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IS THERE A RELATIONSHIP BETWEEN ALCOHOL/DRUG  
COUNSELOR'S STRENGTH OF BELIEF IN THE DISEASE  
CONCEPT OF ADDICTION AND BURNOUT?

A Dissertation

Presented to the Faculty of  
Antioch University Seattle  
Seattle, WA

In Partial Fulfillment  
of the Requirements of the Degree  
Doctor of Psychology

By

Dan D. Dodd

September 2015

IS THERE A RELATIONSHIP BETWEEN ALCOHOL/DRUG  
COUNSELOR'S STRENGTH OF BELIEF IN THE DISEASE  
CONCEPT OF ADDICTION AND BURNOUT?

This dissertation, by Dan D. Dodd, has been  
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the Antioch University of Seattle at Seattle, WA in  
partial fulfillment of requirements for the degree of

DOCTOR OF PSYCHOLOGY

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## ABSTRACT

IS THERE A RELATIONSHIP BETWEEN ALCOHOL/DRUG  
COUNSELOR'S STRENGTH OF BELIEF IN THE DISEASE  
CONCEPT OF ADDICTION AND BURNOUT?

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This study examined the association between substance abuse counselors' (a) level of burnout and strength of belief in the disease concept of addiction, (b) level of burnout and recovery status, and (c) recovery status and strength of belief in the disease concept. Participants were recruited via a purposive convenience survey sampling method of counselors who were certified Chemical Dependency Professionals (CDPs) or Chemical Dependency Professional Trainees (CDPTs) who were employed in substance use disorder outpatient treatment facilities. A total of 130 surveys were distributed of which 72 were returned giving a 55% response rate. Six surveys were removed due to not providing evidence of informed consent or high frequency of missed answers. Of the remaining 66 participants, 45 were female, 20 were male, and one declined to report gender status. The largest age cohort was 41 years of age and over. Participants completed a demographic questionnaire, the Maslach Burnout Inventory—HSS (Maslach, Jackson, & Leiter, 1966), and the Addiction Belief Scale (Schaler, 1995). Analysis of data included Spearman rank order correlation, Chi-square Test for Independence, and Fisher's Exact Test. Results indicated that as strength in the belief in the disease concept

increased, level of emotional exhaustion/burnout decreased. There was no association for the burnout subscales of depersonalization and personal accomplishment. In addition, there was no significant association between (a) level of burnout and recovery status, or (b) recovery status and strength of belief in the disease concept. Future research should determine if results of this study can be replicated and shift its focus from why professionals are leaving the addiction field to why individuals remain working in the field. The electronic version of this dissertation is at AURA: Antioch University Repository and Archive, <http://aura.antioch.edu/> and OhioLINK ETD Center, <https://etd.ohiolink.edu>

**KEYWORDS:** Substance Abuse Counselors, Burnout, Disease Concept, Recovery Status

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## **Chapter I: Background**

The U.S. Department of Health and Human Services ([US DHHS], 2006) published a report sponsored by the Center for Substance Abuse Treatment (CSAT) entitled, “Strengthening Professional Identity: Challenges of the Addiction Treatment Workforce. A Framework for Discussion” (Whitter, 2006). The focus of the report was concern over the increasing shortages of professional addiction staff:

The addictions treatment field is facing a workforce crisis. Worker shortages, inadequate compensation, insufficient professional development and stigma currently challenge the field. Increasingly, treatment and recovery support providers also struggle with issues related to recruitment, retention and professional development of staff. The ability to provide quality addictions treatment and recovery support services is severely hampered by these conditions. (p. iii)

Concern regarding recruitment and retention of substance abuse treatment staff is primarily driven by the acute need for specialty treatment for alcohol or other drug use disorders. As reported by the Substance Abuse and Mental Health Services Administration (Knudsen & RMC Research Corporation, 2006), addictions treatment capacity at the national level is insufficient to provide alcohol or other drug treatment services for the total population needing such services. In addition, according to the National Survey on Drug Use and Health (Substance Abuse and Mental Health Services Administration [SAMHSA], 2014), in 2013, 22.7 million persons age 12 or older needed treatment for alcohol or other drug use problems. Of these, only less than 1% (2.5 million) received treatment at a specialty facility. In other words, over 20 million persons who needed treatment for an illicit drug or alcohol use problem did not receive needed treatment. One contributing factor for the lack of treatment obtained was an insufficient workforce and subsequent limited treatment capacity to meet this demand.

