wonder that examining worker wellbeing has been named as an important priority for workforce development in several national and international reports (Broderick, 2005; Graves & Plouffe, 2008; Roche, 2009; Skinner, 2005; Whitter et al., 2006).

Job satisfaction, turnover intention, and stress

In a study of 705 addiction counsellors in Ontario, Canada, 96.5% reported either “liking” or “strongly liking” the work that they are doing (Ogborne, Braun, & Schmidt, 1998). However,

over half (52%) of addiction counsellors reported feeling stressed at work; one in three agreed that "working in the addictions field leaves me too emotionally drained to enjoy other things;" one in four reported a negative impact on home life as a result of their job; and one in five are reporting a fear of eventual burnout. This demonstrates the strong negative impact on the wellbeing of addiction counsellors due to their occupation. In a more recent Canada-wide study of 1,384 addiction workers called *Treatment Workforce Survey,* 92% of frontline and 95% of executive directors reported gaining *quite a lot* or *a great deal* of satisfaction from their work (Ogborne & Graves, 2005). Conversely, this study found that despite high job satisfaction, there is still indication of turnover intention. 30% of those aged 40 or less reported that they intended to leave the field within 5 years, and 39% indicated that they intended to leave the field before age 55. A substantial number of program managers (25-48%) strongly agreed that retention of counsellors is a concern. Data on actual turnover for addiction counsellors in Canada have not been reported to the author's knowledge.

Thus, although research is showing that Canadian addiction workers appear to be highly satisfied with their jobs, it does not necessarily follow that heightened levels of stress are not experienced or that retention is not an issue. In a study of 1,345 frontline addiction workers in Australia, high levels of work satisfaction and low levels of work stress were generally reported (Duraisingam et al., 2009). However, more than half of participants had thought about leaving their jobs in the past year; one in three claimed having the intention of leaving their organization within the next year; and one in five indicated the intention to leave the field altogether. For those who reported an intention to leave, significant predictors of turnover intention in this study were high levels of stress related to emotional exhaustion, low levels of job satisfaction, negative perceptions of salary, and low levels of workplace support. This research shows that although

there is high satisfaction and low job stress being generally reported among addiction workers, those who do intend to leave the field are those experiencing high levels of stress and low levels of job satisfaction. The majority of Canadian addiction counsellors, too, are gaining high satisfaction from their work – yet one in three are also thinking about leaving the field within five years (Ogborne & Graves, 2005).

It appears that there are reasons not yet clearly identified that motivate addiction counsellors to leave their jobs, despite the satisfaction they derive from working in this field. In order to understand this discrepancy, research that is able to explore addiction counsellors' perspectives on work-related challenges and stress resiliency may be helpful in providing insight. While current studies have provided invaluable descriptive and inferential statistics about working in the addictions field, being able to interact with the participant allows for the uncovering of nuances and reactions that cannot otherwise be obtained using survey instruments.

Results from the *Treatment Workforce Survey* (Ogborne & Graves, 2005) have provided essential information on the overall, general profile of who is working in the Canadian addictions workforce and turnover intention. However, this study used a limited set of four questions about the degree to which respondents were concerned over the shortage and retention of counsellors and workers in their agency. Aside from concerns about salary, educational, and professional development opportunities, this survey did not examine any other problematic employment conditions in their measurement. Moreover, only manager and supervisor ratings on concerns for recruitment and retention were obtained – frontline staff were not asked to include their perspectives on this topic. Thus, due to the mainly demographic and descriptive statistical nature of the information, as well as the restricted range of opinions that were examined, results from

this study are unable to answer questions about how to improve and strengthen the Canadian addictions workforce.

Another limitation of both international and Canadian research on turnover intention is that the data samples were often an amalgamation of different types of addiction workers – which is indeed representative of the addictions workforce as a whole. However, research identifies turnover rates for addiction counsellors in particular as being highly unstable and the majority of respondents for these studies were often nurses and other addiction professionals. For example, in Duraisingham et al. (2009), nurses and general addiction workers (such as welfare, support, and youth workers) made up 71% of the sample. In the Canadian-wide study of addiction workers by Ogborne and Graves (2006), the specific professions of respondents were not reported, though 24-54% were identified as being certified by other professional bodies such as nursing or social work. Thus, it is not entirely clear if these findings are representative of turnover intention and job satisfaction in addiction counsellors.

Overall, it appears that a gap in the literature exists when addressing why one in three addiction counsellors have intentions to leave the field despite reports of high job satisfaction. Furthermore, only one Canadian study addresses the topic of occupational stress (e.g. Ogborne, Braun, & Schmidt, 1998) and data from this study were collected fifteen years ago when trends and challenges of the field were different from what they are currently. Without occupation-specific information, it is difficult to understand what will help sustain the continued employment of addiction counsellors and prevent occupational hazards like burnout and turnover.

Resiliency in the Addictions Field

With the work demands outlined above, it is not hard to imagine how this type of human services occupation is a challenging one. However, there are many therapists who stay in the addictions field for long periods, showing that although there are stresses inherent in this type of work, many addiction counsellors find high satisfaction from their jobs. Data from large scale studies show that a substantial number of addiction workers do have a long tenure within their field, with survey participants reporting an average of 7 to 12 years of experience in providing substance abuse treatment (Curtis & Eby, 2010; Knudsen et al., 2006; Rothrauff et al., 2011; Roche et al., 2004). Some studies have reported that approximately half of the employees had been in the field for 10 years (e.g. Gallon et al., 2003). In a survey of frontline workers in the Canadian addiction treatment workforce, a majority of respondents across the country reported working in the field for 8 to 10 years and have stayed in their current position for 5 years (Ogborne & Graves, 2005). On the other hand, addiction cunsellors appear to have shorter careers in their field in comparison to other health care professionals. For example, nurses have an average tenure of 18 to 22 years, and doctors for 26 to 29 years (Netten & Knight, 1999).

It is possible that those who have burned out have left the field and those who have remained are doing the work out of personal interest or have adopted effective self-care and coping strategies (Clanton, Rude, & Taylor, 1992). This is reflected in research showing that those who are younger, with less experience in the field (Duraisingam et al., 2009; Knudsen et al. 2003, 2006, 2008; Rothrauff et al., 2011) and higher education levels (Ducharme et al., 2008; Knudsen et al., 2003, 2006) were significantly more likely to have intentions of leaving the addiction field. It has also been found that drug treatment counsellors who are younger are more likely to have higher levels of burnout (Garner, Knight & Simpson, 2007). Similarly, in a study of rehabilitation counselors for physical and mental disabilities, it was found that as age

increases, psychological strain decreases (Layne, Hohenshil, & Singh, 2004). Findings also show that those who have been working as addiction counsellors longer experience significantly less stress and more satisfaction than those who have been working in the field for fewer years (Duraisingam et al., 2009). If those who are younger and newer to the field are significantly more likely to have the intention to leave, this presents an issue for a field where workers are aging and will eventually retire.

The addictions workforce is also a unique field where a high percentage of counsellors are in recovery from their own addiction, bringing personal expertise to their clinical work (Allsop & Helfgott, 2002). Many are thus "paraprofessionals," or counsellors who entered the field without formal post-graduate training (O'Donovan & Dawe, 2002) and may or may not have later attained further educational qualifications. Research shows that frontline staff who are in recovery make up about 38 to 57% of the addictions workforce (Curtis & Eby, 2010; Ducharme et al., 2008; Janikowski & Glover-Graf, 2003; Knudsen et al., 2006). In Canada specifically, between 23 to 48% of managers and frontline staff reported having a personal history of substance use problems (Ogborne & Graves, 2005).

Being able to identify with the work in a deeply personal and meaningful way is greatly beneficial to the workforce, as those who are in recovery have been found to show significantly higher commitment to the profession than those who are not (Curtis & Eby, 2010). Some research has found that the personal and interpersonal aspects of the work, such as gaining inner growth, the interaction with clients, collegiality with coworkers, and commitment to treatment brought the most satisfaction to addiction counsellors in their roles (Gallon et al., 2003). It would be valuable to tap into the knowledge and experiences of these professionals who remain in the addictions field for long periods of time. More focus is needed on what addiction counsellors feel

are the problem areas of working in this field, especially early on in their careers. Additionally, examining what helped them to stay in the field, doing work that is inherently challenging, may help to answer some questions surrounding methods for retention and recruitment.

Present Study

As the research has shown, occupational stress is a significant workforce and wellbeing issue in the addictions field, affecting staff retention and stability within treatment organizations. In a report that calls to strengthen the addictions profession, Whitter and colleagues (2006) posit that in order to "maintain skills that will keep pace with the rapidly changing environment, the workforce must be resilient, clinically competent, and adaptable" (p.23). Whether addiction counsellors are able to keep pace with the mounting pressures in the workforce is not adequately known. The sources of stress are many, with an increase in complex and co-morbid client presentations, limited funding resources, heavy caseloads, exhaustive paperwork, staff shortages, and organizational issues being a few examples. A priority of workforce development in the substance abuse treatment field is to create strategies for supporting the wellbeing of addiction workers (e.g. Broderick, 2005; Groves & Plouffe, 2008; Roche, 2009; Skinner, 2005; Whitter et al., 2006). In order to help promote resiliency and long-term careers in the addiction field, occupational stress in addictions counsellors must continue to be acknowledged in the research.

Given that high stress levels have been significantly associated with turnover intention (Duraisingam et al., 2009), it is apparent that managing stress is an important factor in retaining staff and maintaining healthy workers in the field. However, there is not enough empirical research on the nature of the stress occurring in the Canadian addiction services field. Are addiction counsellors having experiences of occupational stress? If so, what are the causes and consequences of experiencing occupational stress? Furthermore, the majority of studies in the

literature focus on examining burnout and turnover intention in addiction workers. Few studies are aimed towards finding early detection of at-risk stress in addiction counsellors, despite the potentially hazardous impact that occupational stress itself has on both wellbeing and effective treatment delivery. Moreover, these studies often sampled participants who held a variety of roles in the addictions field (such as "general addiction worker" or nurses). Thus, we are unclear whether findings from some studies are representative of the addiction counsellor role, which may be qualitatively different from other health professional roles. Lastly, there is also little information on how addictions counsellors process and manage the stress that they experience. How do addiction counsellors process their stress and how would they describe their signs and symptoms of stress? What are their coping mechanisms, if any?

The present study aimed to explore the current wellbeing of addiction counsellors from Ontario, Canada, and the key areas they experience as having positive or negative impact on their wellbeing (Skinner, 2005, p.6). This study focused on recruiting participants who were directly in the role of providing addictions counselling to clients, regardless of their educational background (which may include several areas of health care, such as social work, counselling, psychology, etc.) Using a modified grounded theory research methodology, semi-structured interviews will be conducted with addiction counsellors to examine the nature of the stress and the processes through which stress is experienced. A qualitative exploration of definitions and meanings of occupational stress from the counsellor's perspective may reveal new and rich information.

Specific Aims and Research Questions

The purpose of this study was to address the question: How are the challenges and stressors of working in substance use treatment defined and experienced by addictions counsellors? Using a thematic analysis approach, this study aimed to answer the following questions:

(1) What are the key areas of occupational stress for Canadian addiction counsellors?

(2) What is the nature and impact of stressful experiences on addiction counsellors?

(3) How is stress managed, and what assists or impedes coping for addiction counsellors during experiences of stress?

A secondary aim is to broaden the empirical knowledge base of this area of research by contributing to the perspective of addiction counsellors within a Canadian setting, specifically in the province of Ontario. An understanding of occupational stress in greater detail can help inform those entering the field, suggest solutions to current issues, and highlight what needs to be addressed. Finally, a broader objective of this study is to raise awareness regarding occupational stress in the addictions field and to promote the health and wellbeing of these workers.

CHAPTER III

Method

Although the literature has identified several factors that contribute to occupational stress in addiction counsellors, most of the research has been conducted using quantitative research methods. A substantial amount of knowledge has been gained from these studies investigating the issue of stress in addiction counsellors. However, a benefit of using qualitative research methods is the ability to examine participant experiences in depth and from their perspective, gathering information that may not have been captured in existing quantitative data.

In order to expand on previous research, this qualitative study used a modified grounded theory approach to tap into rich and descriptive information on the experience of stress by addiction counsellors. The goals of qualitative research can differ from "description, to conceptual ordering, to theorizing" (Corbin & Strauss, 2008, p. 53), and focus on understanding the intricate experiences of the participants within their context (Bradley, Curry, & Devers, 2007). Qualitative techniques can also be an effective method for supplementing quantitative analyses in health services research (Pope & May, 1995). The following section will explain the rationale for the current research methodology, recruitment and sampling method, and the data collection and analysis procedures.

Research Methodology

Although many quantitative studies have identified *why* Canadian addiction counsellors could be experiencing high levels of stress, there is very little information on *how* it is experienced and the impact stress has on them. The current research sought to explore meanings of addiction counsellors' experiences in attempt to have a more comprehensive understanding of occupational stress in the addictions field. Grounded theory methodology posits that descriptions, themes, and eventual theory arise from the data using a systematic yet interactive method of gathering and analyzing data (Strauss & Corbin, 1998). Strauss and Corbin state that the conceptualization of phenomena is closer to reality when they are grounded in the data and emerge inductively, and can "offer insight, enhance understanding, and provide meaningful guide to action" (1998, p.12). A common approach to data collection is through interviewing participants in the field until the point of saturation, or when no new information is emerging from data collection (Creswell, 1998). This approach was fitting for the present study, as it aimed to uncover the detailed experiences of occupational stress in Canadian addiction

counsellors that have not been previously captured in the literature. Grounded theory methodology allowed the researcher to explore the thought processes and interpretations of the participants in depth, and extract more descriptive meaning from the data collected.

A modified grounded theory that focused on conceptual ordering (Corbin & Strauss, 2008) was fitting for this study as the current research does not aim to develop a theoretical framework to explain phenomena, as traditional grounded theory aims to do. Corbin and Strauss (2008) describe conceptual ordering as "the organization of data into discrete categories…according to their properties and dimensions, then the utilization of description to elucidate those categories" (p. 54). This modified design allowed for an in-depth perspective on what is experienced while still following systematic data collection and analysis procedures of grounded theory.

Trustworthiness

Trustworthiness of a qualitative study involves ensuring credibility, transferability, dependability, and confirmability in order to uphold the quality of the study (Lincoln & Guba, 1985, p.290). Credibility, or how accurately the results represent participants' perspectives, was be achieved in this study by clarifying researcher bias (see "Researcher As Instrument"). Another strategy to enhance the credibility of the study is to do an in-vivo member check during the interviews. This is where, in order to provide opportunity for participants to verify interpretations, the researcher clarified, paraphrased and reflected back to participants about what was understood throughout the interview. Transferability, or the degree to which the findings can be applied to other contexts, was established for readers through a detailed description of the research context and participant demographics (see "Sample Characteristics"). To ensure dependability, or the consistency through which the research was conducted and could be repeated, a transparent description of the research process was recorded through an audit trail.

The audit trail includes documentation and memos of the data collection and analysis that were regularly recorded throughout the research process. Confirmability, or degree of neutrality and accuracy of the results, was established by an external audit by the researcher's supervisor who has expertise in the research and data analysis methods used in the present study.

Researcher as Instrument. Qualitative research posits that the researcher's own worldview, assumptions, and experiences are clarified at the outset of the research (Creswell, 1998). In a sense, the researcher is also an instrument of inquiry and his or her outlook will inherently underlay the approach, process, and analysis of the research. In order to clarify researcher bias, the researcher engages in self-reflection and acknowledges one's worldview that is carried through the interpretive process (Piantanida & Garman, 1999).

The primary researcher of this proposed study has worked as a research assistant in an addictions treatment centre for six years, and also completed her 8-month Master's level internship at a women's addiction treatment centre. Thus, the researcher views herself as a subjective investigator who is not separate from the context of the participants in the current study (Morrow, 2005). It was expected that the researcher's previous knowledge about the field and personal experiences with stress as a novice addictions counsellor, would alter the lens through which the data would be analyzed. Thus, to encourage reflexivity, or self-awareness in order to minimize biases (Morrow, 2005), reflections on prior experiences and personal assumptions were recorded prior to data-collection. The researcher also engaged in self-reflective practices to manage subjectivity, such as journaling and theoretical memos, which were used from the inception of the project and throughout the course of data collection and analysis. Theoretical memos were a way for the researcher to record ideas, codes, reflections, and queries as they arose during the analysis (Elliot & Lazenbatt, 2005). The researcher also engaged in

consultation with her supervisor to reflect on reactions to the investigation throughout the research process. The researcher's supervisor also audited each coded transcript and provided written feedback regarding the analysis to the researcher.

Procedures

Inclusion Criteria. Since the Canadian addictions field does not have a unified, credentialing body and is comprised of professionals from several areas of health care (e.g. counsellors, paraprofessionals, social workers, psychologists), the selection criteria was defined in terms of job position and not educational background. Any English-speaking individual working in an addictions treatment organization within Ontario, Canada who (a) identified him- or herself as an addictions counsellor working primarily with alcohol and drug addiction and (b) was in direct contact in a therapeutic relationship with clients were eligible to participate. Both genders were approached.

Participant Recruitment. After ethics approval was received from the Office of Research Ethics and Integrity at the University of Ottawa, participants were purposefully selected from addiction treatment centres. Throughout the month of September 2011, managers of agencies were contacted via e-mail or telephone prior to the recruitment process to request permission to recruit participants at the treatment centre and were given information about the study (Appendix A). Of 13 treatment centres that were contacted, managers of 8 organizations responded expressing interest in participating in the study and a total of three treatment centres were involved in the final sample.

Managers of participating treatment centres were asked to sign and fax a form to the researcher stating their agreement to allow participant recruitment (Appendix B). An invitation to voluntarily participate was then made to addictions counsellors through telephone or e-mail

contact and information about the study was provided (Appendix C). For treatment centres that did not participate, two managers cited that their staff members were currently busy with other projects and priorities, and another two ceased contact after the initial response. One manager responded after the recruitment and interviewing phases of this study were over.

Between September and November 2011, eleven potential participants across the three sites expressed interest in volunteering. One participant who had initially expressed interest elected to not participate, giving the reason that his current schedule did not permit him enough time to volunteer. For those who volunteered to participate, a demographic questionnaire (Appendix D) and an informed consent form (Appendix E) were e-mailed to the participant. The final sample was comprised of 10 participants.

Data Collection and Interview Procedure. Data collection was conducted through face-to-face interviews using semi-structured, open-ended questions, and took place approximately over a two-month period (see Appendix F). After consultation with the participant on the time and location of interviews, all interviews were conducted at the office of the participants at a time of their convenience. All participants provided a signed informed consent form at the beginning of the interview, after an explanation of the form was provided and an invitation to ask any questions was given.

After consent forms were collected, the demographic questionnaire was completed if participants had not already completed their e-mailed copy. The demographic questionnaire was adapted from the Treatment Workforce Survey (Canadian Centre on Substance Abuse, 2004), with questions on descriptive information (age and gender), education and certification, years of employment, years intended to stay in the field, and level of job satisfaction.

All interviews were audio-taped with the participants' permission and lasted approximately 45 to 60 minutes long (M = 52.46). The semi-structured interview questions were created based on guidelines in Creswell (1998) to allow for a reflexive and evolving discussion that addresses the research objectives of the present study. Interview questions were developed to cover the scope of research questions that the researcher aimed to examine after having completed a thorough review of the literature. Seven clusters of questions were formed and included central questions, probes and follow-up questions to invite further conversation.

Although each participant was generally asked all of the questions in the guide, the researcher engaged in the interview process with flexibility and fluidity. Prompts for more depth and detail would emerge spontaneously by the researcher in response to the participant's sharing. Furthermore, follow-up questions were omitted if participants had already addressed the question throughout their sharing.

Sample Characteristics

Participants in the present study included 10 female addiction counsellors who ranged from ages 27 to 54 years old (M=37.8). The majority of participants (70%) held Master's degrees in Social Work and were registered social workers. Other participants held a college degree (10%), bachelor's degree (10%) or had both (10%). Six of the ten participants had certification in addictions studies, with four being certified in addictions counselling. Nine of the ten participants worked full-time, and one worked on a part-time basis (four working days a week). The number of years that participants had been working in the addictions field as counsellors ranged from 2 to 25 years (M=9, SD=*7.09)*, and participants had been holding their current position between 2 to 13 years (M=4.95, SD=4).

The majority of participants (90%) reported either *quite a lot* (n=5) or *a great deal* (n=4) of satisfaction with working in their present jobs. One participant reported *a bit of satisfaction* from working in the field. Participants had varied responses to how long they expected to continue working in the field, with a range between 1-30 years being reported (n=5, *M*=14.4, *SD*=11.15). The remaining participants wrote, "Ongoing," "10+," "Many," and "Until retirement." One participant had left the question blank.

Participants represented a diverse group of addiction counsellors who provided assessment, outreach, individual, and group counselling for various populations with substance misuse issues. Participants were employed at non-profit organizations within a greater metropolitan city in Ontario, Canada, which included two smaller treatment agencies (under 20 staff members), and a larger treatment facility with a multidisciplinary team. Participants' clientele included youth, women, adults, and older adults with addiction. In order to maintain anonymity and respect participants' privacy and details unique to their situation have been removed. In particular, specific details regarding their organization and any identifying information about the participant were removed.

Data Analysis for Conceptual Ordering

Thematic Analysis. Data analysis for conceptual ordering was carried out using systemic thematic analysis procedures (Braun & Clarke, 2006) for identifying emerging themes in the challenging experiences, dilemmas, and stressors of providing addictions treatment. Braun and Clark (2006) describe the process of thematic analysis as being conducted in a six-phase process. *Phase 1: Familiarization and transcription of data*, was first initiated during the transcription of audio-taped interviews by the researcher. After transcription was completed, the researcher read

and re-read the transcripts to become familiar with the depth and breadth of the data. Initial ideas related to the research question were identified and noted along the transcription texts.