Compounding these challenges regarding an adequate workforce, many states have suffered severe reductions in treatment dollars despite Federal budget increases. In the rare instance of additional treatment funding, states are most likely to put these valuable dollars towards increasing capacity rather than supporting the treatment workforce infrastructure resulting in continuing low compensation structures for counselors including low wages and benefits.

In addition to issues of capacity and lack of funding to support a healthy workforce infrastructure, a more severe and diverse clinical profile has emerged among those needing services. According to SAMHSA (Knudsen & RMC Research Corporation, 2006) examples of these more severe profiles include: (a) injection use has replaced the previously preferred route of administration (inhalation) with injection rates among youth climbing from 34% to 51% for those under age 18 and from 48% to 63% among those ages 18 to 24, (b) non-medical abuse of prescription pain relievers for the first time has increased to more than 2 million in 2001 compared to 600,000 in 1990, (c) older adults with substance use disorders are expected to reach 5 million by the year 2020 up from 2.5 million individuals in 1999, and (d) an increasing number of clients with substance use disorders are presenting with complex co-occurring disorders that include mental health as well as serious physical health issues.

Challenges associated with the increased need for substance abuse treatment, lack of funding, and greater severity of client problems are also interacting with issues such as: (a) organizational and administrative instability reflected by agency reorganization and closings, (b) lack of a single national credentialing body making relocation substantially difficult and likely contributing to counselors leaving the profession completely,

(c) counselor's perception that new jobs and advancement opportunities are greatly limited within the field, and (d) stigmatization of counselors in that they are often viewed as unequal to practitioners in other health and behavioral science disciplines (Broome, Knight, Edwards, & Flynn, 2009; Eby, Burk, & Maher, 2010; Gallon, Gabriel, & Knudsen, 2003; Shoptaw, Stein, & Rawson, 2000).

### **Literature Review**

Three themes permeate the literature pertaining to counselor retention and burnout: First, the role of management and workplace practices and their related impact on turnover intention; second, the role of clinician's personal characteristics as contributors to susceptibility to burnout; and third, the role of counselor's recovery status in turnover intention, clinical orientation, clinical practices, and burnout.

**Counselor turnover intention and workplace practices.** The majority of studies to date estimate substance abuse counselor annual turnover rates as low as 19% to as high as 50% (Gallon et al., 2003; Knudsen, Johnson, & Roman, 2003; McNulty, Oser, Johnson, Knudsen, & Roman, 2002). In a study of the role of management and organizational practices by treatment providers and the relationship of these practices to counselor turnover intention Knudsen et al. (2003) compiled surveys of 1,074 counselors of privately funded substance abuse treatment centers. Demographic characteristics of counselors surveyed indicated that most were female, Caucasian, over 40 years old, and the majority reported they were in recovery from alcohol or other drugs. Three management practices were measured: job autonomy, support for creativity, and performance-based rewards. Of these three management practice measures, only job autonomy was directly associated with turnover intention. In other words, the greater the

perceived job autonomy by counselors the more likely they were to remain at their jobs. In addition, specific demographic variables were found to be significant predictors of turnover intention. Older counselors and those with longer tenure showed a greater level of commitment compared to younger staff and those with less tenure. Almost paradoxically though, in terms of turnover intention, counselors who were certified and with greater education reported greater intention to quit their jobs.