Once the researcher felt familiarized with the data, *Phase 2: Generating initial codes across the data set* commenced. Initial codes were generated by systematically reviewing the data set line-by-line, with the intent of identifying, briefly describing, and labeling concepts that were interesting or meaningful to the researcher. The objective of this phase was to organize data so that codes could be eventually grouped into categories based on repeated patterns in dimensions and properties (themes). An example of this coding phase is presented in Table 1.

Table 1

Example of Phase 2: Generating Initial Codes Across Data Set

Verbatim Example	Label	Brief Description
So the people we see is largely the people who have fallen through many, many cracks. And that's a very difficult piece to work with. That's a very challenging piece to work with because you're working with, you know, supporting a person to work through their internalized shame and at the same time working within a system that reinforces that	Sources of Stress	- People "fall through cracks" – difficult - Advocacy for clients in social systems that do not promote "lasting change" and devalue client - System further stigmatizes client

through many messages.

When *Phase 2* was fulfilled for each transcription, the researcher began *Phase 3: Searching for themes and collating codes* by reviewing all coded data and noting patterns in a separate document. The goal of this phase is to "re-focus the analysis at the broader level of themes " (p. 89) and begin to examine and identify the relationships between codes. The researcher sorted relevant codes by extracting coded data into tables that represented emerging categories and subcategories (Table 2).

Table 2

Example of Phase 3: Searching for Themes and Collating Codes

Category	Subcategory	Dimensions and Description	Participant (Line #)
Sources of Stress	Systemic Stressors	Lack of resources and funding - A lack of resources for high needs mental health and addiction clients	P1 (38), P2 (501), P3 (40, 54, 83, 292) , P4 (53, 80, 115), P6 (45, 179), P8 (21, 60, 528), P10 (29, 39, 406)
		Stigmatized Clientele - covert discrimination in systems, hospital, other health care setting or professionals; less resources;	P6 (465, 468, 484 – 533), P7 (72, 126, 240), P10 (30)
	Therapeutic Work With Clients	Trauma, Losses, and Heavy Suffering - Sadness and heavy suffering – loss & grief, trauma, sexual abuse, prostitution, incarceration, difficult lives, raw emotions; hearing troubling disclosures	P1 (45, 361, 407), P2 (186, 195, 300, 468), P3 (244, 532), P4 (492), P5 (31, 52, 71, 151, 322, 369), P7 (76), P9 (190, 378, 497), P10 (224)

Stress Management and Intervention	Cognitive Prevention and Coping Skills	Setting Boundaries - maintaining realistic expectations and managing level of care	P1 (71, 111, 168, 351, 413), P2 (207, 281, 468) P3 (405, 415, P4 (2382, 395 – 400-403, 544), P5 (248, 309), P6 (235, 260, 425, 442, 561), P7 (508, 521), P8 (323, 483, 510) P9 (272), P10 (146)

It should be noted that the researcher's supervisor audited each transcript and provided feedback regarding coded data between *Phases 2* and *3*. The researcher then reviewed and integrated feedback, making appropriate adjustments to both completed and ongoing analyses.

In *Phase 4: Reviewing themes and mapping the analysis*, data that had been collated into categories and subcategories were reviewed and refined for clarity and accurate representation. A category was considered evident when data within the categories had distinctive properties and dimensions that were clear and identifiable against other categories. The researcher also followed Braun and Clark's (2006) guidelines when considering the "keyness" (p.82) or the importance given to data when developing and reviewing the categories, subcategories, and dimensions.

Braun and Clark explain that the prevalence or number of times a certain data item appears in an interview does not necessarily denote that this theme of data is more important in comparison to other data with less prevalence. Rather, data is endorsed when it presents meaningful information to the research question, and the present study adhered to this guideline during analysis and in reviewing categories. However, Braun and Clark also emphasize consistency in researcher judgment when determining which data represented keyness to the research question. Thus, the researcher also referred to the tables of collated data developed in

Phase 3 to further inform her of what data represented clear patterns of dimensions, subcategories, and categories.

After reviewing all collated data for clarity, keyness, and accurate representation, the researcher then moved onto *Phase 5: Defining and naming themes* and *Phase 6*: *Producing a report of the analysis*, which are presented in the Results section.

Constant Comparative Method. The constant comparative method (Glaser, 1965) was also applied throughout data analysis and the development of themes into categories. Constant comparative method is a process fundamental to grounded theory research, where data are analyzed and evaluated continuously throughout the course of the data collection against the data that was previously coded. The rule for the constant comparative method as defined by Glaser is: "While coding an incident for a category, compare it with the previous incidents coded in the same category" (p.457). This continuous examination ensures that emergent categories accurately represent and are grounded in the data (Elliot & Lazenbatt, 2005).

CHAPTER IV

Results

The results demonstrate that participants in the current study experience a wide range of stressors. Participants indicated various symptoms of stress that arise from occupational stress and discussed how stress was managed. Four main categories were developed from the data collected: *Sources of Stress, Signs and Consequences of Stress, Stress Management, and Intervention and Resiliency Against Stress.*

Sources of Stress.

The following describes they key areas in which these participants experience occupational stress as addictions counsellors. Sources of stress (Table 3) were divided into five

subcategories: *Individual Stressors, Paraprofessional Stressors, Organizational Stressors, Systemic Issues* and *Therapeutic Work with Clients*.

Table 3

Sources of Stress

Category	Subcategory	Dimensions	Verbatim Example
Sources of Stress	Individual stressors	• Sense of responsibility	• "*I want everyone to succeed and I almost feel guilty if they don't.*"
		• Projection	• *"It's really stressful if that's an expectation or goal that I have [and] it's not a client's…"*
		• Multiple commitments and roles	• "*[Teaching] is something that's outside of this place, but it still adds to the stress…"*
		• Self-doubt	• *"I still have that feeling of just not being really [confident]."*
	Paraprofessional stressors	• Maintaining own recovery	• *"Immersed in their roles as a counselor and then crash and burn and use."*
		• Countertransference	• *"You may trigger the client, you may trigger yourself."*
		• Professionalization of field	• *"Are you in the right field or [is] anyone going to recognize you anymore?"*
		• Self-disclosure of addiction history	• *"I rarely disclose that I'm in recovery."*
	Organizational stressors	• Management turnover and absence	• *"Changing of the managers the last couple years has been really unstable."*
		• Management style	• *The "unreasonable demands of a manager"*
		• Team dynamics and internal politics	• *"Teams in itself can be dysfunctional"*

	• Limited staff and high workloads	• *"You're still doing the work of two."*
	• Inadequate organizational stress management	• *"The support [for stress management] may not be there on a concrete level."*
Systemic issues	• Lack of resources and funding	• *"There isn't anywhere to refer them really."*
	• Waiting lists and the revolving door	• *"[Cutbacks] put more of a workload on us to help accommodate clients that are desperately needing support…"*
	• Chronic work overload	• *"It's kind of this never-ending cycle of people…"*
	• Complex systems and case management	• *"[The referral system] can be quite a navigating nightmare."*
	• Paperwork	• *"You can be drowning in paperwork."*
	• Stigmatized clientele	• *"They get treated really, really poorly."*
	• Lack of trauma training	• *"I was not given any guidance or training around [trauma]."*
Therapeutic work with clients	• Trauma, loss, and heavy suffering	• *"We hear the unspeakable and unthinkable, all the time."*
	• Unpredictable and crisis situations	• *"Having to figure stuff out in the moment.*
	• Rise in concurrent disorders	• *"It's different now. It's more mental health."*
	• Other players involved	• *"The clients that I work with have all of the above issues."*
	• Commitment levels	• *"The difficulty clients have in following through…"*

Individual stressors. One of the major categories that emerged from the interviews is Individual Stressors, or internal reactions that come from the addiction counsellor that cause strain. The dimensions of these individual stressors are: sense of responsibility, projection, having multiple commitments/roles, and self-doubt stressors.

Sense of responsibility. Many participants expressed that stress was often influenced by their desire to "save" or "fix" clients' problems for them and wanting to see clients succeed. As Participant 2 said, "It's hard not wanting to control, wanting to just fix people and make it better and solve their problems for them." Many participants also discussed wishing they had control over the treatment outcome and the difficulty in letting go of that desire. Participant 10 echoed this desire:

> I think a lot of it is my stuff around I want to help clients, I want to see them do well. I want them to have success and to be well and healthy and not suffer. And that's not always within my control and that's stressful. (Participant 10)

It was not uncommon for counsellors to feel personally responsible for the client's progress. Participant 3 reported feelings of guilt and the struggle to maintain the boundary around who was responsible for client change:

> It's an ongoing struggle, not only with trying to help them in treatment that they require and… not doing as much work for the client if the client isn't giving it back. So I'm really trying to find that balance as well. I want everyone to succeed, and I almost feel guilty if they don't – but I have to remember myself that that's not my place.

Participant 1 found that the desire to "fix" the client's problems was a factor that may have led to burnout:

> Knowing that I can provide you with the tools and I can help support you and I can give you counselling, but you have – but I can't fix your situation. You have to take those tools and want to change your life. And if I stay on that path, then I don't burn out. If I start to waver off that path, I begin to want to really rescue and fix this particular client, then I'm burning out.

Participant 8 also described the difficulty in maintaining boundaries:

> It's different than knowing that that's not my job to fix it, but then actually feeling it is. There's a disconnect there sometimes so it can be frustrating for sure. So yeah, I definitely get pulled into that sometimes and a lot of it comes from, you know, the parents sometimes freaking out… It can rub off on you. So you need to sort of stay grounded.

Projection. Imposing one's own ideas about addiction on the client was found by participants to be a source of stress. Some realized that they were unintentionally projecting their own expectations onto their client, which had put more strain on the therapeutic process.

> I was expecting or having this belief that anybody could achieve abstinence if they just worked hard enough, and if I just worked at it well enough that they would achieve this place of abstinence… It might not be their priority and to impose that is not client-centered, [and] it's also really stressful if that's an expectation or goal that I have, when it's not what a client's expectation or goal is. (Participant 10)

Participant 6 experienced that, especially in addictions counselling, projecting personal expectations about recovery is an ineffective and stressful approach to working with clients and will negatively impact therapeutic progress:

> When you go in with this preconceived notion of what rock bottom is, you're going to be very surprised of how much lower that actually is for some people… You can't go in thinking, well, this is what would work for me if I had this addiction. We don't know necessarily what it's like to have that particular addiction. So you can't go in with your own notions of what you think is going to work if it was you in that situation because it isn't you.

She added, "Why encourage someone to achieve a goal that might be unrealistic for them and then it's just going to set them up for failure anyways?"

Multiple commitments and roles. Many participants had multiple commitments and other responsibilities in their lives. For example, some experienced the challenge of balancing the responsibilities of being a parent along with the demands of the job. "As much as you try not to bring stresses from outside… I just had a baby, so I'm trying to experience or trying to figure out the family versus work balance, and I find that can be really stressful" (Participant 3). Others were also supervisors on site, taught courses at schools, or were members of committees. While they found these commitments important and the roles enjoyable, it was an added responsibility that increased their workload. For example, Participant 2 disclosed:

> [Supervising is] the additional thing and right now because everything is doubled, it's just a lot at once. I also teach at [a college] one day a week… So that's something that's outside of this place, but it still adds to the stress, right?

Certain participants had also been completing post-graduate degrees in addition to working at certain points in their career: Participant 1 shared:

> I was finishing doing my master's at one point, which was out of town and I had to commute, working full time and managing part time practice as well, and feeling excruciatingly stressed…

Having multiple commitments related to their profession, as well as personal commitments outside of work, had compounded the stress that participants felt.

Self-doubt. Feeling unsure of their competency was another stressor for many participants. For example, Participant 10 explained, "The other stress that I have is around knowing how to best support clients with their recovery… I guess sort of believing I have the skills to work with the client on what they want to be working on." Self-doubt and having high expectations also seemed to contribute more stress for participants who were earlier in their career. Some expressed that they have unrealistic performance expectations for themselves, which produces added stress. Participant 3 said:

> And I don't know if it's because I'm so new in the field, I've only been in the addictions field for two and a half, three years… I want to save the world still. I still feel like every client can be helped. Consciously I know that's not the truth, but in my heart and soul I want to help everyone. If I keep going this way, I'm sure I will face burnout. I guarantee it.

Participant 8 also expressed that, being a fairly new graduate, she was feeling some self-doubt about her competency in the field. She said:

> "I'm pretty knew to the field, I graduated two years ago so I'm still able to be pretty in tune with that...I still have that feeling of just not being really [confident]."

She further explained:

> I think there's also this expectation sometimes when you're coming out of school like you're the expert, you should really know what you're doing. I never really bought into that, but there is sort of some expectation that I should really know what I'm doing here.

Participants with more experience also shared that earlier on in their career, they had experienced a similar pressure that added stress, but that they now feel more comfortable in their roles.

Paraprofessional Stressors. Personal experience with addiction can be a great source of resiliency and motivation to working in the field. However, there were certain stresses specific to having a history related to addiction that emerged: maintaining own recovery program, countertransference, professionalization of the field, and self-disclosure.

Maintaining own recovery. Being "in recovery" is traditionally considered a transformation from misusing alcohol and drugs into a stage of healing and sobriety, and is often used as a label to identify oneself as being someone who is no longer active in his or her addiction. A unique feature of the addictions field is that, traditionally, the counsellors working in this area were likely to be in recovery from their own addiction. Participant 1 talked about how important it is to first maintain one's recovery program before caring for others:

> The one most key component, because you get a lot of people who come into this field that are in recovery themselves from drug addiction and alcohol…People get involved as counsellors, they let go of their own recovery program and what their self-care was and become immersed in their roles as a counsellor, and then crash and burn and use.

Countertransference. Although the majority of participants spoke about self-awareness of their own biases and personal issues as an important aspect to their work with clients, some participants spoke specifically about addictions-related countertransference that can occur.

Countertransference may include any feelings or reactions to clients that arise from the counsellor's personal experiences with or beliefs about addiction and recovery. For example:

> It's difficult especially because I have a family history of substance abuse. It's hard, it was hard at first to sort of step back…because sometimes it would remind me of certain things in my family and my own experience. I would have to step back and say, this is not you anymore, your family… This is somebody else and you can't control the situation. That was a difficult thing to balance for sure. (Participant 2)

Participants also discussed the negative effects of countertransference on stress and therapeutic work with clients: "If you don't manage your own issues and countertransference with clients, and it spills into the session with clients, then you can end up having to do a lot more work. You may trigger the client, you may trigger yourself" (Participant 1). Participant 5 talked about the stress that can be involved in emotionally laden therapeutic work and countertransference:

> Be prepared to face stresses and strains of working with humans in a very raw way. Having things from your personal life where, if your emotional baggage is not dealt with or in the process of being dealt with – if you've gone through abuse, if you have a father or sister or someone that's misusing substances – it's important that stuff is dealt with as much as possible. A lot of people want to help people they can relate to, but if you haven't closed that door then it's going to keep on triggering and it's not going to be helpful for [the client].

Professionalization of field. Some participants had experienced stress related to the growing professionalization of the addictions field. The professionalization of the workforce, or the adoption of evidence-based practice, moved the addictions treatment field away from its grassroots development and brought more counsellors into the field without a history of

addiction. Participant 7 described one stressor she previously had as being the "dichotomy between service users and service providers":

> I think what could be stressful is the assumption that somebody with a lived experience of substance use is going to do a worse job of doing counselling than somebody who doesn't have one, because they won't be able to be objective… In other fields like feminist counselling, it's a positive thing to have a lived experience of working through your journey. But somehow in this field, it's a different set of rules.

Participant 7 also spoke about a dichotomy on teams that occurs between those in recovery and those who are not, and "this tension around how to work with a team where some people may have a substance use history and some may not, and how to work with that and stay in solidarity with each other."

Participant 4 had similarly illustrated this tension in her sharing. When asked about the professionalization of the addictions field and the impact on counsellors in recovery, Participant 4 said, "There's not even a handful of us. It definitely affects us." She discussed how the stress for her was not about moving ahead in the agency, but about the pressure to obtain further education and feeling undervalued by peers. She said:

> I know other staff get very stressed when a new staff is coming in and they're presenting something, and it's just – makes us feel as though we're not competent enough and that's not the truth… I think it's just when it was first happening, it was stressful and [you] question, you know, are you in the right field or if anyone going to recognize you anymore.

Self-disclosure of addiction history. Participants who were in recovery had varying opinions about disclosing to clients that they had a relationship with substance use. Participant 1

discussed separating one's own recovery values from her work as a professional, and the importance of setting this boundary for counsellors who are in recovery in order to minimize stress:

> I rarely disclose to clients I'm in recovery. It's just not that important to me anymore. You know, it doesn't seem to matter. What matters is the therapeutic alliance you build with the clients who can trust you – for me, regardless of whether you're in recovery or not. I think telling someone you're in recovery is just an easy way to build a rapport, which can sometimes backfire.

She emphasized that having this strong professional boundary is necessary in preventing counsellors from imposing their own recovery values onto the client. She noticed this often occurs for new counsellors in recovery who may not have developed the awareness that they are "pushing their values and belief systems onto their clients because they think that's what worked for them" (Participant 1). Similarly, Participant 4 shared that she does not usually disclose to clients, "unless I really feel that there is someone that really needs to hear it."

Conversely, Participant 7 described that for her, the disclosure of having a history of addiction to managers or colleagues had been more of a stressor than the disclosure to clients when she first began working in the field.

> It's a very tricky thing to disclose that you, that I've had a relationship with substance use. And I find that much trickier with my colleagues than it is with [clients] I work with…I don't subscribe to some of the more rigid ideas around boundaries and authority, in terms of what to share with people. When I disclose, I err on the side of sharing less. I disclose not to work out my own stuff, but it's usually when a person has been revealing a lot and they just want to know something about me, I'll just answer the question.

As she had explained earlier in another section, she found the assumption that paraprofessionals would be less objective with clients as being more stressful than self-disclosure to clients.

Organizational Stressors. It was found that organizational factors affect stress levels in some way for all participants. Organizational stressors are characteristics or functions of the workplace or work culture that may increase feelings of strain in the addiction counsellor. The dimensions that emerged include: management turnover and absence, management style, team dynamics and internal politics, limited staff, high work loads, and inadequate stress management.

Management turnover and absence. The majority of participants experienced higher levels of stress when they felt that there was a lack of presence from or turnover in managers such as managers leaving the agency or changing departments. Participant 2 noted that the level of stress affects all staff members including managers, which impacts the capacity to receive supervision:

> Because we're all so busy, if we need to discuss something with a supervisor or manager, they're often not here, they're often doing other things. Or if I just want to debrief with some of my other staff members, you don't really have the opportunity to do that all the time because everybody is so busy. So just even to track someone down is hard to do.

One participant discussed how instability and turnover at the management level has impeded on her ability to find support.

> Changing of the managers the last couple years has been really unstable… There's not always the same manager in for the same year. You know, there's one year a new manager, next year a new manager, and next year a new manager. It's very unstable and you don't know who you can go to for support. (Participant 4)

Management style. Many participants also felt that the manner in which managers made decisions, communicated, and related to their staff members affected how well the team functioned overall. This would also have a direct impact on the stress levels experienced. Participant 9 discussed the stress of working with a manager who had a micromanagement style of leadership. "That made it so hard. The job was already hard." She explained:

> The biggest stressor is the demands, unreasonable demands, of a manager and it sort of affects the whole culture of the organization… And we just kind of ignored it a lot of the time and just white knuckled it through that time. But it was very hard. It was very hard.

Inconsistent managerial decision-making was also seen as a contributor to stress by Participant 1:

> There have been times where there is not strong management and the team was not functioning well… Particular client decisions were made that maybe certain staff members may not have agreed on. Certain policies were not enforced, there were mixed messages about policies. Certain staff members that needed to be addressed and weren't.

Participant 7 also discussed the difficulty in effectively coping with stress when there was a lack of support and sharing of responsibilities:

> When I'm working in a situation where I don't feel like I have [support from management], then that can also contribute to it because I don't have another person who can say, 'Okay, this is an important issue, we see this as something that affects the broader team…' It doesn't take the work off my plate and it also means that the support is not shared in working together, right? In sort of just working together. So that's another factor I think in terms of quality supervision, quality management.

Team dynamics and internal politics. Another organizational stressor comes from the internal conflict or tensions that can occur within the workplace. The team dynamic can often be "dysfunctional," as one participant described, adding stress to the environment.

> Teams in itself can be dysfunctional, and if the team itself is not functioning well together that can be stressful… If you've got a staff member that is not doing well themselves or maybe burnt out themselves and not able to see it, and in team meetings it's quite, it makes the collaboration more difficult. (Participant 1)

Like many participants, Participant 3 pointed out that the whole team is feeling strained, and she has felt the negative effect of stress on the group dynamic:

> They complain a lot about stuff they have to do, paperwork that has to be filled, computer programs we have to fill out and do with clients. It's like, this is our job, we all have to do it…As a team, we're not really coming together and saying look, we're all stressed out right now, we all have so much to do, but it's not going to change everything if we keep putting up all these roadblocks for each other.

The stressful atmosphere can also affect the morale of individual workers:

> [Group supervision is] twice a month and I only go once a month because I have to take care of myself. I would rather take my notes than hear someone vent about how burnt out they're feeling because, you know, I'm feeling tired too, right? But it's not going to help me sitting in that meeting, it's going to make me more upset. (Participant 4)

Limited staff and high workloads. When organizations had a lack of available staff, participants reported an increased experience of stress, as the extra workload would be divided among current staff who are already overloaded:

> Lack of staff, staff leaving, taking time off, taking whatever leave they're taking, and jobs not being filled or new staff being hired that are not trained…You're still doing the work of two. I mean, that's been quite stressful with all the cutbacks. (Participant 4)

Some participants reported that stress and exhaustion experienced by individual workers also had an effect on the rest of the agency.