Gallon et al. (2003) conducted a survey sponsored in part by the Northwest Frontier Addiction Technology Transfer Center (NFATTC) investigating possible contributing factors leading to counselor turnover. Surveys were sent to a total of 462 treatment agencies throughout Alaska, Idaho, Washington, and Oregon. Of the 462 agencies solicited, a total of 197 agencies (43%) and 469 (34%) individual staff responded. The survey content consisted of counselor characteristics, rates of workforce turnover, recruitment approaches and difficulties, retention strategies, staff professional development methods, and job satisfaction. Specific to turnover, it was determined that overall, agencies experienced an annual turnover rate of 25%, more than twice that of all occupations and substantially greater than other health care fields. Based on the interest and hypotheses of key state and local stakeholders of the study, variables investigated as having some explanatory value related to turnover rate were as follows: (a) the proportion of public funding agencies receive, (b) rural versus urban location of agencies, (c) size of agencies in terms of number of staff, (d) number of treatment models used at the agency, (e) years of experience in the field of the agency director, (f) highest academic degree held by the director, and (g) ethnicity and gender of the director. There were two consistent associations in the final data. Agencies primarily funded by public sources and

with more experienced directors were more likely to experience lower staff turnover. The authors speculated that even though public funded agencies likely pay lower than private facilities, counselors in public funded agencies frequently treat more severely impaired individuals and may have a heightened sense of loyalty to their clients. Regarding the association between length in field of agency directors and staff turnover, directors with less than 5 years of experience were in agencies reporting over 50% turnover, those with 5–10 years were reporting approximately 30% turnover, 11–20 years experience, 22% turnover, and those directors with the greatest experience (21–30 years) reported 12% turnover.

In an attempt to better systematically track employment status of counselors over time to ascertain actual turnover rates Eby et al. (2010) conducted a longitudinal study spanning two years across 27 treatment organizations. As part of the research protocol agencies were asked to systematically track employment status of staff rather than provide estimates of turnover. Data was also gathered from former employees by way of interviews performed by research staff. Of the 27 treatment agencies, three reported no turnover with the remaining providers reporting turnover rates ranging as high as 58%. Agreement regarding voluntary versus involuntary turnover between reports by treatment providers and counselors who had exited their jobs was 86% for counselor cases and 85% of clinical supervisor cases. Overall, study results indicated that the average annual rate of turnover of all agencies was 33.2%. Approximately three quarters (75.2%) left their jobs voluntarily and 22.4% left involuntarily (the remaining 2.4% represented missing data). Specific reasons for voluntary turnover were collapsed into four categories: (a) job-related (new job/other opportunity), job dissatisfaction (higher pay, other job

related), (b) personal reasons (relocation, personal health, family, returned to school, retired, and other personal), (c) resigned, and (d) no reason provided. Conclusions of the study included (a) turnover is, in fact, a significant problem in the substance abuse field; (b) the majority of turnover is voluntary; (c) the most common reason for leaving is job related; and (d) of the counselors who “turned over,” 36% left the profession completely. The authors noted that this study was the first published systematic perspective on substance abuse counselor shortage using longitudinal organizational data.

Noting the exception of Eby et al. (2010), White and Garner (2011) reported that the majority of past survey studies have been cross-sectional in nature and estimates of staff turnover were based primarily on reports by administrators who only estimated annual turnover . In addition, White and Garner noted that turnover estimates may vary due to the different scopes of studies such as different types of service providers (private funded verses public funded providers), inclusion of counselor only verses administration only verses all staff surveys, as well as different formulas for calculating turnover. The authors also noted the “paucity” of scientific studies regarding the status of substance abuse staff turnover rates verses those who exit the field completely and the subsequent potentially serious negative impact on the quality of addiction treatment. They conclude that preliminary findings within the literature generally include (White & Garner, 2011, p. 58):

1. Higher rates of burnout have been found among younger male staff.
2. Four linked factors associated with lower levels of turnover include tenure in the field or organization, age, professional certification, and higher salaries.



3. Recovery status does not predict commitment to a specific organization but does predict greater commitment to the field.
4. Higher rates of turnover are associated with being female, being in recovery, and having a graduate education.