> I think it just all has to do with everybody just has so much on their plate right now. They haven't been able to fill those positions, or if they have been able to fill it, it's an internal move and then that person's position is now open. So it's sort of a domino effect. (Participant 2)

These participants described the consequences of having their peers go on mental health leave, and how it affects the stress of their own jobs.

> I mean, there's people here who have had burnout and they're not here right now, they're on mental health leave. So that itself [is stressful], as there's limited therapists to run groups. So what can I do? So it's just this daily, crappy situation that I have to come into everyday. (Participant 3)

Another participant described how working in an agency with smaller staffing can be stressful. She described feeling unequipped to treat the complex cases they often receive:

> In terms of manpower, [we have] very few people on this team. So it's difficult to try and accommodate sometimes… In a small agency where you're getting the same types of clients [as large organizations] and not having the resources, that's probably the biggest stress for me. (Participant 8)

Without direct access to psychiatrists and other resources that multidisciplinary teams in hospitals might have, as well as being a smaller agency, a lack of staffing resources has added more stress for her.

Inadequate organizational stress management. Some participants felt that management, who were responsible for the organization on a structural level, were not proactive enough in implementing methods for stress management, such as making more connections with resources in the community or reaching out to their employees. For example, Participants 7 explained how her manager does endorse the practice of stress management, but is not necessarily active in helping to reduce stress within the organization:

> I think the idea of stress management is absolutely supported, but when it comes out to sort of concretely problem-solving around how to do that, then that's where I feel like there's a gap... I think the intention is there, but the support may not necessarily be there on a concrete level. And that's due to a host of factors from individual personalities, to funding, to monetary resources that may or may not be available.

All participants agreed their managers encouraged self-care practices, but some participants felt it would help to have more outreach and action-oriented support by management.

> It would be great if we had access to what we needed to do the job better and that would lead to less stress. But that doesn't happen, so I guess you have to figure out what to do with what you have… [For example,] access to a psychiatrist or a psychologist if we need to consult. So things like that, sort of structural – putting things in place so that [we] don't need to burn out in trying to do stuff that we can't really do. (Participant 8)

Participant 8 stated that the lack of support for stress management greatly impacted the impression she had of staying in the addictions field for the long-term. Likewise, several

participants expressed the desire for their agency to increase stress management resources and share more responsibility in helping employees deal with work stress.

Systemic issues. Issues within healthcare and social systems were clearly a significant stressor for these addiction counsellors. Participants expressed that the limited resources available created long waitlists, and complex yet disconnected referral processes increased job demands on workers who felt pressured to help clients until they were connected to appropriate support services. Participant 7 spoke about how advocacy for her clients was the most stressful part of the job due to the barriers that currently exist in the system, and many participants expressed similar experiences. She shared:

> You're dealing with bureaucracies that are actually set up to not create lasting change… So I am trying to move an issue forward, I'm trying to do it in a context where the lens does not necessarily see the work I do as valuable or useful. Useful in terms of, I think a lot of people give up on people. So the people we see is largely the people who have fallen through many, many cracks. And that's a very difficult piece to work with. That's a very challenging piece to work with because you're supporting a person to work through their internalized shame and at the same time working within a system that reinforces that through many messages.

Participants explained that these systemic barriers not only prevent their clients from reaching their recovery goals, but also reinforced the cycle of addiction. These systemic barriers include: a lack of resources and funding, waiting lists, complex systems and case management, stigmatized clientele, and paperwork.

Lack of resources and funding. All participants spoke about the difficulty in connecting their clients to community resources, most often because there simply are not enough resources

available for those with addiction issues. This is made even more difficult if the client also has a concurrent mental health issue. For example, Participant 8 spoke about the difficulty she experiences when the appropriate services clients need are not available. She said:

> You want to try and help everyone who walks in the door, and if you can't, if you're not the right person, then the best thing is to probably refer them somewhere where they can [get help]. The issue with that is that we maybe aren't equipped to deal with concurrent disorders, but there also isn't anywhere to refer them really. So it's trying to do it all, I think. Trying to sort of bite off more than you can chew sometimes, just because there's not that many options really… That has been very stressful…

The helplessness addiction counsellors commonly felt to take on unsuitable clients frequently contributed to an overwhelming workload. It was evident that all participants felt the current health care system did not accommodate the increasing complex and multi-faceted needs of their clients. For example, Participant 3 talked about the obstacles experienced in trying to find support for a client:

> They do need long-term referrals and long-term support. And unfortunately, an added stress is that there is limited opportunity for ongoing counselling. Funding is down, programs are not accepting referrals or they're closed…So right now I'm kind of having this client in limbo and I'm trying to give him that support, when it's really out of my scope of practice.

Since the system does not have available resources to accommodate the clients' needs, counsellors are left to deal with clinical issues that are not within their scope of practice. However, participants reported feeling ethically responsible to continue care since these clients

have nowhere else to turn to for support. These dilemmas compound the stress experienced by counsellors.

Waiting lists and the revolving door. Participants reported feeling frustrated for clients who are on long waiting lists, and felt a certain amount of pressure to keep clients in a safe space. Some spoke about the difficulty of not knowing what happens to clients when they drop off the waiting list. Participant 2 described:

> You often lose clients that way. And they give up, they stop coming, and you don't really know what happens to them. That's a hard thing to just not know where they go or what they do.

Similarly, Participant 4 talked about how it can be stressful to know that "clients disappear" when having to wait for so long to receive support. She explained, "Not losing the client is an important factor for me and it becomes stressful… Losing them when they need it the most. Not being able to get them in when they need it the most."

Although most acknowledged that there was only so much they could do to accommodate the need for services, some participants reported still feeling pressured to take on more clients due to the high-risk for death or overdose in clients dealing with issues of addiction. For example:

> People have to wait several months to get into residential treatment. They have to wait to see therapists individually. And so we try to accommodate as many clients as we can so they don't have to wait as long. There's more and more cut backs in the system, so certain positions that were left and not filled and are eliminated, which puts more of a workload on us to help accommodate clients that are desperately needing support, and

> probably may die waiting for support. So we work harder at accommodating that, and it gives us very busy schedules. (Participant 1)

In knowing that these are clients who are often in "life and death" situations, Participant 1 felt the need to take on more clients despite an already high caseload.

Chronic work overload. The pressure to accommodate as many clients as possible due to the long waiting lists also seemed to create a sense of perpetual overload**.** Some participants expressed that they did not feel the stress and problems with workload were going to get better. For example, as Participant 3 said:

> It comes back to the resources and the lack of resources right now. So it's this forever, daily struggle with finding clients the right resources in the community until they can get into our group. And I don't know if that stress will ever go away… It's kind of this never-ending cycle of people, like a herd of cattle. I want to just keep moving on, moving on, moving on, but it's like when is the end? When are we going to just get a group that should just be at least 15 people? I can't see that for months.

This long-term accumulation of stress brought Participant 8 to feeling burnt out:

> I definitely function in my daily life at high levels of stress that may not be overtly visible…. I was getting the extremes of everything since I walked into work two years ago. And it was acknowledged and it was kind of like, 'Oh, that's funny, that keeps on happening.' But it's sort of not really funny anymore.

She expressed that the intensity of her caseload had taken its toll and that she eventually had to take a break due to the accumulation of stress.

Complex systems and case management. Participants felt that another factor which compounded stress were the systems involved in the client's long-term care (such as the

healthcare, criminal, welfare systems), which were experienced as being complex and frustrating to work through. Case management (or the referral, advocacy, planning, and coordination of support services) was seen as important to their clients' recovery and necessary in helping to stabilize the client, but was often a challenge due to the difficult processes involved in finding appropriate resources. As Participant 1 described, "Just trying to figure out what the referral process is or trying to figure out where to send the person into mental health. It can be quite a navigating nightmare." Participant 7 shared a similar experience:

> It's just really poor coordination between systems. So the criminal justice system doesn't line up with the residential treatment services, does not line up with the court system on bench warrants. There isn't a way to viably communicate together. So a lot of time things, plans fall through, plans fall through, plans fall through. (Participant 7)

Many participants expressed that they did not understand how clients are expected to be able to navigate through the roadblocks in the system if they themselves found it so difficult. As Participant 5 said,

> I just think organizations could be more connected in terms of recognizing that we're all colleagues and making those bridges… Being more open-minded rather than having turf wars. If I have such difficulty navigating through such a complex system, how does someone who is eighty-something or sixty or fifty or whatever, and doesn't know the right things to say, and to jump through these complex systems of how to get service in place.

Indeed, participants voiced that these barriers can become a therapeutic challenge for themselves as counsellors, adding stress that often felt unnecessary and time-consuming. Participants also

felt that a lack of collaboration among other service professionals created difficulties in the advocacy role. For example, Participant 6 disclosed:

> Perhaps this client had some services through some particular agency and our representative from that agency decided that okay, well, this client no longer qualifies for this amount of services or any services at all. So then trying to advocate – sometimes when you're advocating on behalf of a client and you're just facing walls, it's very frustrating because there are certain things that I can't do… It's harder for me to do my role when those things are happening.

Participant 6 further explained that when basic needs like housing or personal support are not addressed first, they become triggers to stress and shame, which then becomes a trigger to use. Thus, when she is unable to help a client with having these basic needs met, it affects her ability to help them with their substance use treatment goals.

Paperwork. One frustrating and stressful aspect of working in the addictions field reported by the majority of participants was the amount of paperwork that needs to be completed, which many felt took valuable time away from supporting clients. The Ontario provincial government mandates several assessment measures to be completed in addictions services, and similar paperwork is often repeated across referral resources. Participant 1 illustrates the time-consuming nature of paperwork in her sharing:

> A lot of paperwork that the Ministry of Health wants done, outcomes measured, tools done. It can be quite an arduous task, just paperwork alone… I mean, in order to do an assessment here, it takes a good two hours. There is about eight different tools that the government wants done plus another mental health one and then another 8 page

> assessment, and then to do the paperwork to refer clients somewhere else… It can be really, you can be drowning in paperwork. (Participant 1)

Although most participants recognized that the paperwork is important in receiving funding, they felt that their time could be better spent doing other work-related tasks – especially in the case where the same information is being produced again.

> My big stress with [the paperwork] is the darn stuff that's redundant. There's two reporting systems or three reporting systems and that's duplication of the clinical information… There's such a demand on that, it means other things go by the wayside. I have other things that I'd like to do during the year and [the paperwork] sort of eats away at the time. (Participant 9)

Stigmatized clientele. Individuals with addiction are often portrayed as and assumed to be morally weak, dangerous, blameworthy, manipulative, and to have limited skills. Participants found that due to this stigma associated with addiction, their clients often experience covert discrimination in the systems, hospitals, and other healthcare settings or professionals.

> A number one stressor for all of us in the field is that our clients get treated differently than other clients. So the client comes into the hospital with diabetes, and is sick from diabetes or they have heart problems – but our clients come in with mental health and addiction issues and they get treated really, really poorly. So it's hard to see that, to witness that all the time. (Participant 9)

This stigma also further limits the resources that clients are able to access in an already complex system. Participant 7 discussed how it was stressful to work with other healthcare professionals who held negative views of her clients, especially in a recent experience where it hindered her client from having a home. She explains,

> I was having a conversation with the social worker – it was a short one, but I just said, you know I hope we're not having a discussion about whether or not she's deserving about having a place because she does need to have a place… I felt that there was a lot of judgments and these judgments were actually affecting her ability to have a safe place to live. Where I became really stressed, too, and I shared this with the person, was that I am going to be picking her up. Where am I supposed to take her? …But there was the added stress of having to have this conversation that I thought was actually very offensive and insulting.

Many participants spoke about how difficult it was to witness the harm other health professionals cause through their judgmental attitudes, and it can become a therapeutic issue as it takes time away from processing issues related to the client's substance use.

One participant talked about how this stigmatized attitude also affected addiction counsellors professionally. Participant 9 highlighted that addictions counsellors are not remunerated at the same level as those working in the mental health field, despite treating a large majority of the clients with concurrent mental health issues in their agency. She explains,

> We're the poor cousin of the mental health field. We're not compensated in the same way as mental health is. And the reality is that we are working with a population that – about 70% of our clients [have] concurrent disorder, it's not just addictions. We all have different backgrounds. My background is gerontology, and we have somebody else who's background is medicine, somebody else is nursing, and some others are social work. So we have a multi-disciplinary team, but we're treated as addiction workers and not compensated in the same way as people in the mental health field.

Participant 9 illustrates the frustration in receiving unequal compensation, despite having similar qualifications and providing support to the same disorders along with addiction.

Lack of trauma training. All participants spoke about having clients with experiences of trauma (such as physical, emotional, or sexual assault) as being a part of their caseload. However, many participants also spoke about the lack of trauma training they received either in school or with their agency. For example, Participant 8 shared:

> With the more serious trauma, it's a challenge because there's a whole skill set on how to work with that. And for me, I was not given any guidance or training around that. So I had to seek it out myself, which I did. So I tried to speak to people who know what they're talking about around [trauma]…There should probably be more training at agencies where people are coming with very little background, and my experience is there really isn't. So that is, yeah, stressful.

Similarly, Participant 3 also felt that in the addictions field, they are not informed about trauma, which she has found surprising given the high prevalence of trauma in the population:

> We don't have a lot of trauma background and when we hear these significant stories, it can really affect us. And the burnout comes, but this vicarious trauma happens as well. So I think it would be interesting and necessary for an addictions therapist to get more information and support about that…People usually for the most part don't just wake up one day and say, 'I'm going to start using.' It doesn't happen like that. I would say probably 75% of the clients I've seen have trauma. Physical, sexual, or emotional. And that's significant, and the fact that we're not getting support on that piece makes me questions this field in some respect with not supporting us through that.

Participant 3 highlights the gap in workforce and educational systems in providing knowledge and training so that counsellors may feel more prepared to deal with intense and complicated client issues they are likely to encounter, like trauma, when entering the addictions field.

Therapeutic Work With Clients. Participants also described that although they found the work with clients to be the most fulfilling aspect of their jobs, certain aspects of their therapeutic work can also be a source of stress. Bearing witness to the trauma, loss, and heavy suffering; experiencing unpredictable situations; clients with multiple issues and concurrent disorders; and a lack of client commitment were reported to be some sources of stress.

Trauma, loss, and heavy suffering. Participants spoke about how their client's addiction is used as a way of coping with adversity and pain in their lives. It often then becomes part of an addiction counsellor's role to process intense emotions with the client. As Participant 9 described, "we hear the unthinkable and unspeakable, all the time." A majority of participants shared how they have found it hard to be witnesses to the sadness, suffering, trauma, and losses of their clients. Participant 5 talked about the stress of having "a very intensive caseload" and the difficulty of "continually witness people suffering." She further explains:

> Having someone who hasn't really engaged in the community too well or too much. The stigma and just the frustrations, isolation, loneliness, and wanting just to talk or someone to talk with and not knowing how to communicate those needs… Trauma, some partner is dying or overdosing, or people dying. I have several – I have many people who die of overdosing [or] living in a shelter for over a year.

When Participant 2 was asked what she found to be the most challenging, stressful, and difficult aspect of her job as an addictions counsellor, she illustrated what it was like to hear the range of difficulties that her clients have experienced.

> I would say hearing the traumas that some of these individuals have been through. Losing ones they love or being abused by other people. A really difficult one for me would be the sexual abuse. Hearing things like that, especially if it's incestuous. Or hearing the stories of those clients coming from jail and some of the abuse they experienced in the jail system was really difficult, and some of the things they felt they had to do in order to protect themselves or in order to get drugs or alcohol. The desperation and the things they would do in order to – and the shame they felt because of that. I find that very hard.

Many participants spoke about the reality of working with clients who have an addiction, where clients overdose and commit suicide. For example, Participant 1 shared:

> We work in an area where a lot of clients will die from this, so we deal with loss and death from drug abuse…I've had a number of clients who have died from addiction. Sometimes we don't know. They come to treatment, they relapse, and disappear and they may have died. So, it's really the challenge of being ["Jane"] the human and ["Jane"] the professional, and managing them both. (Pseudonym used)

Likewise, other participants spoke about how loss and death of a client are often an inevitable part of the job. Though they realize this, it is still a challenge to experience the death of someone they have been working closely with for some time.

Unpredictable and crisis situations. It was not uncommon for clients to be under crisis where they were feeling overwhelmingly distressed and could not cope, or for unpredictable situations to arise. Participants reported finding crises and unpredictabile client events to be stressful. Participants also discussed the stress of having to react on the spot in situations where they were not certain about what to do, and this was especially stressful because others would be

affected by their decisions. As Participant 9 said, “The adrenaline really gets going.” Participant 6 elaborated on what she found stressful about crises situations and explained:

> Just dealing with crisis issues. I’m not part of a crisis response team. I mean, we do [practice] some crisis intervention, but sometimes what happens is that there’s a crisis where we’re needed to respond to right away and we don’t always have the resources to do that kind of stuff. So if it’s a client who doesn’t have a lot of other resources, it isn’t unusual that the social worker [is] calling me for things I really don’t have the resources to respond to.

These situations would potentially leave participants feeling unprepared and needing to immediately improvise their response. One participant had a client who would frequently act out towards her in sessions, and the transference from the client’s intense reactions to trauma caused feelings of hyper-vigilance for her:

> There was sort of an event that was a catalyst to this relational stuff exploding, and it was well over a year of peaks and valleys of things being okay and then something triggering a big response on his part and then us having to deal with that. So it was always, I was on eggshells for most of that time… I almost didn’t feel very safe here, emotionally safe. I was always wondering what’s going to happen today, what’s going to get triggered, what do I, I have to be so careful about what I say.

Having to constantly engage in impromptu problem solving can be wearing for participants and lower confidence levels in their skills.

Rise in concurrent disorders. Participants discussed how the rise in concurrent disorders and complex cases have been a significant stressor for them. Participant 1 explained that concurrent disorders are particularly stressful when their symptoms are more severe:

> Client that are more ill can be more challenging. Particular kinds that may be diagnosed with personality disorders, like borderline personality or paranoid personalities, and are further up the scale of not doing well, as well as active suicidal clients.

Several other participants pointed out that a large majority of their clients struggled with mental health issues in addition to their addiction. Much of the stress stemmed from having clients with issues that were beyond their scope of practice and learning how to deal with symptoms of mental health conditions. Participant 4 said:

> It's different now. It's more mental health, it's more mental health. When I started working in the field, it was more addiction. There was some mental health – not as severe, not as many clients on medications. It's changed. The clientele has changed a lot and that can be stressful on its own. Learning and adapting, trying, going to different courses to understand it.

Participant 4 also described the difficulty for her clients in gaining access to mental health services and coming to a consensus with other healthcare professionals on which condition (the addiction or mental health issue) gets treated first. "…If they're not stable mentally, it's difficult to really work with them around addiction. So that's a stressful issue here also" (Participant 4). Furthermore, limited resources for concurrent treatment also meant that the participants often had to assume responsibilities beyond their competency. As Participant 8 described:

> People sometimes will only work with the addiction and not the mental health piece, instead of working with them together. And so [it's] hard to find people who will or are able to do both when needing to find that resource for our clients… And again, maybe not being the best place to deal with it here, but not really knowing where else to refer. So trying to deal with it here and that leads to… not feeling effective and knowing that this is beyond what this agency should be dealing with.

Other players involved. Participants discussed how their clients often have multiple basic needs issues that require the involvement of other social systems. Participant 4 illustrated the multi-system client when describing, "The clients that I work with have all of the above issues. So it's housing, they've been using for a number of years, there's legal issues, [Children's Aid] issues, mental health issues." What become stressful for participants is when they are met with numerous barriers while advocating for clients with high social service needs. The barriers, such as not being able to find housing or food, often become uncertainties with how to help the client. As Participant 8 expressed:

> When you add some of these other issues to it, it's just kind of overwhelming. You don't even know really where to start when you're working with someone, but the substance use is not, in my opinion, the biggest issue that sort of walks in the door. There's a bunch of other [issues]… You don't know what's going to walk in the door.

Participant 8 also described that in addition to multi-system needs, there is the difficulty of having "other players involved" (like family members) and the complexity of issues that this may bring to the therapeutic work (for example, when youth use substances with their parents). Conversely, other participants discussed how they are often the only support available in their

clients' lives and the counsellor becomes the main person their clients rely on for their many needs.

> Some clients don't have a full understanding of what I do, they just know I see them in some kind of trusting, professional helping relationship. So then they'll call me for every little thing and I can't address every little thing. And that can be stressful for me. (Participant 6)

Commitment level. Many participants talked about the range in motivation and readiness for change that their clients show, and how it can be stressful when clients display what may be perceived as a reluctance in taking responsibility. As Participant 10 explained:

> I think another thing that can be stressful can be the nature of peoples issues…Like the difficulty clients have in following through, keeping appointments, and showing up to things that are important to show up to… Also knowing that he does, even though he has a lot of concerns, he does have responsibility and does have some capacity. So that's also frustrating because he's not picking up what he necessarily could.

Participant 6 shared how the motivation level of a client can affect stress levels of her work:

> It's really frustrating for me because then I'm always seeing somebody who really is just putting up with me because that is just what is expected of them… Sometimes I do feel like I'm wasting my time a little bit. It could be better spent with a client who really is more willing to do or has more insight and is just more receptive to having somebody come work with them [on clinical issues], not just a social visit.

Similarly, Participant 3 spoke about the frustration she felt when she has given her clients her fullest effort and they do not seem to be progressing:

> So it's like, what is stopping you and why can't you move forward? You know, you've been here for so long, you've tried all these different programs. Still not working. So I feel bad saying it, but it's like, I would rather you move on, try something else, so I can get a client in who I know will use the services to its fullest… It's frustrating on a personal level where clients don't utilize what I'm giving them.