It appears that studies to date have made positive strides in identifying actual turnover rates within the industry but as White and Garner (2011) point out there often is no distinction made between organizational turnover verses exiting the field completely. In addition, while demographic variables have been identified that are associated with greater turnover intention, the contribution of counselor recovery status remains ambiguous. For example, in the three studies cited in this review, two failed to consider recovery status as a variable in their study (Eby et al., 2010; Gallon et al., 2003). The remaining study by Knudsen et al. (2003) included recovery status as a demographic characteristic of counselors but did not include this characteristic in either their analysis or discussion.

**Burnout.** Historically, the term “burnout” has primarily been associated with “people who do people work” and has been credited to Herbert Freudenberger (1974) when he recognized staff fatigue and frustrations as well as his own fatigue and frustration while working in the helping profession. Freudenberger’s early descriptions of the signs of burnout included exhaustion and fatigue, rigidity, irritability, cynicism, and an “unproductive effort” (1974, 1977). According to Cordes and Dougherty (1993 ) definitions of burnout following Freudenberger’s early discussions soon included

- (a) to fail, wear out, become exhausted; (b) a loss of creativity; (c) a loss of commitment for work; (d) an estrangement from clients, co-workers, job, and agency; (e) a response to the chronic stress of making it to the top; and (f) a

syndrome of inappropriate attitudes toward clients and toward self, often associated with uncomfortable physical and emotional symptoms. (p. 623)

Pearlman and Hartman (1982) completed a review of writings pertaining to burnout that extended from Freudenberg's early contributions through 1980 and proposed that burnout was "a response to chronic emotional stress with three components: (a) emotional and/or physical exhaustion, (b) lowered job productivity, and (c) over depersonalization" (p. 293). It was during this period that Maslach and Jackson (1981) put forth that burnout could be conceptualized as a syndrome consisting of two factors: emotional exhaustion and cynicism. According to Maslach and Jackson, the primary aspect of the syndrome was an increase in feelings of emotional exhaustion experienced as the helper's personal resources are drained and they are no longer able to give of themselves psychologically. The second indicator of burnout is a cynical and negative attitude directed towards clients by the worker that could be directly related to the experience of emotional exhaustion. These negative feelings can then lead to thinking that clients, in some way, deserve their troubles. In addition, these negative feelings may then result in treating clients as objects, that is, the "He's a typical crack head," instead of personalizing clients by using their names (Jackson, Schwab, & Schuler, 1986). As research progressed, a third factor identified was a tendency to evaluate one's personal work potency and satisfaction with one's job negatively by devaluing personal efforts and accomplishments in one's work (Maslach, Schaufeli, & Leiter, 2001). It was also recognized that burnout can lead to serious negative consequences for clients, workers, as well as organizations. These negative consequences can contribute to a decline in the quality of care given to clients, increased absenteeism, job turnover, and low morale. In addition, individuals suffering burnout may also become more rigid and resistant in their

approach and acceptance to change (Broome et al., 2009). Burnout has also been correlated with self-reports of physical exhaustion, insomnia, marital and family problems, and increased use of alcohol or other drugs (Maslach et al., 1996).

The original Maslach Burnout Inventory—Human Services Survey (MBI-HSS) was developed specifically to measure burnout among professionals in the human services fields (Maslach & Jackson, 1981). Over time there has been further refinement of the MBI-HSS and two additional versions have been introduced. The first adaptation is intended for use in education, Maslach Burnout Inventory—Educator Survey (MBI-ES); the second adaption was created for use with workers in occupations other than human services or education, that is, the Maslach Burnout Inventory—General Survey (MBI-GS). The Maslach Burnout Inventory is recognized now as the leading measure of burnout and normative sample characteristics and cut off scores have been established for:

(a) teaching (K–12), (b) postsecondary educators (college, professional schools), (c) social services workers (social workers, child protective service workers); (d) medical workers (physicians, nurses), (e) mental health workers (psychologists, psychotherapists, counselors, mental hospital staff, psychiatrists), and (f) others (legal aid employees, attorneys, police officers, ministers, librarians, and agency administrators). In addition, studies have been conducted in multiple countries using this inventory and the Maslach Burnout Inventory has been translated into numerous languages (Maslach et al., 1996).