Although participants agreed that relapses are part of the therapeutic process, and therefore an expected part of their job, it can be a challenge to work with clients who have not broken out of the cycle of relapse. Participant 1 highlights the challenge in working with relapses:

> There's clients that may do treatment and then not make it and then die of overdoses, clients that are in the revolving door, a lot of relapsing. That kind of stuff. It's a relapsing disorder, right… I guess feeling the frustration of knowing the person will probably die… that their lives are struggling and there's a lot of consequences.

In summary, the major categories regarding *Sources of Stress* have been presented and the results demonstrate in detail the challenges, dilemmas, and difficulties that participants experience in their work as addiction counsellors. The data indicate that there are several individual, paraprofessional, organizational, systemic, and client stressors in providing addictions treatment that may contribute to heightened levels of stress. Participants shared their physical, behavioural, emotional/psychological, and occupational reactions to these stressors, which will be discussed in the following section on *Signs and Consequences of Stress*.

Signs and Consequences of Stress

The second major category that emerged from the analysis was *Signs and Consequences of Stress*. All participants described the nature and impact of stress on their wellbeing, and the

responses that warned them they were overly strained. The categories that emerged from their sharing included physical and behavioural signs, social signs, psychological and emotional signs, and occupational signs of stress.

Table 4

Signs and Consequences of Stress

Category	Subcategory	Dimensions	Verbatim Example
Signs and Consequences of Stress	Physical signs		• *"Headaches, muscle tension, just feelings of exhaustion."*
	Behavioural signs	• Effect on sleep	• *"I know things are bugging me here when it does affect my sleep."*
	Social and interpersonal signs		• *"When you've been talking all day, you kind of just want to sit on the couch by yourself."*
	Psychological and emotional signs	• Anxiety and irritation	• *"Feeling sort of tense and anxious."*
		• Rumination	• *"I'm starting to think about work and clients at home and that's a big indicator for me."*
		• Emotional exhaustion	• *"Feeling tired emotionally."*
	Occupational signs	• Compromised job performance	• *"Not putting your all in certain sessions…"*
		• Questioning self and profession	• *"Why am I doing this work? Why do I keep on doing this?"*

Physical signs. All participants reported a number of disturbances in their bodies' functioning that alerted them that they were feeling stressed. Physical signs for most participants consisted of headaches, muscle tension, and physical exhaustion. For example, Participant 2: "I

would say headaches, muscle tension, just feelings of exhaustion," Participant 1: "I have neck pain, so the neck pain comes back," or Participant 4: "Very tired. Very tired, run down." Participant 5 said:

> I get stressed out at the end of the day, I can feel knots in my arms. And that's when I do a lot of typing of my case notes, later on in the day. If I've gone through a stressful event, it's in my neck.

Some participants experienced significant consequences on their health that they attributed to being under continual stress. For example, Participant 9 shared:

> I know I'm stressed when I'll get rundown with a cold. And if I'm really, really stressed and I get a bad cold, I'll end up with laryngitis. My body forces me to shut down. So that's my instrument to work with, and that was something that was happening on a regular basis and I eventually did lose my voice and I had to do some speech therapy because my vocal chords went. And again, I do all the speaking for the agency and so that was a big deal. So that taught me to deal better with the stress and take better care of myself.

Behavioural signs. Behavioural patterns also changed for a majority of participants. A disturbance in sleep and eating patterns were frequent among several participants as a sign of stress. For example, many participants reported skipping meals or eating more junk food when they were feeling stressed by their jobs. Participant 6 described the changes in her eating habits when she was stressed:

> My heart rate might go up a bit. I just kind of feel like I don't want to eat anything, you know? I kind of just want to get through the day and focus on [work], but then I'm not focused on the fact that I should drink water or eat lunch or take a break.

Effect on sleep. A common behavioural sign of stress described by participants was having difficulty falling or staying asleep. Participant 10 remarked:

> And I know that things are bugging me here when it does affect my sleep. Like when I have a hard time falling asleep because I'm thinking about things and trying to plan things or ruminating about getting stuff done, and how I'm going to do it and how I'm going to schedule my time. Or waking up in the middle of the night and not being able to fall back asleep immediately. I know things are bugging me if that's the case.

Some participants described needing to sleep for long periods of time in order to recuperate from exhaustion. For example, Participant 4 shared:

> It was really overwhelming. I couldn't believe I got stuck with all this [work] to do. And you get the message, 'But we know you can do it.' Right? And that's the pat on the back and that's nice that you know I can do it – but you need to take care of your staff. And that weekend I was in bed for two days. And I couldn't get up, I was just so burnt out… I kind of just looked at it and said, you know, either I'm going to sink or swim here.

Likewise, Participant 5 felt a severe physical exhaustion from the intense workload and multiple commitments that, as described earlier, many participants also have:

> I remember feeling very, very tired and not knowing – I wasn't familiar with what was going on… But I did have a lot – I was moving, I was applying for my Master's, I was carrying my caseload. I was doing numerous things that weren't typical. Additional stuff

> to the stuff. So I slept for practically two months, in between getting my school stuff ready. And I didn't want to go anywhere.

Social and interpersonal signs. Some participants withdrew from social activities and engagement during times of stress and described wanting to just stay home and be by themselves. As Participant 8 said, "At the end of the day I'm usually pretty tired. I don't really care to talk to anyone again. You know, when you've been [talking] all day, you kind of just want to sit on the couch by yourself." She also described how the stress can have a cyclical pattern, with one symptom influencing another symptom to arise:

> Worrying and trying to plan, to work out something for the next day. I guess [feeling] on edge and so that leads to maybe not sleeping so well, being tired the next day. And so that kind of leads to the whole cycle of going home, not wanting to talk to anyone. I don't want to do anything. It all has sort of an after-effect on each other.

Similarly, Participant 1 noticed that she was less engaged in social interaction when she was stressed:

> I think [stress] impacted my ability to give back to others, like to friends. I could not and won't pick up the phone as much to talk to friends. I don't think I was as engaging with my husband as I could be. I'm involved – I'm in recovery 20 years and I'm involved in 12-Step programs and less likely to engage and participate there with people because I'm feeling tired and stressed.

Some participants talked about the consequences of stress when it is displaced from work onto their loved ones like friends, parents, or partners. As Participant 4 discussed:

> I'll bring it home and I'm not a happy camper. There's arguments and stuff like that. I have to get reminded, I have to get reminded. And that's being totally honest. I mean, I'm not a perfect person and sometimes the stress gets to me to the point where I bring it home. It's not a healthy thing to do, but it happens… I'll get on everyone else's case at home [laughs]. My husband, my poor husband. And he knows how I am. In a few days he'll just remind me of that. "Are you done? Are you done now?"

Thus, the stress they felt often had consequence for not only their health and wellbeing, but the interpersonal relationships they had with others, as well.

Psychological and emotional signs. Participants reported psychological and emotional signs of stress, the most common of which being anxiety, irritation, rumination, and emotional exhaustion.

Anxiety and irritation. Anxiety and irritation were often signs of stress for participants. For example, as participants shared: "Feeling sort of tense and anxious" (Participant 10) and "I would say anxious. Irritable." (Participant 6). For Participant 5, she reported how the stress from work can heighten the level of anxiety for areas outside of work, as well:

> My mind is – I feel anxious. I start to also get worried about lots of things in my own life, like I have to pay that bill or I have to go here and I have to do that, because I'm on this treadmill on my day.

Participant 7 described, "I usually pick it up on a level of body sensations. So parts of my body will start freaking out, like I'll get really buzzy inside." She also pointed to the distinction between feeling irritated due to countertransference and irritability from work stress:

> It also shows up for me I think in terms of becoming really easily irritated. And that can also be [irritated] at women that I'm working with, so noticing that. And I think there's a difference. There are times when women's stories attach to my own unresolved stuff or activates my own stuff… So that's separate then what I'm talking about – the burnout stress of somebody saying something reasonable, it's not particularly activating any of my own stuff and I'm irritated at them.

As noted in other sections, participants reported that feeling irritated and less tolerant affected their interactions with others, which alerted them that they were feeling overly stressed.

Rumination. A majority of participants indicated that they knew they were stressed when they would "bring it home" and were worried about their clients after they left work. For example, as Participant 1 described:

> [When] I'm starting to think about work and clients at home and that's a big indicator for me. So if I'm starting to be at home and thinking about work, then I know I'm burning out. Or when I'm dreaming about it…That means I'm doing too much and getting too tired. That's a big indicator because I think for me it's important that I do what I need to do at work, then close the office door and go home and not ruminate or think about my work. And if I'm doing that then I'm starting to burn out.

Although most participants were aware that for self-care they needed to relax during their off-time, they often found it difficult to avoid ruminating about particular clients when outside of work. Participant 3 shared:

> As much as I tried to focus on my baby and my husband and kind of just enjoy the weekend, I was like, okay, Monday morning, I have to call the clinic, then I have to send

> in a referral. It was like this replay over and over in my head of what I'm going to have to do. And I just couldn't relax because I felt – I don't like leaving things unfinished, especially when a client is so severe, they need our help. (Participant 3)

Thus, an increase in how porous the work/home boundary became was a common sign of stress and, as a consequence, participants often did not get the full rest and relaxation needed.

Emotional exhaustion. Participants also described the depleted energy they felt after having an emotionally intense session with a client (e.g., "feeling tired emotionally" – Participant 2). Participant 5 described how listening to difficult client disclosures can sometimes affect her own emotional wellbeing:

> Towards the end of the day and my hope's lacking and I'm tired, then sometimes I realize – what are the words I've heard today, what have we talked about today? I can struggle with hopelessness myself because to be empathetic you come alongside people, so you tend to start to carry things and then you have to be careful yourself to let that go.

Likewise, When Participant 1 was feeling overly stressed, she said, "I'm not putting as much energy into the sessions. I'm feeling overwhelmed. I'm feeling negative about the client's success or feeling that there's no hope. Or little hope."

For some participants, crying was both a sign and a release for when they were feeling emotionally overwhelmed. For example, when asked about what her signs of stress were, Participant 9 replied, "I'm a crier." Similarly, Participant 2 disclosed:

> Sometimes I would find at the beginning when I started working in this field I would just need to cry. And that's something that might sound silly, but I would just go home, I would just sit down and I would cry sometimes, just to let it out.

Thus, for many participants, feeling emotionally overloaded or drained signaled to them that they needed to take action to remedy the stress.

Occupational signs. Participants also noticed certain work-related indictors of stress. Two main subcategories that emerged: compromised job performance and questioning self and profession.

Compromised job performance. Participants reported that feeling stressed would also impede their performance at work. Some discussed how feeling stressed would directly affect clients. For example, Participant 6 felt the need to cut down her sessions when overly strained:

> If I'm feeling a lot of stress, I might have shorter visits with clients. So if I normally see a client for 45 minutes, I'll probably just do half an hour because I feel like I'm just almost too stressed to focus just on the person.

Some participants also discussed how stress from one client experience had the potential to spill over to the next session with another client. Participant 8, for instance, said:

> [If] I was with a kid and something happened, I can tend to dwell on things. So that may affect how I may work with the next kid that walks through the door, if my mind isn't really in it.

Many participants described feeling avoidant of certain types of duties as being a sign of stress. Participant 1 found that stress affected her energy with clients and students, and expressed feeling less effective and engaged:

> Dreading to see particular clients because it's so, you're so exhausted. Not putting your all in certain sessions maybe. Avoiding teaching certain things that may be more complex. You know not wanting to teach students, that kind of stuff… Trying to avoid

> more demanding [tasks], you know, wanting to do less assessments, wanting to do less groups.

Although all participants were highly dedicated to their clients and students, feeling avoidant of demanding work seemed to occur as a consequence of being overloaded and strained. Participant 3 also spoke about feeling avoidant of particular clients as being a sign of burnout for her:

> If I'm feeling anxious, if I don't want to come into work, or I'm hesitant about seeing a certain client, that's a real big red flag for me. That transference-countertransference. If I don't want to see a particular client, something's going on. Yeah, and it's happened and it's the truth. There are some clients in my groups that I don't want to see because I know they require, x, y, and z… So that's kind of what I do, that's how I know if I start feeling some sort of burnout. Those are my triggers, I guess.

Indeed, several participants mentioned that a sign of stress for them was when they felt as though they did not want to go into work. It is speculated that feeling avoidant may be due to the need for self-preservation when experiencing high levels of stress. Participant 7 knew she was stressed when she felt as though an extended break from work would not help the exhaustion:

> Feeling tired all the time. Feeling like a week vacation or two-week vacation is not going to be enough, and needing to really try to take a month off… There's times when I'm taking a week off and I'm like, that's not going to be enough time. I know that's not going to be enough time. How am I going to work this? So when I have that, too, that's another sign for me. (Participant 7)

Thus, not wanting to go into work was a common sign of stress and it appeared that many participants did struggle to find the time within their schedules to take that time until they felt it was necessary.

Questioning self and profession. Participants described how stress can affect their confidence levels and they would begin to question their intention to stay in the field. Participant 5 shared that she had concerns for her wellbeing working as an addictions counsellor during an experience of burnout earlier on in her career:

> I could feel in the first two months of getting ready for school that I was experiencing exhaustion and aware that these could possibly be burnout symptoms, and feeling scared because I enjoy helping people, but feeling scared about my profession and how to manage that level of tiredness. [And] going back to school to study more, going further with this field wondering would I be okay.

Participant 4 discussed how over the years, her reactions to stress has changed as the accumulation of more stressors have increased. Specifically, she would begin to question the meaning of the work for her. She disclosed:

> It used to be different where I felt like I needed to just take a day off. But now it's more, why am I doing this? Why am I doing this work? Why do I keep on doing this? I question, why am I still working in this job for so long? So I start questioning myself, maybe someone that I assessed or maybe a referral or something that I did…So that's where I know I'm not up to my usual self and I'm stressed out. I'm not feeling confident.

The prolonged stress had affected both her self-confidence and enthusiasm for the work in important ways, though Participant 4 further explained that this occurred mostly during times of

stress. For Participant 8, who has been working as an addictions counsellor for two years, there was uncertainty about whether the addictions field was the right fit for her:

> I'm not sure. I'm here for now. I know that I think I want to continue working with youth. In addictions? I'm not totally sure…I don't think I would be in addictions for the rest of my career, to be honest.

When asked what she was feeling unsure about, Participant 8 said, "All the things that cause stress that I talked about…I don't have faith in that really changing so much." The stresses with available resources and structural issues within the organization had greatly influenced her intention to keep working in the addictions sector.

Thus, a sign – and a consequence – to feeling overly stressed in their jobs was that some participants began to reconsider whether working in the addictions field was still suited to them. In summary, there are various physical, behavioural, emotional, and occupational signs and symptoms of stress that appear to negatively impact worker wellbeing. Participants had strategies for coping with and preventing stress, which are described in the next section.

Stress Management and Intervention

The third major category that emerged from the interviews was *Stress Management and Intervention.* Stress management are the methods and actions participants utilized to help prevent, reduce, combat, and resolve the symptoms of stress they experience as a result of job demands. Many counsellors also referred to stress management and intervention as "self care." The following section outlines the prevention and coping skills that participants used for handling their stress. Subcategories that formed included cognitive coping skills, practical stress management skills, and the role of the organization in stress management.

Table 5

Stress Management and Intervention

Category	Subcategory	Dimensions	Verbatim Example
Stress Management and Intervention	Cognitive prevention and coping skills	• Set boundaries	• *"All I can do is attempt to make that happen, but I have no control."*
		• Focus on small changes	• *"We see amazing treatment outcomes all the time and to focus on that, too."*
		• Develop self-awareness	• *"Recognizing symptoms."*
	Practical stress management skills	• Engage in enjoyable leisure	• *"Making sure you have a life outside of work that is fulfilling, as well."*
		• Schedule and setting limits	• *"You do have to kind of manage how many people you do see in a day…"*
		• Take a break	• *"I just make sure I get out of here and get some air."*
		• Expand client's support resources	• *"I always try to make referrals for those clients to have the supports that I can't provide them."*
		• Seek supervision and peer support	• *"[To] leave it someplace else other than take it home with us."*
	The role of the organization in stress management	• Quality supervision	• *"It's accessible and effective."*
		• Group supervision	• *"Hearing that other people experience [and] find it challenging to go through these things, too, is helpful"*

• Team cohesiveness	• *"We have a really good…informal support network here."*
• Proactive intervention at the organizational level	• *"Maybe being more involved in what their workers are doing."*
• Encourage autonomy and work-life balance	• *"We have a level of flexibility in our job, which helps a lot."*
• Professional development and training	• *"Days away to be thinking in different ways and learning."*

Cognitive prevention and coping skills. Coping skills in this study are healthy and positive techniques that participants used to effectively deal with stress. Many participants reported engaging in coping skills that involved changing their thought processes to manage stress. Dimensions that emerged for cognitive prevention and coping skills also included: setting boundaries, focusing on small change, developing self-awareness, and engaging in enjoyable leisure activities.

Set boundaries. Boundaries are the personal and professional limits placed in the therapeutic relationship that separate the counsellor from the client. Boundaries help to define the role of the counsellor and promote wellbeing by setting guidelines to what is acceptable to the counsellor's physical and mental/emotional needs. All participants spoke about the significance of boundaries in preventing stress and burnout, and strategies for establishing them. Setting boundaries to most participants in this study meant maintaining realistic expectations of their responsibilities with their clients and accepting their professional limits.

> Just remembering and reminding myself I'm here to help people… and not everybody gets better. That's a hard thing to accept as well for sure, but letting go and realizing that I don't have control over these people's lives. (Participant 2)

The majority of participants emphasized the importance of realizing that they were not responsible for the client's progress and that letting go of this responsibility was considered necessary in managing stress. Participant 6 described how accepting that she did not have control over the client helped prevent stress from arising:

> A lot of things are not in your control. If you let it bother you or take it out on the client – there's a variety of reasons why clients don't show for things and you can't take it personally…All I can do is attempt to make that happen, but I have no control. I can't influence somebody. I can advocate, but I still don't have control.

Participant 4 shared that she would not have been able to stay in this field for over a decade if she had not developed strong professional boundaries:

> I've learned a long time ago that I can't fix everybody. And some clients have a lot more issues than I'm trained to work with, but I can only do what I can… We're taught that our job is to help and I talked about all the issues that the client comes in with. It contributes to stress if you think that you're going to take care of all the issues for the client. And you're not.

Participant 1 also discussed the importance of managing the level of caring and investment in the client's progress in preventing prolonged stress:

> If a clinician does not learn to detach in an empathetic way, it can be very exhausting and draining in trying to save a client from dying from the disease. So you have to almost

> have kind of a component of detaching empathically, right? So that you don't get exhausted from the person's ongoing struggle and consequences, and watching them deteriorate over time…If you're too attached and too involved, it'll be too much grief. Too much, you'll grieve too much. And yet gauging that you're detaching with empathy, but also [if] the client does die, to grieve in a way that's healthy. So, it's quite the balancing act. We're all human, right? You don't want to be so detached that you don't care.

Like Participant 1, many participants emphasized that in order to develop boundaries, they had to learn to "meet the clients where they are" (Participant 6) and respect the client's choices and decisions.

Focus on small changes. In addition to learning how to "pick and choose your stress" (Participant 3) and "your battles" (Participant 7), participants discussed how an important stress management tool was to focus on the positive moments and successes in their work with clients. Participant 9 discussed the value in recognizing the joy in her work with clients:

> You know, as awful as that house was, there were a lot of funny moments like that, too – that really when you look back, [you] remember those times with fondness as opposed to the really horrific stuff. I don't focus much on the horrific stuff. I'm telling you about the horrific stuff because it's stress, but there is also a lot of joy in the job, too…We see amazing treatment outcomes all the time and to focus on that, too. And celebrate those times when you see people making some amazing changes through their own courage and self-determination to work through their issues. That's a wonderful thing to celebrate and to not focus on the ones that didn't make it. (Participant 9)

Participant 1 emphasized the necessity of being able to see the small changes as a way to prevent disillusionment from the work:

> And therapists over time, if they're doing this for a long time, can get disillusioned with how many people do succeed and do well. But I'm a firm believer that any little change is success. And we have to focus on the little changes and the baby steps of change that happen with people. And that is great in itself, because if we don't see it that way, then we can burn out very quickly and be disillusioned…You see change in all clients but various different degrees, and you have to be able to see it, right? And have realistic expectations of the change that's going to happen.

It seemed that many participants with more years of experience in the field had developed the ability to see the significance in smaller changes, and this ability has helped them build resiliency against cynicism and discouragement.

Develop self-awareness. Participants also spoke about paying attention to and being more mindful of their signs of stress, and continuing to manage their own recovery and mental health. For example, Participant 1 explained:

> And I think the most important thing is to be aware of your own issues and have self-awareness, and heal some of your own issues in order to do this work. Because I've seen a lot of new therapists who come into this field, who don't have the self-awareness and have issues, and how those issues are transferred onto clients…You have to have awareness of how abandonment and rejection and loss are for you, and how your family of origin impacts that, and how that will be working with clients. And all of this is important as therapists because you deal with some very difficult feelings.

When asked how addiction counsellors could learn to develop this awareness, Participant 1 suggested supervision and personal counselling. Likewise, Participant 5 found personal counselling important for stress management:

> Awareness. Recognizing symptoms. Over the last six years, recognizing, oh I felt like this before. I have met with counsellors myself to talk through things… I think everyone needs someone to talk with and I think very often you can't go to your family and you can't go to your friends. Like, people can't come to me. And people are very busy, so it's important to have a safe and confidential and objective place to go.