**Burnout and counselor accreditation level.** Studies of the prevalence of *burnout* as a contributing factor to workforce shortages among substance abuse professionals have often shown inconsistent results (Aksamit, 1997; Broome et al., 2009; Davis, 2008; Elman & Dowd, 1997; Knudsen, Ducharme, & Roman, 2006, 2008;

Lacoursiere, 2001; Oyefeso, Clancy, & Farmer, 2008; Price & Spence, 1994; Shoptaw et al., 2000; Vilardaga et al., 2011).

Aksamit (1997) investigated the extent of burnout in substance abuse counselors in a study consisting of 178 certified substance abuse treatment counselors practicing in Idaho. Two specific certification groups of counselors were included. Group one consisted of entry level alcohol and drug counselors or Chemical Dependency Technicians (CDT). Group two was comprised of advanced certified counselors, Certified Alcohol and Drug Counselors (CADC). Results indicated a high level of burnout among both groups of counselors specific to emotional exhaustion and depersonalization. On the other hand, scores within the subscale of personal accomplishment were in the low category indicating a high degree of sense of personal accomplishment for both groups. In addition, Aksamit found little difference in the level of burnout between the two groups of counselors compared to the MBI normative sample for mental health counselors other than personal accomplishment scores were in the high range for both groups compared to the MBI normative sample that scored in the average range for personal accomplishment. Similar to prior studies investigating the role of management and organizational practices (Knudsen et al., 2003) Aksamit found that pressures related to work, time to complete one's job, and poor clarity of rules and policies were found to be predictive of emotional exhaustion though differences between the two groups were noted in regards to the impact of clarity of rules and policies. Results specific for depersonalization indicated that work pressure was the primary predictor variable for both groups of counselors. It should be noted that counselor

recovery status was included in this study as a demographic variable but was not included as a distinct variable in the burnout analysis.

**Burnout and clinical supervision.** Davis (2008) examined the association between burnout and (a) participation in clinical supervision, (b) level of education, (c) number of years employed in the field of addictions, and (d) 12-step participation. Using the Burnout Measure Short Version (BMS) (Maslach-Pines, 2005) Davis surveyed a total of 477 study participants of which 370 reported receiving clinical supervision either weekly, one to two times per month, quarterly or sporadically. Individual supervision versus group or a combination of individual and group supervision was distributed among the group. Perhaps somewhat counter intuitive, results indicated that there was no significant difference in burnout scores for those receiving supervision versus those that did not receive supervision. Davis noted that this lack of association between clinical supervision and burnout was similar to prior studies while also pointing out that prior studies were more focused on the impact, process, and implementation of supervision whereas Davis' study focused only on participation. In addition, Davis found that burnout was positively associated with level of education and negatively associated with 12-step participation and age. To clarify, Davis reported lower levels of burnout were associated with older counselors and those counselors who participated in 12-step activities; and higher levels of burnout were seen in counselors with higher levels of education.

As an extension of their previous studies of the relationship between the primary indicator of burnout (emotional exhaustion) and counselor turnover intention, Knudsen et al. (2008) investigated the importance of how counselor's overall perceptions of their

supervisors influenced their evaluations of job autonomy and organizational justice, both of which in prior studies have shown a negative relationship with emotional exhaustion and turnover intention. In this study, job autonomy was defined as “the degree to which managers empower counselors to make decisions about how to perform their jobs” (p. 188). Regarding organizational justice, the authors identified two dimensions. The first dimension was that of distributive justice. Distributive justice referred to counselor’s perceptions of how fairly job demands and rewards were distributed among employees. The second dimension was that of procedural justice, how counselors perceived how fair the process of decision making was within their organization. Consistent with their prior studies the authors found clinical supervision to be valuable in mediating the effects of both emotional exhaustion and turnover intention. In addition, Knudsen et al. explored how counselor’s perceived quality of supervision rather than only the presence of supervision might influence their perceptions of job autonomy and organizational justice and subsequent level of emotional exhaustion and turnover intention. Results suggested that clinical supervision’s direct associations with turnover intention and emotional exhaustion were completely mediated by job autonomy, distributive justice, and procedural justice. In other words, the quality of supervision entered into and influenced counselor’s evaluations of job autonomy and fairness in the workplace and consequent feelings of emotional exhaustion and turnover intention (p. 392).