Participant 3 also talked about how being aware of her stress symptoms is important in helping her to manage her depression:

> I have my own depression. I've had depression for about ten years. So I know with my own mental health, if I'm feeling overwhelmed – if I start feeling anxious about coming to work or if I'm at work and I'm putting things off, I know that's a bad sign for me. There's something going on that I need to check in about, and I have to be that aware because if I don't I'll end up with my own break down, which I did many years ago and I just can't go there again. So now, working with other people's stresses, I really have to check in on my own. (Participant 3)

Practical stress management skills. In general, all participants emphasized the importance of practical self-care activities for stress management and prevention. Exercise, eating properly, resting, and not doing work at home were among common behavioural self-care practices for maintaining a healthy lifestyle. Engaging in enjoyable leisure, scheduling and setting limits, taking breaks, expanding the client's support resources, and seeking supervision and peer support are other practical strategies for managing and preventing strain.

Engaging in enjoyable leisure. Participants discussed the importance of having an enjoyable life outside of work. As Participant 2 explains, "It's really just learning how to balance everything out. Making sure you have a life outside of work that's fulfilling as well…" Many participants reported that enjoyable hobbies, such as reading or listening to music, were a form of stress relief and a healthy escape. Participant 5 found that her hobbies were also a form of self-help for stress:

> Self-help through writing, self-help through painting or pottery or having expressional outlets to release tension, I find really works well for me…. Tapping into my creative, more my right side of my brain rather than the always thinking and organizing that I do in my day. So being able to – escapism in a healthy way, I find [helps]. (Participant 5)

Participant 5 also learned through experience that setting strong limits with helping activities in her personal life was important to her self-care.

> I've cut back on a lot of [volunteering] that I used to have a lot more energy to do. Now I just, it's all – my private life is all about things of planning a holiday or getting together with friends for a cup of tea, or going out and enjoying my community.

Recognizing that her job involved an intense amount of helping behaviour, she said, "I can't give anymore than what I can give." Participant 10 spoke about spending time with her husband traveling and engaging in leisure activities with friends and family as forms of self-care:

> We absolutely 100% commit ourselves to spending time. We have vacation time, and it's not [taking] vacation time and staying home to clean the house. That's not my idea of a vacation… So we have real quality time and that's important. And we like to entertain,

> we like to have dinner parties and all that. So there's – it's not all this chaos here on the job. There's always something to look forward to…

Scheduling and setting limits. An important tool for stress prevention and management that many participants reported was "to say no" and not accept more work on top of their already demanding workload. Participant 1 discussed the importance of such setting of limits:

> Trying to manage a more reasonable load, knowing that you can't save the world and everybody. So you do have to kind of manage how many people you do see in a day, and how much work you do [complete] in your day and really try to balance that out. And you learn to say no when you're asked to do certain tasks when you can't do anymore. To say no is very important as well.

As Participant 1 suggested, managing a balanced workload requires maintaining a realistic expectation for how much work can be completed in a given day. Participant 6 felt that she was able to manage her stresses by scheduling her appointments strategically:

> There are certain clients that may cause you stress just because of their high needs…The times of the day when I have the most energy will be the time of the day I'll see the clients with the most need and then there are times I'll see the clients that are managing much better or are much more stable. So I try to schedule visits in a way that it's not one full day of seeing high need clients because that would be very stressful.

Take a break. Many participants recognized that scheduling time off was a preventative and effective method for managing stress levels. For example:

> Are there times where I'm feeling more stressed out than not? Yeah, and you know what, at those times then I take a break. I take what I need to do. Make sure I go on a vacation or take a sick day if I absolutely need to. (Participant 2)

Participant 4 talked about how it has been important to get outside of the office daily and leave the environment for a break.

> Like I brought my lunch today, but I went out instead because I knew my assessment was a very difficult one this morning, and I knew I needed to just get out of here. Because I need to let that go, right? You meet people that have had very difficult lives…. I just make sure I get out of here and get some air. And that's really why I'm not off on a two-year leave.

Having some physical distance away from the office helped participants to have a healthy level of detachment from their work.

In more severe incidents of stress, many participants reported that taking a longer period of time off was necessary in order to cope with what was identified by Participant 8 as being "the burnout point":

> What that kind of looks like is just – the only words that come to mind are 'I'm done with this.' Like, I've reached my limit of whatever's bothering me and I need a break. Yeah, and I actually took steps to give myself a break at work because it just – certain things build up and you needed to take a break from that and sometimes you need to speak with your supervisor or someone who is responsible for making that happen, I think.

Expand the client's support resources. Participants reported that helping the client build autonomy and independence is a method of stress reduction, as it reduces reliance on the counsellor as the client's main support system. As explained by Participant 6:

> I always try to make referrals for those clients to have the supports that I can't provide them. So kind of anticipating what's going to be needed and to make sure that this person has what they need so that I'm not going to be stressed out by this person calling every other day for things… I try to get them do the things that they're capable of doing and also by reminding them of the strengths they have. Like you know you can make the call and I know you can do this because you've done x, y, and z in the past. But, you know, it's twofold where it builds them up and their self-esteem, where it also ensures that they're not calling me and using me as a crutch to get everything else done.

Participant 10 described how knowing the community resources and the systems can be beneficial for her own self-care as well as the client's:

> That is helpful for clients, to be able to know how to navigate things, to know what's out there, to be able to refer clients or help them get through, systematically. To take good care of yourself and to not try to be everything because that's not possible… So you don't feel like you have – it's impossible to do everything for a person.

Seek supervision and peer support. The majority of participants spoke about the importance of seeking supervision and peer support as vital components for stress management. Participant 7 emphasized that when her agency was not able to provide the quality supervision needed, she advocated for herself and was supported in obtaining external supervision.

> Supervision pushes you as a worker to grow… Advocate for yourself in terms of staying in this field, growing as a worker, growing as a counsellor and being fed because there's a lot of output. But I think in order for us – for this to be viable work for us over the long term, we have to be supported in our work.

Participant 3 discussed how she could not imagine working in addictions treatment without supervision. Supervision helped her to process the difficult feelings that often come up during counselling, as well as to provide care for secondary trauma symptoms.

> So I saw my supervisor and I just cried the entire time and I just said, you know, his story was so awful. He had sexual abuse like I never heard before, he had physical abuse, he was misusing any substance you could think of. It was just a sad story where I didn't see much hope… And we would work through it so I could understand what my feelings are. It's so vital to get that piece from a clinician or a supervisor. It's like your own therapy session, and you need it.

Many participants felt that reaching out to peers was central to helping them cope with stressful situations. Participant 9 described the rapport she had with her peers, how she is very open with them when she is stressed, and the support that it has provided her:

> Sometimes the stories that clients tell, they're – they can be hard to hear. What we do, what I do personally, is that we go around and debrief with each other and sort of take it and leave it someplace else other than take it home with us… We're a small agency and we're really, really close. And so we all, even if it's not job related stuff – if it's family-related stuff – we all come together and we support each other. (Participant 9)

The role of the organization in stress management. In addition to hiring more staff and networking with community resources, participants talked about the different ways that an organization could support stress prevention and management. The categories that emerged were: having quality individual and group supervision, team cohesiveness, proactive intervention at the organizational level, autonomy and work-life balance, and professional development.

Quality supervision. Although most participants suggested seeking supervision as a personal coping skill, some participants also wished that the agency itself offered quality and effective supervision. As illustrated by Participant 4:

> It would be nice to go to someone who has worked 10 years, 12 years, 15 years in the addictions and mental health field that can answer my questions, right? Because a lot of times for me, it felt like I was [the one] problem solving… It's difficult when they don't, when they don't have it… because [then it's them saying],'What do you think?' Well, what are you here for? (Participant 4)

Some participants did need to seek external supervision when their organization did not have someone internally with the experience needed to provide supervision. Participant 7 felt that it has been clinically helpful to find a supervisor with an expertise in trauma and is a good fit in terms of treatment philosophy and approach. Participant 3 also found that the "troubleshooting," "brainstorming," "validation," and her supervisor's non-judgmental approach provided her with necessary guidance and understanding of her difficult counselling work with clients. Participant 10 described qualities of supervision that she appreciated in her manager as being "knowledgeable," "skillful," "accessible," and "effective."

Group supervision. All participants spoke about the importance of peer support as well as supervision. Group supervision validated and helped normalize the stress experience for many

participants. It also helped these counsellors gain confidence in their problem solving skills. Participant 2 shared:

> I mean, the saying two heads are better than one. Well, a bunch of heads are better than two, right? It's good to just talk about [difficult clinical situations] and kind of strategize on ways to avoid them or improve our response to them in the future… Hearing that other people experience [and] find it challenging to go through these things, too, is helpful. That I'm not the only one. I am human and I can find these certain situations challenging and it's okay to talk about it and not feel judged about it.

However, not all participants were comfortable with group supervision. For example, Participant 4 explained:

> I don't go in and vent in my supervision meetings because there's too many staff and I don't trust to go in and vent to a whole bunch of staff I don't really know… I found that it doesn't do anything and started feeling uncomfortable around people knowing how I'm feeling in my job and it felt a little unsafe.

This disclosure by Participant 4 illustrates the importance of having smaller groups for supervision and creating an environment in which staff feel safe and supported.

Team cohesiveness. Many participants emphasized that having positive interpersonal relationships with coworkers greatly influenced how supported they felt in their work. Participants discussed how a sense of closeness within the organization and receiving expressed appreciation for their work has helped in stress management. As demonstrated in the agency that Participant 6 is employed:

> We'll have work get-togethers sometimes if we're all here. [Our manager has] occasionally ordered pizza for everybody for lunch, and just little things like that. And it helps because it's a small agency and even though we're all very different, we do get along. Because when someone who is managing is showing by example, it really helps.

Participant 4 discussed how in her experience, the sentiment of appreciation was often lost in larger organizations, and that acknowledgment of staff is an important organizational stress management technique:

> We know what it was like in a smaller agency type of thing and then when you go to a big organization, it's not the same… We kind of do our own [small parties]. It's not management that does this and it would be nice if management would do this. That's the type of things that they should be doing [to show appreciation].

Feeling a sense of closeness within a smaller team was also something that other participants valued and echoed. In addition to regular clinical team meetings, Participant 10 described other ways her team has been supportive, which helped her manage stress:

> We have a really good, I think, informal support network here, too, where our relationships are really positive and I always feel like I can approach my colleagues or my manager to get just ad hoc support. And I feel really confident in their skills. And anytime I've had a need or a request about, I think this should happen with this client or I need this around this client, it's always been provided here.

Proactive intervention at the organizational level. Although participants acknowledged it was their responsibility to speak up and advocate for their needs, some participants felt that the organizations they worked for needed to share that responsibility in providing stress

management. As Participant 4 had shared during her experience of exhaustion, "You need to take care of your staff." Similarly, Participant 8 also talked about knowing she needed to assert her boundaries when she was feeling strained by her intense caseload, but that it would have helped if her supervisor had more awareness of stress levels of her staff.

> I probably would have said no to things more easily except I didn't know to. You know, when you're coming in and someone says 'Take this case,' you think you're supposed to because you're new. Like, what do I know...Perhaps a supervisor should be monitoring the situation or maybe being more involved in what their workers are doing.

Participant 8 stated she felt it would have helped alleviate her stress if the manager had "a more hands-on approach in terms of like, let me jump in there and deal with this so that you don't have to if you're at your limit." Participant 10 was appreciative of her manager's proactive approach to stress management.

> [He is] managerially skillful and willing to do some of the hard things that could interfere with my sort of clinical relationship or therapeutic relationship with a client… I don't always have to be the one to do that, [which] is really great. (Participant 10)

Having colleagues who notice and acknowledge each other's stress was important to feeling supported by other participants as well:

> If we know about someone or one of my colleagues look tired – not ignoring it. So all these people will say to me, you're doing, it seems like you got a lot going on. So sharing of information and observation is key. (Participant 5)

Participant 5 also suggested that creating forums within the treatment community and organizations to discuss stress openly would help reduce the stigma for counsellors in admitting strain:

> Organizations can have something where staff can maybe write down a stress if they're worried about it, but they don't want anybody knowing that they're thinking that or feeling that. Have some kind of thoughts of this is what I'm experiencing, without any name or anything. Or even typing it and then putting it in so it remains confidential, and then having a space created at a team meeting to talk about what's going on. Things like that I often think would promote wellness.

Participant 5's suggestion of inviting counsellors to share experiences of stress by writing them down anonymously exemplifies ways in which an agency can be creative in providing opportunities for discussing and effectively managing occupational stress.

Encourage autonomy and work-life balance. Participants discussed how it has been helpful for them when their managers are supportive of maintaining work-life balance. Participant 5 said:

> I would consider myself to be treated really well by having good supervision and having opportunities to step back when I need… Having people really understand and having supervisors and managers recognizing that what we do is, you know, it's difficult stuff.

Participant 10 emphasized that her work environment supports her in keeping boundaries and work-life balance, which allowed her to be productive in the office and thus helping her to manage her stresses:

> Our manager [and] the team is great with me saying I'm done, I'm full, I can't take anymore clients. And [he's] like, okay, that's totally fine, you don't have to. So I feel like I'm supported in my boundary setting here and in terms of setting my time here. I'm just really diligent about it, so I feel like I get stuff done here and I get everything done that I need to get done and I don't need to think about it at home.

Indeed, having the autonomy and flexibility to take time off for personal matters as needed has been a key component in reducing stress for many participants. Participant 7 talked about feeling supported on an "unofficial level" when she needed to take a long break from work:

> [I asked], 'Do I have any sick days I can use?' So the office manager says…'Just use them.' I said, 'Do I need a doctor's note?' And she's like, 'We can tell you're burnt out.' She just kind of looked at me and was like, 'No, don't worry about it.'…There was the ability to kind of do my life because I was also getting my paycheck. And to know that I was being supported versus coming back and feeling like it wasn't an option. Being in a situation where I'm not going to leave my job because I love it, but carrying this resentment. Having to do extra stuff on my extra time for self-care that's actually not feeling like self-care because it's like I have to do it so that I don't burn out and totally unravel.

It made a valuable difference for Participant 7, as well as many other participants, to receive support by the agency for self-care and boundary setting.

Professional development and training. For these participants, receiving education and training were important aspects of stress management and prevention. Professional development was seen as a way to grow and gain confidence for participants, as well as taking themselves outside of their routine schedule and environment – "Days away to be thinking in different ways

and learning, and having a break from frontline" (Participant 5). For example, Participant 2 disclosed:

> I feel like I need to constantly be learning because things change. Things constantly change, theories change, ways of looking at substance abuse… I feel more confident and just knowledge is power, right? And having that knowledge and being able to better understand some of the things that clients go through or experience

Professional development was a way for many participants to build competency and keep up with emerging trends of the field. As many participants shared, they enjoyed working in the field because of the continuous learning with interesting people.

In summary, participants were resourceful in finding ways to prevent and combat stress. Using various cognitive and practical skills, these addiction counsellors were able to manage the strain that often resulted from work demands. Another source of resilience against stress aside from stress management strategies were occupational rewards, which are discussed in the following section.

Resiliency Against Stress

The fourth and final major category that emerged from the analysis were the characteristics of the work that participants found rewarding. These rewarding experiences were also found to be sources of strength against the negative consequences of stress. Participants shared many reasons for staying in the field despite the stress and challenges they face in their jobs. Having a personal connection, a love for learning and challenges, and being in a helping relationship were among common factors of what motivated participants to continue in their careers as addiction counsellors.

Table 6

Resiliency Against Stress

Category	Subcategory	Verbatim Example
Resiliency Against Stress	Personal connection	• *"I could have died twenty years ago if somebody…wasn't here to care."*
	Love for learning and challenges	• *"I like challenging things or otherwise I wouldn't be doing this…"*
	The helping relationship	• *"Knowing that potentially people's lives have been improved."*

Personal connection. Being in recovery from their own addiction seemed to add a greater sense of meaning to some of the participants' work as addiction counsellors. When asked what motivates her to continue working in the addictions field despite the challenges faced, Participant 1 answered, "Well, first of all, because I'm in recovery and pulled out of a debilitating addiction. I could have died twenty years ago if somebody didn't, wasn't here to care. I firmly believe in what we do here." Participant 4 also shared:

> I have a lot of personal experience with addiction, and I say that this is my calling. So it's kind of giving back to the people and that's why I got in the field. So I think that's what keeps me going is just reminding, you know, where I see the clients and how they're not doing well, that they need someone that they can trust and feel safe with. And if I'm that person, then I've got to be here.

Conversely, Participant 8 was able to identify that she did not have this relationship to buffer work stress, which contributed to her intention to leave the field:

> People in this field are passionate about it for a reason. I just have found that people have some sort of personal background connection with this area. And so it brings a whole different dynamic to their work, I think, and their drive to do it and the fact that it does balance the stressors out. I just don't have that, so what can do you, right?

Love for learning and challenges. Having a love for challenges and being offered continual learning opportunities were common positive aspects cited among participants and were often given as reasons for staying in the field. For example, Participant 2 felt that one of the reasons she enjoyed working in the addictions field was because the work offers challenging learning opportunities for her:

> This whole field is difficult and I like challenging things or otherwise I wouldn't be doing this because it is something that is very fulfilling for me…You're constantly learning. If there's one day I didn't learn or at least experience something different, I feel like it's not a good day. So, I'm the first to say, I might have made a mistake or I think I could have done this differently or improve it.

Similarly, Participant 3 said:

> The fact that this job is challenging and I'm the Type A personality where I'm always taking a challenge for myself whether that's taking on an individual client who has severe mental health and addiction issues – that's a challenge and it kind of keeps me on my toes. And also knowing that in this field and at this particular organization, I'm able to get more education…So that also makes me want to keep going in this field because education is always growing and I'm always seeking more information to help clients.

Although Participant 8 admitted that she was having doubts about staying in the field, she also expressed the conflict she felt about leaving because of how much she learns:

> I do enjoy learning more about the field. I try to and go to training opportunities outside. I just went to one two weeks ago and it really is interesting learning [about] what's going on out there and the different professionals [that] are involved in the field. And I do find that really interesting. So, I find the field – so it's torn. It's torn because I find it interesting.

Many participants also found that their work in this field has been a source of personal growth for them. For example, Participant 6:

> It's personally satisfying, but it also dispels a lot of myths and preconceived notions I had before ever getting in the field… Now I know this is someone who had – there's a story behind that. This is somebody, could be somebody's dad, somebody's brother. Like, it really makes it – it humanized that population for me on a personal note.

The helping relationship. Many participants spoke about the gratification they felt from seeing positive change and helping others. Furthermore, feeling effective and knowing they had made a difference in someone's life gave many participants a sense of fulfillment, keeping them satisfied in their jobs as addictions counsellors. Participant 6 shared her admiration for the positive changes clients make and the inspiration she gains from witnessing their journey:

> It doesn't happen all the time, but it happens enough to make it seem like this is something worthwhile. Like when you get to see really just how strong a client can be despite the odds against them. And there are a lot of odds against some people… When I see that person growing and getting stronger, it's like despite everything that's happened

> to that person or what's lacking in their lives – it's inspiring to see that despite those things, despite an addiction or despite a mental illness, they're still able to grow and improve. It is inspiring.

Participant 2 said that what motivated her to continue in the field were: "The successes. And just knowing that I could have potentially played a part in enriching someone's life." She further described:

> It's so inspiring listening to them at [graduation] and their experience in hearing how thankful they are. It's pretty amazing how close people get because they're being honest and talking about real issues, whereas outside of here, it's often formalities and not that deep conversation that people get into when they get into therapy. So it's just that human connection and knowing that potentially people's lives have been improved. That makes it all worth it, for sure.

Many participants who had the opportunity to work with clients over extended periods of time (e.g. several years) were able to see their clients "through the course of their lives" (Participant 7):

> I don't just see people when they're at their crisis point. I get to see women go back to college and deal with their relationship to substance use as they're going back to college. Or start to work in the field or have children and keep them, or get back in touch with children who may be Crown wards. Because of the long-term nature of my work, that's something very satisfying and keeps me going because I can see women reach their goals and maintain their goals.

Participant 7 also illustrated the fulfillment she gained from contributing to the progress clients have made:

> It's amazing how resilient people are, and I'm certainly not going to take credit where women move to, but there are times when you can see really concrete things playing out and benefitting people that are part of a skill set that you are bringing to deal with things like relapse of trauma recovery.

Several participants described that the relationship they had with their clients were inspiring and meaningful to them, which kept them gratified with their roles. Participant 10 shared how the therapeutic relationship was the most gratifying aspect to her work as an addictions counsellor:

> It's the relationship. The relationship is just really satisfying. Because it's not necessarily [that] they're success story clients. There's a few clients where there's really a remarkable change from when I first met them to now, and how their lives look like now versus how they looked then is like, wow. And that's really nice and it's lovely, but those aren't the only clients I feel a great deal of satisfaction from. It's even the clients where maybe not even a lot has changed and what their life looks like, but there's still a lot of satisfaction I have in this relationship that we've formed.

Indeed, despite the various challenges these addiction counsellors are confronted with, it was apparent that all participants felt deeply passionate about the helping relationship with their clients and saw significance in the work they did together.

CHAPTER V

Discussion

Results from the current study provide rich and deep descriptions of the daily experience of addiction counsellors and the multiple challenges that they face. The following section will provide a summary of the findings, compare the results to the accumulated body of literature, and outline implications for stress management on individual, educational, and organizational levels. Limitations of the current research will be discussed, and suggestions for future research will be made.

Summary of Findings

Using systemic thematic analysis, four main categories related to occupational stress in addiction counsellors were found: (1) *Sources of Stress,* (2) *Signs and Consequences of Stress*, (3) *Stress Management and Intervention*, and (4) *Resiliency Against Stress*.

Information regarding the *Sources of Stress* that participants experienced were divided into five subcategories: (i) individual stressors, (ii) paraprofessional stressors, (iii) organizational stressors, (iv) systemic issues, and (v) therapeutic work with clients. These subcategories describe the key areas that impact stress levels for these participants, and descriptive information is provided around the nature of the stress that is experienced. Five subcategories emerged from *Signs and Consequences of Stress* that participants reported: (i) physical signs, (ii) behavioural signs, (iii) social and interpersonal signs, (iv) psychological and emotional signs, and (v) occupational signs of stress.

Three subcategories were found within the theme *Stress Management and Intervention*: (i) cognitive coping and prevention skills, (ii) practical stress prevention skills, and (iii) role of organization in stress management. Lastly, the theme *Resiliency Against Stress* included occupational rewards which motivate participants to stay in the field. Three subcategories

emerged from their sharing: (i) personal connection, (ii) love for learning and challenges, and (iii) the helping relationship.

Impact of Researcher as Instrument on Results

Having worked in the addictions field as a researcher and counselling intern, the author of the current study believes that she is a subjective investigator, and is not separate from the research context of this study. As such, she views her previous experiences within the field to have influenced the analysis and interpretation in certain ways. For example, as a novice addictions counsellor, the researcher could relate to the participants' feelings of doubt in their own skills and learning how to adjust the expectation of what client success may look like for this particular disorder. She also experienced the difficulty in finding available and appropriate resources for her clients, the disconnect between different social services when helping clients with case management, and the barriers due to the stigma of addiction.

By approaching the data from an insider's point of view, the interpretation of the results was conducted with a heightened awareness for particular stressors, while simultaneously relying on strategies for reflexivity to evaluate the subjectivity of the findings. For instance, the researcher paid extra attention in monitoring her subjectivity by referring to her list of collated data during the analysis as well as having an external audit throughout the process. However, instead of separating personal reactions and biases, previous experience was also used as a lens for sensitivity towards detecting and highlighting the frustrations, stresses, and needs of the field and introduced an added layer of richness to the interpretation.

Comparing Results to the Literature

All participants easily acknowledged that they experienced stress in their work as addiction counsellors. Through the course of their interviews, a few had even expressed having

previously experienced burnout at some point in their career. The following section will compare the results from the present study to what has been found in the literature.

Sources of stress. To examine what the key areas of stress were for the participants, questions such as "What are the contributors to this stress?" or "What do you find to be the most difficult, stressful, and/or challenging aspects of your job as an addictions counsellor?" were asked. Participants reported various stressors that support findings from international studies in the United States and in Australia. There was some overlap in the present findings and existing research in terms of organizational sources of stress, systemic sources of stress, and therapeutic work with clients in the addiction field. Although individual stressors in the general counselling field have been well studied, fewer studies on sources of internal stress stemming from the addictions counsellor are found in the literature.

Individual and internal stressors. Participants in the current study reported that they experience increased stress when their boundaries around who was responsible for client change were blurred, and when they began to feel ownership of client setbacks. This has been similarly found in the research with psychologists providing general psychotherapy and treatment (Rupert & Morgan, 2005). These researchers found that "overinvolvement with clients" (e.g., feeling responsible for clients) was associated with higher levels of emotional exhaustion. This stressor occurred for several participants in the current study as well – if not currently, then in the past when they were earlier on in their careers.

In general, however, research has not looked at internal sources of stress in addiction counsellors. It seemed that some stress experienced from working in addictions treatment may be elicited by factors unique to the field and client population. It was evident that, although these addiction counsellors were strongly dedicated to helping, they also had to be mindful of the

natural struggle for clients in reducing or abstaining from substance use. For example, participants shared that obtaining services for stabilizing the client and managing symptoms are frequently met with several barriers and are thus not obtained. Participants expressed that, because of this, their advocacy efforts seemed futile at times. Furthermore, strong withdrawal symptoms and triggers can make it difficult for clients to not use alcohol or drugs to cope. Challenges such as these are inherent to the field of addictions, and are also beyond the counsellor – and often the client's – control. It is thus speculated that the counsellor's internal stressors, such as projecting expectations and having a desire to fix, may be attributed to the difficulty and frustration in dealing with the ambiguity of client outcome.

Participants in this study reported feeling more stressed when they were not feeling effective and were having doubts about their skills in helping clients. Research on professional self-doubt in the addiction field is also less common, although more widely examined in research for the general counselling profession. It was gleaned from the participants' sharing that a difficulty of working in the addictions field is that the effectiveness of a counsellor is not always reflected in the treatment outcome of the client. This, in return, can affect the counsellor's sense of self-efficacy. Feelings of incompetence are found to be a common stressor in novice therapists (e.g., Theriault, Gazzola & Richardson, 2009**)** and were reported more often by addiction counsellors in the current study who are newer in the field.

Other findings in the research show that a predictor of turnover in the addictions field is being younger in age with less experience, and higher education level (e.g., Knudsen et al., 2006), which can be an issue for workforce recruitment and retention (Whitter et al., 2006). One younger participant in the current study, whose first job upon graduating from school is her current position as an addictions counsellor, exemplifies the issue of retaining new graduates.

She shared that she did not intend to stay in the addictions field for much longer, as she did not believe the organizational and systemic stresses she has experienced would improve. She admitted that being a new graduate affected her confidence in her work as an addiction counsellor, and these stressors appeared to further influence her ability to be and feel as effective as she potentially could be.

Recovery status and stress. The current study highlighted potential stressors for participants who are in or have family members in recovery from their own addiction. However, having a history with addiction has generally been found in the research to be a protective factor against stress (e.g. Curtis & Eby, 2010). Being in recovery was not found in the literature to be associated with higher levels of emotional exhaustion in addiction counsellors (e.g. Ducharme et al., 2008; Knudsen et al., 2006). Participants in the current study with a relationship to addiction also did not appear to be more emotionally drained or stressed than those who are not in recovery. Rather, counsellors in recovery seem to experience a different set of stressors, and thus will have different stress management needs and tools. For example, self-disclosure of recovery status to clients emerged as an issue that may indirectly affect the stress levels of participants with a history of addiction, but is not as relevant to participants who are not in recovery.

In general, all participants felt that the therapeutic relationship can become stressful for both the counsellor and client when personal values are imposed on the client, and can hinder the treatment process. However, a stressor particular to counsellors in recovery that can potentially occur is when professional detachment from the client's recovery experience is compromised. Myers and Salt (2007) explain that what can become stressful is when counsellors "overidentify" (p. 219) with the client's recovery and does not separate the client's experience from their own experience with recovery. These authors ascribe this reaction to countertransference, or "those

reactions to clients that stem from the counsellor's own needs, relationships, or recovery issues" (p. 256). Similarly, participants in the current study who were against disclosing their recovery history to clients seemed to associate self-disclosure with raising the potential of imposing personal recovery values and biases onto their clients.

Results also illustrate the stress for counsellors in recovery that are produced by the professionalization of the addiction field. As the field has evolved over the past couple of decades, more health professionals who may not necessarily be in recovery have entered the addictions sector. Although personal experience with addictions is seen as an asset, counsellors are selected based more on credentials and education. As one participant highlighted, team dynamics can be affected by this shift by creating a "dichotomy" between workers in recovery and those who are not. One participant shared how she was negatively affected by the growing professionalization of the field, particularly when she felt unappreciated by newer peers with higher levels of education. This stressor has not been examined in the research, although it may relate to research showing a lack of proper recognition and appreciation by managers as a contributing factor to stress and burnout (e.g. Duraisingham et al., 2009, Knudsen et al., 2003).

Organizational stressors. The organizational conditions reported in this study support research showing that ineffective supervision, lower perceived workplace support, and absence of performance recognition and rewards (e.g. Duraisingham et al., 2009; Knudsen et al., 2003, 2006, 2008; Lacoursier, 2001) are contributors to occupational stress in addictions counselling. Participants in the present study also reported some instability due to management turnover, which was reflective of the literature as well (e.g. McLellan et al., 2003). Some participants discussed how the lack of presence from managers meant that they were receiving less support. Support from colleagues and managers have been found to be a mediating factor in buffering

stress (e.g. Ducharme et al., 2008). Similar to results found in the literature, having perceived trust, flexibility and autonomy from management greatly helped counsellors in the current study to manage stress (Knudsen et al., 2003; 2006; 2008).

All participants agreed that managers have a significant influence on stress levels, in both positive and negative ways. It was apparent that they felt that having a manager who was supportive and provided quality leadership and supervision was a pertinent factor in reducing stress.

Systemic issues cited in the literature. There was some overlap in systemic sources of stress in the current study with what is found in the literature. For example, a lack of resources and funding, excessive paperwork, large caseloads, stigmatized clientele (e.g. CSAT, 2000; Skinner, 2005) were stressors also reported by participants in the current study. The inadequacy of available addiction treatment services, particularly for concurrent substance use and mental health issues, substantially affected stress levels for addiction counsellors in the present study. This is not surprising when considering that funding from 1998/99 to 2006/07 for substance use treatment increased in Ontario by only 7% (Office of the Auditor General, 2008). Resources have not expanded while prevalence of those seeking treatment for addiction has increased – thus, case management workloads are heavy, waiting lists continue to grow, and counsellors feel a sense of perpetual overload. As one participant said, “When is the end?”

Although limited resources for clients is not a new concept when examining stress in the human services field, the current study showed a heavy emphasis by participants on how this systemic issue is a significant stressor for them as addiction counsellors. Some participants even mentioned the systemic issues as being more stressful than their work with clients. The literature, however, places more emphasis on stressors related to management and leadership within an

agency, conceivably because organizational issues have immediate solutions that are more tangible than attempting to affect systematic change. However, the present study shows that issues related to insufficiencies within the healthcare system, such as a lack of resources, complex referral systems and case management, were key stressors for participants in providing addictions treatment.

It seemed that having to advocate and constantly "push for change" (Participant 9) is something that is characteristic of being an addiction counsellor, as resources are sparse and clients are often treated as less worthy of care by other health professionals. More funding and supports for clients are quite obviously needed in order to alleviate the strain on addiction counsellors. Furthermore, the apparent resistance to change shown by clients may be influenced by issues and barriers in the health care system (such as the stigmatization of addiction in hospitals and mental health services). Thus, these addiction counsellors reported exerting continued energy to advocate for the services and rights of their clients, which was often an exhausting and discouraging task.

Moreover, participants did not seem to view the possibility of systemic changes (such as funding for developing more services) occurring within the near future. This appeared to add a sense that the heavy workload, waiting lists, stigma, and continued advocacy would not likely end for them. It seemed that participants were often fighting against the grain without knowing whether their efforts would lead to a positive client outcome. These participants usually did not have the privilege of viewing immediate, direct and observable benefits to their client's recovery, which would normally help instill a sense of accomplishment and effectiveness in the counsellor. With all aspects considered, it is easy to see how the multiple barriers and challenges involved in providing addictions treatment can have a considerable drain on enthusiasm for the work.

However, the majority of participants maintained a persistent and optimistic attitude towards client change and reported the use of particular coping techniques to do so, (as discussed in Implications for Stress Management in Addictions Counselling).

Stressors related to clinical work. Although the therapeutic work with clients is widely recognized in non-empirical literature and within the addictions field as being particularly stressful, few studies have surveyed addiction counsellors themselves to describe this experience (Farmer et al., 2002). The current study describes the experience of participants in dealing with challenges with their clients, and how it affects their stress.

Some research has identified client instability (Newman, 1997) and having multiple presenting issues (Gwyn & Colin, 2010) as being characteristic of the disease of addiction. In addition, the rise in co-occurring mental health conditions have also been speculated as being a challenge of working in the addictions field (Saunders & Robinson, 2002). These client characteristics have been found in the current study as being strong sources of stress for participants. One dimension of providing substance abuse treatment that has not been addressed as thoroughly in empirical research is the way trauma and emotional intensity of issues may have an impact on the stress experienced by addiction counsellors. Participants in the current study reported that one of the most challenging and stressful aspects of their jobs was indeed hearing the trauma and heavy suffering of their clients. This may relate to findings that 75% of addiction counsellors in one study had at least one symptom of secondary traumatic stress within the past week (Bride et al., 2009).

Participants in the current study reported feeling stressed and frustrated with low client motivation and commitment levels. Other research has shown that “a lack of observable progress” is one of the top five most stressful work experiences in therapists, with “apparent

apathy or lack of motivation in client" as one of the top seven stresses (Deutsch, 1984). The stress associated with a lack of observable progress reported by current participants may be explained by recent research which found that diminished personal accomplishment significantly predicted psychological distress by four times in addiction workers in comparison to those who did not report lowered personal accomplishment (Oyfeso et al., 2008).

Current findings reflect results from research by Farmer and colleagues (2002), which shows that there are indeed certain stressful aspects unique to providing treatment for addiction. In particular, client characteristics such as aggressive, manipulative, and demanding clients were found to be among the top ten sources of stress in addiction workers. Findings from the present research descriptively demonstrate, from the counsellor's point of view, the heightened stress that arises from various client interactions (such as unpredictable situations, comorbidity issues, multiple needs clients, trauma, or client motivation levels).

Signs of stress. The majority of participants reported a variety of symptoms that informed them that they were stressed, ranging from physical, behavioural, emotional and occupational signs. Stress and burnout are terms that are, as previous mentioned, used interchangeably in the literature and participants also seemed to use these terms synonymously in their sharing. However, participants did seem to find importance in stress reduction for the purpose of preventing burnout, which indicated that they differentiated burnout from the normal stress experience.

Some of the signs of stress found in the current study coincided with what is found in the research on stress within the helping profession in general. Most research on addiction workers from the literature examines stress in relation to experiences of burnout. Since burnout is a result of experiencing prolonged and chronic stress (Maslach et al., 2001), it is not surprising that there

is some overlap in the symptoms of stress from the current study with studies examining burnout. For example, a lack of energy or feeling that one's emotional resources are depleted is a symptom of emotional exhaustion (Maslach, 1986) and was reported by participants in the current study. However, signs of stress in addiction workers from the literature are usually measured on the Emotional Exhaustion subscale of the Maslach Burnout Inventory (Maslach et al., 2001), and are examined in relation to what variables predict emotional exhaustion or how emotional exhaustion predicts turnover (e.g. Broom et al., 2009; Duraisingham et al., 2009; Knudsen et al., 2003, 2006, 2008). The current study shows, though, that there are other signs of stress aside from emotional fatigue that may indicate that an addictions counsellor is overly strained.

Results provide information on when to intervene or prevent the effects of stress from worsening. For example, ruminating, disrupted sleep, change in eating habits, feeling less engaged in client sessions, not wanting to socialize, anxiety, or irritation were all ways that participants in this research knew that they were feeling stressed. Skinner and Roche (2005) created a useful tool for addiction workers to check-up on their stress levels. The criteria for being "at risk of chronic stress and potentially burnout" are met if the addiction worker recognizes two to three (or more) of the 12 listed symptoms (Skinner & Roche, 2005, p. 40).

Skinner and Roche's check-up tool was adapted from information on general organizational stress, and the current study can be used to support the accuracy of the symptoms for addictions counsellors. For example, participants in the current study did experience the following listed symptoms: *exhaustion, tired and physically run down; cynical and negative towards work; frequent headaches and/or gastrointestinal disturbances; weight loss or gain; difficulty sleeping; unable to relax and concentrate (at home and/or work);* and *feeling weepy or*

tearful. Symptoms that were not found among the current participants were: *feeling annoyed or irritated towards coworkers; care less about doing a "good job;" a sense of being besieged; losing your temper;* and *difficulty thinking logically and making decisions*. Other signs shared by current participants that could be added to the checklist as symptoms are: withdrawing from social activity, ruminating about clients at home, feeling ineffective, or lacking confidence.

Resiliency against stress. It has been shown in other research that "personal and human aspects of work" (Gallon et al., 2003, p.189) brought the most satisfaction to addiction counsellors in their jobs. Specifically, satisfying aspects included: gaining personal growth, the interaction with clients, collegiality with coworkers, and commitment to treatment. The current study found similar results, where the abundance of opportunity for learning, the helping relationship with clients, and camaraderie on their teams were occupational rewards that helped participants build resiliency against the multiple stressors they experience in their jobs.

Though many participants emphasized that client change is not made by "any magic wand that we have" (Participant 9), there is no doubt that these addiction counsellors contributed great efforts to helping their clients achieve their goals. The benefit that clients would potentially gain, the ability to maintain belief in human strength and healing, and the therapeutic process were common convictions that participants held that appeared to be protective against stress. Perhaps knowing that those with addiction have a serious need for help allow counsellors to view their work as meaningful, necessarily, and significant. Thus, hearing gratitude from clients and witnessing successes may confirm the belief in their work as important, despite the futility that can be experienced otherwise.

Those in the present study who had a history related to addiction expressed finding deep personal meaning in the work, and were thus strongly motivated to continue working as

addictions counsellors. Studies in the literature have also shown that those in recovery have a significantly higher commitment to the profession than those who are not (Curtis & Eby, 2010). However, an interesting finding of the current research suggests that those who are not in recovery also displayed high level of commitment to staying in the field. These participants also appeared to have a meaningful connection to the work that was comparable to those who were in recovery. For example, 9 out of 10 participants in the current study all expressed high dedication to their work as addiction counsellors, reporting an average of 14.4 years intended to remain in the field.

Implications for Stress Management in Addictions Counselling

The present study illustrates what the demands of the addictions counselling profession are, and the harm of stress that can be inflicted regardless of whether burnout is reached. Similarities of current findings to national and international studies also reaffirm that certain stressors are inherent and specific to the addictions field, and the results call for better promotion, support, and contribution to addiction counsellor wellness.

Summary of major contributions. New information on sources of stress that have been found include individual stressors and internal reactions (e.g. projecting expectations, having a desire to fix, professional self-doubt); stressors related to having a personal history with addiction (e.g. self-disclosure to clients); stressors stemming from systemic issues (e.g. stigma of addiction, navigating and obtaining services); and client stressors (e.g. trauma and emotional intensity). This study also took an inventory of the participants' symptoms and signs of stress, which may be helpful in identifying early signs of occupational stress and burnout. The present research found new information on cognitive, practical, organizational, and educational strategies useful for stress management and intervention as described by participants themselves.

Lastly, this study describes characteristics of resiliency against occupational stress. The following section outlines the implications of these results, and how they might provide practical information for addiction counsellors, educators, and organizations.

Implications for counsellor practice. Some new dimensions about occupational stress in this field were found and may have important implications for addictions counselling practice. Specifically, more information was discovered on individual stressors like professional self-doubt in novice counsellors; the stress involved for counsellors in recovery related to countertransference or the professionalization of the field; and the therapeutic challenges of providing treatment for this particular clientele. Encountering difficulties within the mental healthcare system appeared to play a large part in the daily work of addictions counselling for these participants. Thus, it may be of benefit for addiction counsellors to be informed of the way in which systemic issues are intertwined within their roles.

Results also show that some of this stress was influenced by a lack of preparation by educational institutions and organizational induction programs during early professional development and training processes. Providing context- and role-specific information may help impart counsellors with the appropriate knowledge and realistic expectations needed to prepare them for the work, as well as cautioning them to the multitude of stressors they may encounter. The goal of training counsellors with occupation-specific information at the inception of their careers is to equip trainees with the necessary tools to recognize and assess early warning signs of burnout; learn how to deal with heightened stress immediately and effectively; and to manage strain before any risk of impairment to their health is reached. Furthermore, there may be value in providing them with the particular coping skills that have been helpful to other addiction counsellors.

Education on stressors and stress reactions – at all experience levels – may also open the opportunity for addiction counsellors to reach out for help from others. As there may be some perceived stigma attached to admitting feeling overly stressed, or that it will negatively reflect on their professional capability, normalizing the stress experience may help encourage employees to share how they are feeling with peers and supervisors. In order to promote a culture of self-care and awareness towards levels of stress, the potential for counsellors to experience occupational strain, despite having expertise in helping others cope with stress, must be openly communicated and recognized (Everall &Paulson, 2004). Proactive support for stress management by educators and organizations are discussed further in the section on *Implications for Educators and Organizations*.

The interplay between sources of stress. The detailed descriptions of the nature of providing addictions counselling from this study demonstrate how the demands involved have the potential to produce stress at unhealthy levels. It was apparent that these participants experienced strain in the workforce from various sources of stress. Many of these stressors affected the other, creating subsequent negative effects for the addiction counsellors. A common interplay between stressors experienced by participants were (a) the inadequacy of resources being chronic and pervasive, and (b) clients who were not always as committed and engaged in treatment as the counsellors were. The strain of maintaining motivation and hope despite the lack of responsiveness by the system (and sometimes the clients) seemed taxing on counsellor enthusiasm for the work. Stressors from clinical work also influenced (c) internal stressors and the effectiveness that counsellors felt, especially when workloads were high. Adding (d) the strain of an organization that is understaffed or is not effectively supportive of stress management creates an elevated risk for long-term stress.

These results indicate that addictions counsellors need to wear many different hats while being skillful at each, doing the work of many. It is no wonder participants often felt the weight of responsibility on them, which would further add to stress levels. Keeping this interplay of stressors in mind, what can addiction counsellors themselves do to minimize stress?

Individual stress management strategies. Participants provided cognitive and practical interventions that have been helpful to them in preventing and coping with stress. Although long-term systemic and organizational interventions are vital to reducing occupational stress, the results suggest that it is also important to ensure each counsellor has the tools to manage the stresses that are within his or her control.

Setting boundaries. Each participant had discussed the benefits of setting and maintaining strong professional boundaries as a method of stress prevention. A cognitive strategy to managing blurred boundaries (e.g. feeling overly responsible) was to learn professional detachment from clients. For example, participants realized, in working with clients struggling with addiction, that there are a variety of factors that affect client change and noticed how their expectations affected their stress levels. Professional detachment was achieved by having realistic expectations of client progress and acceptance of factors not within their control.

Practical ways to maintain boundaries in the workplace were to intentionally schedule appointments with more demanding clients at particular times (e.g. earlier on in the day or not all in one day) or to make sure that they took breaks or left the office throughout the workday.