Support for the importance of the quality of supervision rather than simply the presence of supervision and subsequent turnover intention has also been noted by the Northwest Frontier Addiction Technology Center (NFATTC) (RMC Research

Corporation, 2006). In a survey of Washington State substance abuse counselors more frequent clinical supervision was associated with greater turnover intention. The authors suggested two possible explanations for this troubling relationship: (a) clinicians may choose to quit because they are not open to clinical supervision, or (b) the focus of clinical supervision is administrative or disciplinary rather than mentoring and professional development.

**Burnout and size of caseload.** In a cross sectional survey comprised of 550 clinical staff and directors from 94 programs Broome et al. (2009) investigated the relationships between substance abuse counselor's perceptions of job satisfaction, leadership, and burnout. The authors used an abbreviated burnout measure comprised of six items with many of the items focused on emotional exhaustion in addition to indicators of cynicism and inefficacy. Results indicated that both case load size and case load composition impacted burnout. Those counselors with high caseloads (more than 30 clients) showed significant higher levels of burnout. In addition, burnout levels and case load size appeared to be mediated by the percentage of clients referred and monitored by the criminal justice system (CJS). As the percentage of CJS clients increased within caseloads the associated level of burnout related to case load size decreased. Broome et al. postulated that these CJS referred clients may have less variability regarding needs and services. Support given to clients by the justice system may reduce the time and effort of assessment and planning, that is, medical and housing services, thereby reducing the impact of additional clients on one's caseload.

**Burnout and severity of client clinical profile.** As reported by the United States Department of Health and Human Services ([US DHHS], 2006), substance abuse

counselors are facing more severe and diverse clinical profiles. Shoptaw et al. (2000) investigated burnout in substance abuse counselors serving clients with HIV (human immunodeficiency virus) noting that substance abuse clients infected with HIV often have multiple severe problems that include physical and mental health, housing, transportation, finances as well as substance abuse that can quickly overwhelm even the most enthusiastic clinician (p. 117). Shoptaw et al. surveyed 134 counselors dispersed among three treatment environments. Forty-seven counselors worked in drug free clinics (35%), 67 worked at methadone clinics (50%), and 20 counselors who worked at the Salvation Army. Counselor burnout was measured by the Maslach Burnout Inventory (MBI) (Maslach et al., 1996) and compared with counselor's sense of self-efficacy and support. Self-efficacy was defined as counselor's ratings of their confidence that they could effectively perform the various aspects of their counseling in their current job setting. Three aspects of self-efficacy were defined: a) client skills —“I have effective strategies for working with HIV-positive/AIDS clients,” b) collaborative skills —“I can collaborate effectively with the other staff at this program,” and c) job skills —“I can complete my charting daily” (p. 120). Support consisted of counselor ratings of how available help was from their organization when the counselor had a problem and how much care and concern did the counselor receive from their supervisor. Results indicated that greater job support from coworkers and supervisors and greater feelings of job efficacy were associated with lower levels burnout. Additionally, caseloads with a higher percentage of clients with HIV reduced counselor's perceptions of personal accomplishment thus inferring a greater level of burnout.



**Burnout and counselor characteristics.** Multiple surveys of the substance abuse workforce specific to counselor characteristics have shown similar demographics (Gallon et al., 2003; Hubbard & Hayashi, 2003; Mulvey, Hubbard, & Hayashi, 2003). According to a survey conducted by the Addiction Technology Transfer Center National Office ([ATTC], 2009) substance abuse counselors are predominately women, over 40 years old, Caucasian, certified in addiction studies, with most having a bachelor's or higher degree. Similar counselor characteristics have been found by NFATTC (RMC Research Corporation, 2005) in the combined data gathered from Alaska, Hawaii, Idaho, Oregon, and Washington revealing that the workforce is 60.6% female, 71.8% Caucasian, and having an average age 46.4 years.