Adjusting the focus. Another important cognitive coping skill that participants shared that helped them prevent and cope with stress was to focus on the small positive client changes. It seemed that participants were aware of the high levels of recidivism and relapse that, if focused on, could be disillusioning and discouraging. When participants were asked, “What

would you say to someone who is entering the addictions field to expect from the work? What should they be prepared for?" participants recommended that, in order to thrive working as an addiction counsellor, it is helpful to have an appreciation for smaller degrees of achievement.

Participants also encouraged others to have a belief in the work and faith in the potential for change, while knowing that not everyone can be helped. A balancing and managing of these two realities was an approach many of the counsellors developed and learned over time, and it appeared that they realized the necessity in this approach in order to sustain themselves in such a challenging field. As Participant 9 said, "It's about achieving balance."

Build self-awareness to stress symptoms. Participants shared that being aware of what their indicators of stress are is a key strategy in preventing burnout. Taleff and Swisher (2001) discuss self-knowledge as part of a "core function" to ethical practice as an addictions professional. Likewise, participants in the current study discussed the need to develop awareness of their stress symptoms and unresolved issues. This is essential for preventing harm to the addiction counsellor's own wellbeing, as well as averting interference with the client's therapeutic process.

Results showing individual stressors resulting from internal reactions such as projecting personal expectations on clients emphasize the need for counsellors to explore their assumptions about addiction and how these assumptions might affect stress levels. As suggested by participants, developing awareness can be encouraged through supervision, personal counselling, and using self-monitoring activities (e.g. through journaling). Participants also indicated that building an awareness of stress symptoms and finding coping skills that suited their own needs took time and exploration, which may be helpful to keep in mind for those who are earlier on in their careers.

Implications for educators and organizations. Much of the research on stress management for addiction professionals involve changes to the structure, culture, and management practices of an organization. As mentioned previously, this may be because strategies by educators and organizations for stress prevention are one of the more tangible and effective avenues for reducing strain, as other sources of stress inherent to providing addictions treatment (like systemic or client stressors) are not necessarily subject to change. Furthermore, addiction counsellors likely expect their clientele to have various high needs, and thus accept it as part of the work (Farmer et al., 2002). This may help buffer the negative effect that client demands can potentially have on addictions counsellors and allow them to focus their efforts on treatment delivery and advocacy.

However, several participants in the current study expressed the desire for their organization to take more initiative in implementing more stress management practices and outreach, as opposed to simply encouraging their staff to engage in self-care practices on their own. How can educations, organizations, and the field as a whole be effective in helping addiction counsellors manage stress?

Inform counsellors of stressors and symptoms. In addition to individuals newly entering the field, it may also be beneficial for current addictions counsellors to have knowledge about stressors to help normalize the stress experience as well. Educators and organizations can offer knowledge by providing literature or discussing stressors and symptoms with counsellors under supervision. Providing knowledge may help validate stress reactions as being part of the work and prepare counsellors for experiencing stressors unique to the addictions field.

Opening a conversation around occupational stress may also help both staff and managers stay informed of employee stress levels, as well as creating a forum for discussing needs and

developing self-care plans. Providing this information to all staff may also help them provide peer support when it is needed. Training staff on occupational stress may allow coworkers to feel better equipped to recognize symptoms, and more prepared in supporting their colleagues. This could be particularly helpful when supervisors are not available. Furthermore, regularly supplementing previous training related to stressors can buffer some strain related to self-doubt counsellors may feel in their roles. Concepts that may be important in training may include similar information to what has been found in the current study, such as common sources of stress; symptoms and signs of stress; and strategies for preventing and coping with stress.

Encouraging professional development. Training and professional development was also reported to help counsellors feel more confident in their ability to help clients. As participants have suggested, it also seems that having some knowledge foundation on concurrent disorders, trauma, loss, and symptoms of vicarious trauma may be helpful in preparing counsellors for the addictions field. The prevalence of participants in the current study who felt they had limited competency to deal with these issues point to a need for organizations and educational programs to support professional development in these areas. Although full competency for practice in these areas would require more extensive training, participants expressed the value for them in receiving more training around complex treatment issues. It seemed that participants had to face these issues whether it was a mandate of the agency or not, thus it is possible that feeling equipped to handle these issues will help reduce stress. Having skilled, well-prepared, and knowledgeable counsellors can also strengthen the workforce, and relies in part on continued professional development.

Facilitate team cohesiveness. A sense of team cohesion played a key role in reducing stress for all participants by creating an outlet for ventilation and sharing concerns. For example,

having small group supervision meetings, departmental lunches or excursions for employees to interact with each other regularly are some suggestions participants made that may help promote a sense of group cohesion. Given that a feeling of togetherness can become diluted within mid-sized and larger organizations, it may be necessary to implement activities that promote similar supportiveness often found in smaller agencies.

Helping counsellors process stress through supervision. It was found that although participants appeared empathetic when their managers were sometimes unavailable to provide support due to their own high workloads, participants still expressed the need for supervision that could be easily accessed as well as effectual. It is speculated that, based on participants' sharing, supervision allows the counsellors to process stressful experiences, and help them feel validated and supported during these times. If supervision is not available, this may lower their morale and leave the counsellors feeling isolated and without resources. To combat this isolation, it may be important for agencies to have increased supervisory support available to counsellors, especially during times when caseloads are high. Group supervision may also be a cost-effective method to help receive support and normalize stressful clinical experiences.

Quality supervision would involve having clinical expertise and knowledge, and would share responsibility of coping with stress and help participants with troubleshooting. Participants also considered supervision effective when it was approachable, nurturing, validating, and proactive. If there is no available or qualified staff member to provide supervision, it may be helpful to have access to an external supervisor who can provide support or come in on a regular basis for group supervision.

Limitations of the Study

This research provides the description of occupational stress from the perspective of 10 Canadian addiction counsellors. Although rich information has been found about working as an addictions counsellor within a Canadian setting, all participants who volunteered for this study are from addiction treatment centres within a specific metropolitan area. Results may therefore not reflect experiences of addiction counsellors from other areas across Canada, as was originally intended by the researcher. Furthermore, all participants worked in outpatient treatment centres, thus it is unclear whether sources of stress are similar for addiction counsellors working in inpatient treatment facilities, private practice, or other forms of treatment service delivery.

The current study used semi-structured interviewing to elicit deep and nuanced views from participants on occupational stress in addictions counselling. A risk of using semi-structured interviewing is that the results may be influenced by the interviewer's personality characteristics and interviewing approach. Furthermore, the use of semi-structured questions also poses the risk of pre-determining categories and themes.

The use of semi-structured interview protocols is also limited in nature by the reliance and accuracy of self-report by participants. Since permission from treatment centres was required before participants could be recruited to volunteer for the study, it is possible that upper management who agreed to allow recruitment were more interested in sharing their experience than centres that did not provide permission. In addition, it is possible that addictions counsellors who volunteered to participate were more motivated to speak about work stress than those who did not volunteer. It is also likely that those who did not respond may have been occupied with work demands and are not represented in the current sample. Lastly, because data was collected through means of self-report, conclusions cannot be drawn about cause and effect relationships.

Participants who volunteered for this study also included all females and no males. Although the counselling field generally has a higher ratio of females than males, females represent 30-70% of the addictions sector in Canada (e.g. Ogborne & Graves, 2005). It is therefore unclear whether results from this sample can inform us regarding the experience of male counsellors.

As outlined in the Methods section, the use of qualitative methods allows for the exploration of thought processes and interpretations of the participants in greater depth. However, a limit of this study is that the sample size consisted of only 10 participants and thus may not present a complete picture of the occupational stress experience for the majority of addiction counsellors. The results are not directly transferable to other groups beyond this sample, and are intended to be information rich instead. However, they may inform other attempts to study and assist addiction workers.

Future Directions for Research

The current study used a modified grounded theory approach to contribute more knowledge on occupational stress from the perspective of addiction counsellors themselves. Systemic thematic analysis was used to analyze data for conceptual ordering, and in-depth descriptions of the challenges, dilemmas, and stressors of working as an addiction counsellor were offered. Categories that emerged from the present study can be used in future research to guide the development of a theoretical framework on occupational stress in addictions counsellors.

The limitations in the current research also present opportunities for future investigation. For example, future qualitative studies may aim to recruit male addiction counsellors in order to have a more gender-proportionate representation of the addictions workforce. The sample could

also be expanded to include treatment centres across Canadian cities and towns. In addition, recruitment of addiction counsellors from inpatient treatment centres to the sample may also help provide a more complete representation.

Participants in the current study were not asked to identify whether they are in recovery from an addiction. In keeping with grounded theory methodology, it was the intention of the researcher to allow recovery status to emerge on its own through the participants' sharing. Future studies on occupational stress in addictions treatment may focus on recruiting participants who specifically are in recovery, and further expand on the experiences specific to being a paraprofessional found in the current study.

A final area for future exploration may be to examine professional self-doubt in novice addiction counsellors. As other research has shown, an issue for worker retention within organizations is the turnover of younger, less experienced addiction counsellors. The current study described some of the experiences of being a novice counsellor and feelings of incompetence involved which can be stressful. It may be helpful to explore in greater depth, the impact of stressors on feelings of self-efficacy and self-doubt in addiction counsellors who are newer in the field, and to find methods to enhance intention to stay in the field.

References

Abouyanni, G., Stevans, L.J., Harris, M.F., Wickes, W.A., Ramakrishna, S.S., Ta, E., Knowlden, S.M. (2000). GP attitudes to managing drug- and alcohol-dependent patients: a releuctatnt role. *Drug and Alcohol Review, 19*, 165-170. doi:10.1080/713659318

Adlaf, E.M., Begin, P., & Sawka, E. (Eds.). (2005). *Canadian Addiction Survey (CAS): A national survey of Canadians' use of alcohol and other drugs: Prevalence of use and related harms: Detailed report.* Ottawa: Canadian Centre on Substance Abuse.

Annis, H.M. (1986). A relapse prevention model for treatment of alcoholics. In: Miller, W.R., and Heather, N. (Eds). Treating Addictive Behaviors: Processes of Change (pp. 407-433). New York: Plenum.

Allsop, S.J. & Helfgott, S. (2002). Whither the drug specialist? The work-force development needs of drug specialist staff and agencies. *Drug and Alcohol Review, 21,* 215-222. doi:10.1080/0959523021000002660

Barrett, K., Riggar, T.F., Flowers, C.R., Crimando, W., & Bailey, T. (1997). The turnover dilemma: A disease with solutions. *The Journal of Rehabilitation, 63*(2), 36-47.

Bradley, E.H., Curry, L.A., & Devers, K.J. (2007). Qualitative data analyss for health services research: Developing taxonomy, themes, and theory. *Health Services Research, 42*(4), 1758 – 1772. doi:10.1111/j.1475-6773.2006.00684.x

Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology, 3,* 77-101. doi:10.1191/1478088706qp063oa

Bride, B.E., Hatcher, S.S., & Huble, M.N. (2009). Trauma training, trauma practices, and secondary traumatic stress among substance abuse counselors. *Traumatology, 15*(2), 96-105. doi:10.1177/1534765609336362

Broderick, E.B. (2005). Strengthening professional identity: Challenges of the addiction treatment workforce. Rockville, MD: U.S. Department of Health and Human Services, Center for Substance Abuse Treatment. Retrieved from: http://www.pfr.samhsa.gov/docs/Report_to_Congress.pdf

Broome, K.M., Knight, D.K., Edwards, J.R., & Flynn, P.M. (2009). Leadership, burnout, and job satisfaction in outpatient drug-free treatment programs. *Journal of Substance Abuse Treatment, 37,* 160-170. doi:10.1016/j.jsat.2008.12.002

Canadian Centre on Substance Abuse (2004). *Treatment Workforce Survey*. Ottawa, ON: Canadian Centre on Substance Abuse. Retrieved from http://www.ccsa.ca/2004%20CCSA%20Documents/ccsa-004026-2004.pdf

Canadian Centre on Substance Abuse (2007). *Considering a Career in the Substance Abuse Field.* Ottawa, ON: Canadian Centre on Substance Abuse

Center for Substance Abuse Treatment (2000). *Changing the conversation: The national treatment plan initiative*. Rockville, MD: Author.

Clanton, L.D., Rude, S.S., & Taylor, C. (1992). Learned resourcefulness as a moderator of burnout in a sample of rehabilitation providers. *Rehabilitation Psychology, 37*(2), 131-140. doi:10.1037/h0079105

Collin, C. (2006). *Substance Abuse Issues and Public Policy in Canada: I. Canada's Federal Drug Strategy*. Ottawa, ON: Parliamentary Information and Research Service. Retrieved from http://www2.parl.gc.ca/content/lop/researchpublications/prb0615-e.html

Conner, K.O. & Rosen, D. (2008). "You're nothing but a junkie": Multiple experiences of stigma in an aging methadone maintenance population." *Journal of Social Work Practice in the Addiction, 8*(2), 244-264. doi:10.1080/15332560802157065

Corbin, J. & Strauss, A. (2008). *Basics of Qualitative Research, 3rd Ed.* California: Sage Productions.

Corrigan, P.W., Kuwabara, S.A., & O'Shaughnessy, J. (2009). The public stigma of mental illness and drug addiction: Findings from a stratified random sample. *Journal of Social Work, 9*(2), 139-147. doi:10.1177/1468017308101818

Corrigan, P.W., Lurie, B.D., Goldman, H.H., Slopen, N., Medasani, K., Phelan, A.B. (2005). How adolescents perceive the stigma of mental illness and alcohol abuse. *Psychiatric Services, 56*(5), 544-560. doi:10.1176/appi.ps.56.5.544

Curtis, S.L. & Eby L.T. (2010). Recovery at work: The relationship between social identity and commitment among substance abuse counselors. *Journal of Substance Abuse Treatment, 39*, 248-254. doi:10.1016/j.jsat.2010.06.006

Deutsch, C.J. (1984). Self-reported sources of stress among psychotherapists. *Professional Psychology: Research and Practice, 15*(6), 833-845. doi:10.1037/0735-7028.15.6.833

Ducharme, L.J., Knudson, H.K., & Roman, P.M. (2008). Emotional exhaustion and turnover intention in human service occupations: The protective role of coworker support. *Sociological Spectrum, 28,* 81-104. doi:10.1080/02732170701675268

Dupuis, T. & MacKay, R. (2010). *Bill S-10: An act to amend the Controlled Drugs and Substances Act and to make related and consequential amendments to other acts* (Publication No. 40-3-S10-E). Retrieved from http://www2.parl.gc.ca/Content/LOP/LegislativeSummaries/40/2/c15-e.pdf

Duraisingam, V., Pidd, K., & Roche, A.M. (2009). The impact of work stress and job satisfaction on turnover intentions: A study of Australian specialist alcohol and other drug workers.

Drugs: education, prevention and policy, 16(3), 217-231. doi:10.1080/09687630902876171

Eby, L.T., Burk, H., & Maher, C.P. (2010). How serious of a problem is staff turnover in substance abuse treatment? A longitudinal study of actual turnover. *Journal of Substance Abuse Treatment, 39*, 264-271. doi:10.1016/j.jsat.2010.06.009

Elliott, T.R. Shewchuk, R., Hagglund, K., Rybarczyk, B., & Harkins, S. (1996) Occupational burnout, tolerance for stress, and coping among nurses in rehabilitation units. *Rehabilitation Psychology 41*(4), 267-284. doi:10.1037/0090-5550.41.4.267

Elliot, N. & Lazenbatt, A. (2005). How to recognize a 'quality' grounded theory research study. *Australian Journal of Advanced Nursing,* 22(3), 48-52.

Elman, B.D., & Dowd, E.T. (1997). Correlates of burnout in inpatient substance abuse treatment therapists. *Journal of Addictions & Offender Counseling, 17*(2), 56-66. Retrieved from: EBSCO*host.*

Everall, R.D. & Paulson, B.L. (2004). Burnout and secondary traumatic stress: Impact on ethical behaviour. *Canadian Journal of Counselling, 38*(1), 25-35. Retrieved from: http://cjc-rcc.ucalgary.ca/cjc/index.php/rcc/article/view/244/552

Fahy, A. (2007). The unbearable fatigue of compassion: Notes from a substance abuse conselor who dreams of working at Starbuck's. *Clinical Social Work Journal, 35*, 199-205. Doi: 10.1007/s10615-007-0094-4

Farmer, R., Clancy, C., Oyefeso, A., & Rassool, G.H. (2002). Stress and work with substance misusers: The development and cross-validation of a new instrument to measure staff stress. *Drugs: education, prevention, and policy, 9*(4), 377-388. doi:10.1080/09687630210131445

Flynn, P.M. & Brown, B.S. (2008). Co-occurring disorders in substance abuse treatment: Issues and prospects. *Journal of Substance Abuse Treatment, 34*, 36-47. doi:10.1016/j.jsat.2006.11.013

Figley, C.R. (2002). Compassion fatigue: A psychotherapists' chronic lack of self-care. *Journal of Clinical Psychology, 58,* 1433-1441. doi:10.1002/jclp.10090

Gallon, S.L., Gabriel, R.M., & Knudsen, J.R. (2003). The toughest job you'll ever love: A Pacific Northwest Treatment Workforce Survey. *Journal of Substance Abuse Treatment, 24,* 183-196. doi:10.1016/S0740-5472(03)00032-1

Garman, A.N., Corrigan, P.W., & Morris, S. (2002). Staff burnout and patient satisfaction: Evidence of relationships at the care unit level. *Journal of Occupational Health Psychology, 7*(3), 235-241. doi:10.1037/1076-8998.7.3.235

Garner, B.R., Knight, K., Simpson, D.D. (2007). Burnout among corrections-based drug treatment staff: Impact of individual and organizational factors. *International Journal of Offender Therapy and Comparative Criminology, 51*(5), 510-522. doi: 10.1177/0306624X06298708

Goodwin, L.R. (2007). A comprehensive substance abuse counselor education program. *Journal of Teaching in the Addictions, 5*(2), 59-80. doi:10.1300/J188v05n02_05

Goodwin, L.R., & Sias, S.M. (2007). Substance abuse and clinical counseling students' characteristics and career goals. *Journal of Teaching in the Addictions, 6*(1), 1-18. doi:10.1080/15332700802126203

Graves, G., Csiernik, R., Foy, J., & Cesar, J. (2008). *An Examination of Substance Abuse Core Competencies in Academic Curriculum: The Social Work Example.* Ottawa: Canadian Centre on Substance Abuse.

Graves, G., & Plouffe, K. (2008). *Core competencies for the substance abuse field: Educational and training experts consultation report.* Ottawa: Canadian Centre on Substance Abuse

Griffeth, R. W., Hom, P. W., & Gaertner, S. (2000). A meta-analysis of antecedents and correlates of employee turnover: Update, moderator tests, and research implications for the next millennium. *Journal of Management*, *26*, 463−488. doi:10.1177/014920630002600305

Gymn, P.G. & Colin, J.M (2010). Research with the doubly vulnerable population of individuals who abuse alcohol: An ethical dilemma. *Journal of Psychosocial Nursing and Mental Health Services, 48*(2), 38-43. doi:10.3928/02793695-20100108-01

Hayes, S.C., Bissett, R., Roget, N., Kohlenberg, B.S., Fisher, G., Akihiko, M.,…Niccolls, R. (2004). The impact of acceptance and commitment training and multicultural training on the stigmatizing attitudes and professional burnout of substance abuse counselors. *Behavior Therapy, 35*, 821-835. doi:10.1016/S0005-7894(04)80022-4

Health Canada (2002). *Best Practices: Concurrent Mental Health and Substance Use Disorders.* Ottawa: Health Canada.

Howard, M.O. & Chung, S.S. (2000). Nurses' attitudes toward substance misusers. III. Emergency room nurses' attitudes, nurses' attitudes toward impaired nurses, and studies of attitudinal change. *Substance Use & Misuse, 35*(9), 1227-1261. doi:10.3109/10826080009147480

Janikowski, T.P. & Glover-Graf, N.M. (2003). Qualifications, training, and perceptions of substance abuse counselors who work with victims of incest. *Addictive Behaviors, 28,* 1193-1201. doi:10.1016/S0306-4603(02)00217-4

Johnson, J. A., Knudsen, H. K., & Roman, P. M. (2002). Counselor turnover in private facilities. Frontlines: Linking Alcohol Services Research & Practice, *November*, 5,8.

Jones, P., & Williams, A.M. (2007). *Self-Care: A Guide for Addiction Professionals.* Silver Springs, MD: Central East Addiction Technology Transfer Center.

Keyes, K.M., Hatzenbuehler, M.L., McLaughlin, K.A., Link, B., Olfson, M., Grant, B.F., & Hasin, D. (2010). Stigma and treatment for alcohol disorders in the United States. *American Journal of Epidemiology, 172*(12), 1364-1372. doi:10.1093/aje/kwq304

Knudsen, H.K., Ducharme, L.J., & Roman, P.M. (2006). Counselor emotional exhaustion and turnover intention in therapeutic communities. *Journal of Substance Abuse Treatment, 31*, 173-180. doi: 10.1016.j.sat.2006.04.003

Knudsen, H.K., Ducharme, L.J., & Roman, P.M. (2008). Clinical supervision, emotional exhaustion, and turnover intention: a study of substance abuse treatment counselors in the Clinical Trials Network of the National Institute on Drug Abuse. *Journal of Substance Abuse Treatment, 35,* 387-395. doi:10.1016/j.jsat.2008.02.003

Knudsen, H.K., Johnson, J.A., Roman, P.M. (2003). Retaining counseling staff at substance abuse treatment centers: Effects of management practices. *Journal of Substance Abuse Treatment; 24,* 129-135. doi:10.1016/S0740-5472(02)00357-4

Lacoursiere, R.B. (2001). "Burnout" and the substance user treatment: The phenomenon and the administrator-clinician's experience. *Substance Use & Misuse, 36*(13), 1839-1874. doi:10.1081/JA-100108430

Layne, C.M., Hohenshil, T.H., & Singh, K. (2004). The relations of occupational stress, psychological strain, and coping resources to turnover intentions of rehabilitation

counselors. *Rehabilitation Counseling Bulletin, 48* (1), 19-30. doi:10.1177/00343552040480010301

Lincoln, Y.S., & Guba, E.G. (1985). *Naturalistic Inquiry*. Thousand Oaks: Sage Publications.

Maslach, C. (1986). Stress, burnout, and the workaholic syndrome. In R. Kilburg, R. Thoreson, & P. Nathan (Eds.), *Professionals in distress: Issues, syndromes and solutions in psychology* (pp. 53-75). Washington, DC: American Psychological Association.

Maslach, C., Schaufeli, W.B., & Leiter, M.P. (2001). Job burnout. *Annual Review of Psychology, 53*, 397-422. doi:10.1146/annurev.psych.52.1.397

McLellan, A.T., Carise, D., & Kleber, H.D. (2003). Can the national addiction treatment infrastructure support the public's demand for quality care? *Journal of Substance Abuse Treatment, 25*, 117-121. doi:10.1016/S0740-5472(03)00156-9

Morrow, S.L. (2005). Quality and trustworthiness in qualitative research in counseling psychology. *Journal of Counseling Psychology, 52*(2), 250-260. doi: 100.1037/0022-0167.52.2.250

Myers, P.L. & Salt, N.R. (2007). *Becoming an addiction counselor: A comprehensive text.* London: Jones and Barlett Publishing.

Neuman, D.A. & Gamble, S.J. (1995). Issues in the professional development of psychotherapists: Countertransference and vicarious traumatization in the new trauma therapist. *Psychotherapy, 32*(2), 341-347. doi:10.1037/0033-3204.32.2.341

Newman, C.F. (1997). Establishing and maintaining a therapeutic alliance with substance abuse patients: A cognitive therapy approach. In Onken, L.S., Blaine, J.D., Boren, J.J. (Eds.). *Beyond the Therapeutic Alliance: Keeping the Drug-dependent Individual in Treatment.*

(pp. 181-206) [*Monograph*]. Retrieved from http://archives.drugabuse.gov/pdf/monographs/monograph165/download165.html

Netten, A. & Knight, J. (1999). Annuitizing the human capital investment cost of health service professionals. *Health Economics, 8*, 245-255. doi:10.1002/(SICI)1099-1050(199905)8:3<245::AID-HEC430>3.3.CO;2-W

O'Donovan, A. & Dawe, S. (2002). Evaluating training effectiveness in psychotherapy: Lessions for the AOD field. *Drug and Alcohol Review, 21*, 239-245, doi: 10.1080/0959523021000002697

Office of the Auditor General of Ontario (2010). *2010 Annual Report of the Auditor General of Ontario, Chapter 4.01: Addiction Programs – Follow-up on VFM Section 3.01, 2008 Annual Report*. Toronto, ON: Queen's Printer for Ontario. Retrieved from http://www.auditor.on.ca/en/reports_en/en10/401en10.pdf

Office of the Auditor General of Ontario (2008). *2008 Annual Report of the Auditor General of Ontario, Section 3.01: Addiction Programs*. Toronto, ON: Queen's Printer for Ontario. Retrieved from http://www.auditor.on.ca/en/reports_en/en10/401en10.pdf

Ogborne, A.C., Braun, K., & Schmidt, G. (1998). Working in addictions treatment services: Some views of a sample of service providers in Ontario. *Substance Use & Misuse, 33*(12), 2425-2440. doi:10.3109/10826089809059333

Ogborne, A. C., & Graves, G. (2005). Optimizing Canada's addiction treatment workforce: Results of a national survey of service providers. Ottawa: Canadian Centre on Substance Abuse (CCSA).

Oyefeso, A., Clancy, C., & Farmer, R. (2008). Prevalence and associated factors in burnout and psychological morbidity among substance misuse professionals. *BMC Health Services Research, 8*, 39-48. doi:10.1186/1472-6963-8-39

Pearlstein, T. (2002). Eating disorders and comorbidity. *Archives of Women's Mental Health, 4*(3), 67-78. doi:10.1007/s007370200002

Peiro, J.M., Gonzalez-Roma V., Tordera, N., & Manas, M.A. (2001). Does role stress predict burnout over time among health care professionals? *Psychology and Health, 16,* 511-525. doi:10.1080/08870440108405524

Piantanida, M. & Garman, N.B. (1999). *The Qualitative Dissertation: A Guide for Students and Faculty.* Thousand Oaks, CA: Corwin Press

Pope, C., & Mays, N. (1995). Reaching the parts other methods cannot reach : An introduction to qualitative methods in health and health services research. *BMJ British Medical Journal (International Ed.), 311*(6996), 42-45. Retrieved from www.csa.com

Raquepaw, J.M. & Miller, R.S. (1989). Psychotherapist burnout: A componential analysis. *Professional Psychology: Research and Practice, 20*(1), 32-36. doi:10.1037/0735-7028.20.1.32

Rehm, J., Baliunas, D., Brochu., S., Fischer, B., Gnam, W., Patra, J., et al. (2006). *The costs of substance abuse in Canada 2002: Highlights.* Canadian Centre on Substance Abuse (CCSA): Ottawa.

Ritter, A., Bowden, S., Murray, T., Ross, P., Greeley, J., & Pead, J. (2002). The influence of the therapeutic relationship in treatment for alcohol dependency. *Drug and Alcohol Review, 21*, 261-268. doi:10.1080/0959523021000002723

Roche, A. (2009). New horizons in AOD workforce development. *Drugs: education, prevention and policy, 15*(3), 193-204. doi: 10.1080/09687630902886386

Roche, A., O'Neill, M., & Wolinski, K. (2004). Alcohol and other drug specialist treatment services and their managers: Findings from a national survey. *Australian and New Zealand Journal of Public Health, 28* (3), 252-258. doi:10.1111/j.1467-842X.2004.tb00484.x

Rothrauff, T.C., Abraham, A.J., Bride, B.E., Roman, P.M. (2011). Occupational turnover intentions among substance abuse counselors. *Journal of Substance Abuse Treatment, 40*, 67-76. doi:10.1016/j.jsat.2010.08.008

Rupert, P.A. & Morgan, D.J. (2005). Work setting and burnout among professional psychologists. *Professional Psychology: Research and Practice, 36* (5), 544-550. doi:10.1037/0735-7028.36.5.544

Saunders, B. & Robinson, S. (2002). Co-occuring mental health and drug dependency disorders: Work-force development challenges for the AOD field. *Drug and Alcohol Review, 21,* 231-237. doi:10.1080/0959523021000002688

Sherman, M.D. (1996). Distress and professional impairment due to mental health problems among psychotherapists. *Clinical Psychology Review, 16*(4), 299-315. doi:10.1016/0272-7358(96)00016-5

Shoptaw, S., Stein, J.A., & Rawson, R.A. (2000). Burnout in substance abuse counselors: Impact of environment, attitudes, and clients with HIV. *Journal of Substance Abuse Treatment, 19*, 117-126. doi:10.1016/S0740-5472(99)00106-3

Skinner, N., Feather, N.T., Freeman, T., Roche, A. (2007). Stigma and discrimination in health-care provision to drug users: The role of values, affect, and deservingness judgments.

Journal of Applied Social Psychology, 37(1), 163-186. doi:10.1111/j.0021-9029.2007.00154.x

Skinner, N. (2005). *Workplace Support*. In N. Skinner, A.M. Roche, J. O'Connor, Y. Pollard, & C. Todd (Eds.),Workforce Development TIPS (Theory Into Practice Strategies): A Resource Kit for the Alcohol and Other Drugs Field. National Centre for Education and Training on Addiction (NCETA): Adelaide, Australia

Skinner, N. & Roche, A.M. (2005). *Stress and Burnout: A Prevention Handbook for the Alcohol and Other Drugs Workforce.* National Centre for Education and Training on Addiction (NCETA): Adelaide, Australia.

Skinner, N., Roche, A.M., Freeman, T., & McKinnon, A. (2009). Health professionals' attitudes towards AOD-related work: Moving the traditional focus from education and training to organizational culture. *Drugs: education, prevention and policy, 16*(3), 232-249. doi:10.1080/09687630902876338

Smith, P.L. (2009). Psychologist impairment: What is it, how can it be prevented, and what can be done to address it? *Clinical Psychology: Science and Practice, 16*, 1-15. doi:10.1111/j.1468-2850.2009.01137.x

Strauss, A. & Corbin, J. (1998). *Basics of Qualitative Research: Techniques and Procedures for Developing Grounded Theory (2nd Ed.).* London, UK: Sage Publications.

Taleff, M.J. & Swisher, J.D. (1997). The seven core functions of a Master's degree level alcohol and other drug counselor. *Journal of Alcohol and Drug Education, 42* (3), 1–17. Retrieved from EBSCO*host*

Taylor, B., & Barling, J. (2004). Identifying sources and effects of career fatigue and burnout for mental health nurses: A qualitative approach. *International Journal of Mental Health Nursing, 13,* 117-125. doi:10.1111/j.1445-8330.2004.imntaylorb.doc.x

Theriault, A., Gazzola, N., & Richardson, B. (2009). Feelings of incompetence in novice therapists: Consequences, coping, and correctives. *Canadian Journal of Counselling, 43* (2), 105-119.

Whitter, M., Bell, E. L., Gammond, P., Gwaltney, M., Magana, C. A., & Moreaux, M. (2006). Strengthening professional identity: Challenges of the addictions treatment workforce. Available from http://www. samhsa.gov/workforce/workforcereportfinal.pdf

Wierzbicki, M., & Pekarik, G. (1993). A meta-analysis of psychotherapy dropout. *Professional Psychology: Research and Practice, 24*, 190-195. doi:10.1037/0735-7028.24.2.190

Zeddies, T.J. (1999). Becoming a psychotherapist: The personal nature of clinical work, emotional availability and personal allegiances. *Psychotherapy, 36* (3), 229-235. doi:10.1037/h0087730

Appendix A

Letter of Permission to Recruit

Date

Dear

This letter is a request for permission to recruit participants for a research study at ***[name of organization]***'s. I am conducting this research as part of my Master's degree in Educational Counselling at the University of Ottawa, Ontario, under the supervision of Dr. Anne Theriault. The title of my research project is "Exploring the Challenges and Stressors of Being an Addictions Counsellor."

The purpose of this study is to examine the occupational experience of being an addictions counsellor. The goal of the research is to broaden our understanding of what counsellors face when providing addictions treatment, and to identify the key areas of stress that occur. Knowledge generated from this study ultimately aims to provide information on how to best support those entering and working in the field. It is my hope to contribute Information towards self-care and stress management practices, as well as training and retention strategies.

With your permission, I would like to connect with counsellors who work primarily with alcohol and/or drug addiction at ***[name of organization]***, and invite them via e-mail or telephone to participate in this research project. I am looking for approximately two to three participants per organization. Semi-structured interviews will take place on site of ***[name of organization]*** in the counsellor's office, and will last approximately 45-60 minutes. If ***[name of organization]*** would prefer to have the interviews conducted off site, interviews will be held at the researcher's lab at the University of Ottawa. A recruitment letter containing information about the study and its procedures will be provided to all counsellors, along with my contact information as well as my thesis supervisor's. If a counsellor is interested in participating, she or he will be invited to contact me to discuss participation in this study in further detail.

Participation is completely voluntary. All participants will be informed and reminded of their rights to participate or withdraw before any interview, or at any time during the study. An informed consent form will be given to all participants.

Names of participants or the organization will not appear in the thesis or reports resulting from this study. To support the findings of this study, quotations and excerpts from the interview will be used, labeled with pseudonyms (e.g. "Participant 1") to protect the identity of the participants.

I would like to assure you that this study has been reviewed and has received approbation from the Office of Research Ethics and Integrity at the University of Ottawa. If you have any questions regarding this study or would like additional information to assist you in reaching a decision about allowing me to recruit in your setting, please contact me or my supervisor at the contact information given below.

I will follow-up with a telephone call next week and would be happy to answer any questions or concerns you may have. I very much look forward to speaking with you and thank you in advance for your support.

Sincerely,

Victoria Ho
Master's Candidate
Educational Counselling
Faculty of Education
University of Ottawa
[Telephone number]
[E-mail address]

Dr. Anne Theriault
Associate Professor
Educational Counselling
Faculty of Education
University of Ottawa
[Telephone number
[E-mail address]

Appendix B

Organization Permission Form

We have read the information presented in the information letter about a study being conducted by Victoria Ho from the Educational Counselling program at the University of Ottawa, under the supervision of Dr. Anne Theriault. We have had the opportunity to ask any questions related to this study, to receive satisfactory answers to our questions, and any additional details we wanted.

We understand that the name of our organization or its employees who may participate will not be used in the thesis or any publications that comes from the research. We also understand that employees will be contacted at the organization via telephone or e-mail by the researcher.

We were informed that this organization may withdraw from assistance with the project at any time. We were informed that study participants may withdraw from participation at any time without penalty by advising the researcher.

We have been informed this project has been reviewed by, and received ethics clearance through the Office of Research Ethics and Integrity at the University of Ottawa. Questions we have about the study may be directed to Victoria Ho at ***[telephone number]*** or by email ***[e-mail address]*** and Dr. Anne Theriault at ***[telephone number]*** or ***[e-mail address]***

We were informed that if we have any comments or concerns with in this study, we may also contact Protocol Officer of the Social Sciences and Humanities Research Ethics Board at the University of Ottawa.

Victoria Ho
Master's Candidate
Educational Counselling
Faculty of Education
University of Ottawa

Dr. Anne Theriault
Associate Professor
Educational Counselling
Faculty of Education
University of Ottawa

We agree to help the researchers recruit participants for this study from among the counsellors of the *[name of organization].*

□ **YES** □ **NO**

Approved by:
Name: _____ Signature:_____
Title: _____
Date: _____

Appendix C

Recruitment Letter

Greetings, Addictions Counsellors!

You are invited to participate in a research study that I am conducting as part of the requirements for completion of an M.A. degree in Counselling at the University of Ottawa.

The purpose of this study is to examine the challenges and stressors of being an addictions counsellor. The goal of this research is broaden the knowledge and understanding of what counsellors face when providing addictions treatment, to identifying sources of occupational stress, and ultimately to discover how to best support those entering and already in the field.

Criteria for participation:

- You are employed in a substance abuse treatment centre or department as a counsellor working primarily with alcohol and drug addiction
- You are in direct contact with clients seeking treatment for substance misuse
- You are willing to discuss your experiences as a helping professional in the addictions field

If you volunteer to participate in this study, I would ask you to take approximately 45 - 60 minutes in a sit-down interview with me, where I would ask you some questions on your experiences as an addictions counsellor. This will include sharing your previous or current dilemmas, challenges, and successes with working in addictions treatment services. The interview will be audio recorded to provide an accurate record of our discussion, then later transcribed with all identifying information removed.

If you have any questions or concerns about the research, please do not hesitate to voice them to me ***[telephone number]*** or by email ***[e-mail address]*** or contact Dr. Anne Theriault at ***[telephone number]*** or ***[e-mail address].***

Thank you!

Victoria Ho
MA Candidate, Educational Counselling
University of Ottawa

Appendix D

Demographic Information Interviewee #_____

1. ***Age*: _____**

2. ***Gender:*** ☐ Female ☐ Male

3. ***What level of education have you reached?***

   ☐ High school not completed
   ☐ High School
   ☐ Certification/diploma
   ☐ Bachelor's degree
   ☐ Masters degree
   ☐ Ph.D

3. ***What is your professional title?*** _____

4. ***Do you have or are working towards a certification or diploma in addictions studies?***

   Have certification/diploma ☐ Yes ☐ No
   Working towards certification/diploma ☐ Yes ☐ No

If yes, what was the certification/diploma and where did you receive it? _____

_____

5. ***Are you currently certified or are working towards certification as an addictions counsellor?***

   Have certification ☐ Yes ☐ No
   Working towards certification ☐ Yes ☐ No

*If yes, what is the certifying body?*_____

_____

6. ***Are you currently otherwise registered or certified as a health professional?*** ☐ Yes ☐ No

If yes, please indicate your profession: _____

7. ***Are you currently a member of any professional associations?*** ☐ Yes ☐ No

*If yes, please indicate which association(s):*_____

_____

8. ***Do you work:*** Full-time ☐ Part-time ☐ Casual/Relief ☐

9. ***How long have you been working in the substance abuse field as a counsellor or therapist?*** _____ Years

10. ***How long have you held you present position*** _____ Years

11. How much longer do you expect to continue working in the treatment field? _____ Years

12. How much personal satisfaction do you get from working in your present job?

☐ None or very little satisfaction ☐ Quite a lot of satisfaction

☐ A bit of satisfaction ☐ A great deal of satisfaction

GLOSSARY

Certification: The end result of a process whereby a non-government agency or association grants recognition to individuals with specific qualifications. Certification is intended to signify and promote specific competencies among those involved and to enhance their reputations with the public. The drive for certification in the addictions field has been fuelled by public interests and the expectations of health insurers, funding agencies and governments.

Counsellors/Counsellors or similar: Those designed as such by their job titles and others, except doctors, nurses and psychologists who meet face to face with clients (individually or in groups) to address significant personal issues concerning substance abuse and related problems.

Appendix E

Informed Consent Form

Researchers:
Victoria Ho
M.A. Candidate
Educational Counselling
University of Ottawa
Tel:
E-mail:

Dr. Anne Theriault
Professor, Thesis Supervisor
Educational Counselling
University of Ottawa
Tel:
E-mail:

You have been invited to participate in the study conducted by Victoria Ho, called ***Exploring the Challenges and Stressors of Working as an Addictions Counsellor***. This research is being conducted as part of the requirements for completion of Victoria Ho's M.A. degree with the Department of Educational Counselling at the University of Ottawa.

Purpose of Study:
The purpose of this study is to examine the occupational experience of addiction counsellors. The goal of this research is to broaden the knowledge and understanding of what counsellors face when providing addictions treatment, to identify potential sources of occupational stress, and ultimately to discover how to best support those entering and those already in the field.

Procedures:
If you agree to participate in this study, you will be interviewed about your experiences working in the addictions treatment services field. The interview will take approximately 45 - 60 minutes and will be audiotaped to provide a record of our conversation for later transcription. You will also be asked to complete a short demographic questionnaire that will take approximately 10 minutes to complete.

Potential Risks and Discomforts
A potential risk is that in discussing the challenging aspects of your work, some emotional discomfort may be experienced during or after the interview. While the potential risk is minimal, if you do experience discomfort at any time, please contact the researcher to discuss your reactions.

Potential Benefits of Participation
Participation in this study will help contribute knowledge about occupational stress in addictions counsellors. This information may help in the development of stress prevention initiatives and can be used in the training and supervision of addiction counsellors.

Confidentiality
Any information obtained in this study that could lead to your identification will remain confidential and will only be disclosed with your permission or as required by law. In order to maintain confidentiality, all identifying information will be removed from the transcripts of audiotaped responses. Only the researcher and her thesis supervisor will have access to the data set.

Data Collection and Storage
The data collected will consist of your demographic information questionnaire, audiorecording of your interview, and transcription of the interview. All data will be stored in a locked filing cabinet at the University of Ottawa, in the researcher's office. The data will be accessible to only Victoria Ho and Anne Theriault. The data will be preserved for two years after completion of the research study, at which point all data will be destroyed and disposed of.

Participation and Withdrawal
Your participation in the research is entirely voluntary and you are free to withdraw at any time. This means that even though you agree initially to the interview, you can withdraw from the interview at any point. You may ask questions of the researcher at any time and you may refuse to answer any of the questions without any negative consequences.

If you have any questions, you may contact the research or her supervisor. There are two copies of the consent form one of which you may keep. Any information requests or complaints about the ethical conduct of the project can be addressed to the Protocol Officer of the Social Sciences and Humanities Research Ethics Board at the University of Ottawa.

I, _____, understand the procedures described above and agree to participate in this study.

Participant's
signature: _____Date:_____

Researcher's signature:_____Date:_____

Appendix F

Semi-structured Interview Protocol
Exploring the challenges and stressors of working as an addictions counsellor

Date: _____ (M/D/Y) Time of interview: _____ Interviewee #: _____

A. Information for participants:
The purpose of my study is to examine whether addictions counsellors experiences particular challenges and stressors, and to understand how these challenges and stressors are experienced. The goal of my research is to broaden the knowledge and understanding of what counsellors face when providing addictions treatment, to identify potential sources of occupational stress, and ultimately to discover how to best support those entering and those already in the field.

I am going to ask you some questions about your experiences as an addictions counsellor. This will include sharing your previous or current dilemmas, challenges, and successes with working in addictions treatment services. In order to provide an accurate record of our discussion, this interview will be audio recorded with your consent and later transcribed with all identifying information removed.

B. Review consent procedures

C. Collect demographic information

D. Interview questions
Tell me very briefly, what do you do?

1. Do you experience stress in your work?
   What are some contributors to this stress?
   What do you find to be the most difficult, stressful and/or challenging aspects of your job as an addiction counsellor?

2. Can you give me an example of a moment or work situation that you have experienced recently where you felt stressed or upset? What happened? What did you experience? What did you do? Was it resolved, and if so, how? If not - where did it go?

3. How do you know when you are stressed? What are some signs? How do you define stress?

4. Do you feel you are you able to manage these stresses?
   How did you manage the stress? What helped you to manage the stress?
   What happens when the stress does not dissipate?
   What would need to help the stress alleviate?

5. Have the organization(s) you've worked for been supportive towards stress management?
   In what way are they supportive/not supportive?

6. What would you say to someone who is entering the addictions field to expect from this work?
   What should they be prepared for?

7. What are some limitations of working in the addictions field?
   What motivates you to continue working in this field, given the challenges you face?
   What do you find the most satisfying about your job as an addictions counsellor?

Is there anything else you would like to add that you feel is important that we have not talked about?