Conclusions of studies investigating the possible relationship between burnout and substance abuse counselor's personal characteristics have been mixed.

Broome et al. (2009) reported that counselor background variables such as gender, ethnicity, certification status, and level of education were generally not significant predictors of burnout or job satisfaction. On the other hand, both a positive and negative relationship between counselor characteristics such as age, gender, educational level and emotional exhaustion has been noted in a number of other studies (Davis, 2008; Knudsen et al., 2006; Oyefeso et al., 2008; Vilardaga et al., 2011). Knudsen et al. (2008) found in their study of the possible relationship of turnover intention and emotional exhaustion that counselors who were male, Caucasian, younger, and held a master's degree or higher showed greater levels of emotional exhaustion. In addition, having a master's degree, regardless of gender, was associated with significantly greater intention to quit (p. 178). Elman and Dowd (1997) examined the possible relationship between burnout and

working with the “pure” alcoholic or mono-substance user versus the greater demands of working with “poly-substance” users. The authors hypothesized that female substance abuse counselors would show a higher rate of burnout than their male counterparts but results showed no significant gender effect.

**Burnout and recovery status.** Limited studies of the role of recovery status of counselors and burnout have been undertaken. A survey by the NFATTC (RMC Research Corporation, 2005) indicated that counselors who identified themselves as “in recovery” accounted for 41.8% of the northwest workforce. The majority of these were male (55.6%).

Rubington (1984) conducted an exploratory qualitative study of burnout among staff at a well established detoxification center. Staff that were interviewed Rubington described as “mostly with members of the medical and counseling staff.” As a result of interviews Rubington concluded that his findings suggested three general propositions. First, recovering counselors run a greater risk of burning out than non-recovering counselors. Second, burnout was associated with not only frequency of contact with clients but also with the nature of contact, duration, intensity and outcome of contacts with clients. Lastly, “informal work relations” (support) among counselors may help mitigate burnout among counseling staff.

In addition to Rubington’s (1984) study, McGovern and Armstrong (1987) surveyed recovering and non-recovering counselors from a state and national sample. The authors noted how previous literature, when comparing the advantages and disadvantages of utilizing counselors who are in recovery, negative characteristics often

outnumbered those that were positive. These negative characteristics included being more vulnerable from burnout because:

- he is involved with his or own recovery;
- he is over compensating for his lack of a professional degree or personal feelings of inadequacy by overworking;
- he is unable to allow himself to dilute or eliminate services when his workload becomes too large; and
- by working an 8 to 5 job and going to AA meetings at night, even his social and recreational life becomes tied to his work (McGovern & Armstrong, p. 45).

Results of their survey did not specifically address the issue of burnout but did indicate that recovering counselors tended to agree with the statement that recovering counselors tended to give too much of themselves in treatment settings. In addition, both groups (recovering and non-recovering counselors) agreed that recovering counselors have the same need of support and the same risk of relapse as their clients who are involved in the recovery process.

Elman and Dowd (1997) proposed that substance abuse counselors who were in recovery may be at a risk of higher levels of burnout due to greater identification and involvement with their clients. Elman and Dowd then compared burnout levels between counselors who identified themselves as in recovery and counselors who did not. The authors found no significant differences for emotional exhaustion and depersonalization between the two groups. On the other hand, counselors who were in recovery scored

significantly higher on personal accomplishment indicating a greater degree of sense of self-efficacy in their work.

Davis (2008) found a somewhat similar relationship between recovery status and burnout compared to Elman and Dowd (1997). Davis examined the relationship between burnout and participation in a 12-step fellowship, clinical supervision, level of education, and years in the field. The author did not specifically state that participation in a 12-step fellowship indicated recovery status though the assumption of attendance of 12-step meetings in conjunction with being in recovery and in the context of a substance abuse environment seems reasonable. Davis stated her results as:

Level of education was positively related to participation in 12 step, work role, age, gender, and race and negatively related to burnout score. NAADAC members with a higher level of education were more likely to participate in a 12-step fellowship, be an administrator, be older, be female, white and have a lower burnout score. (p. 87)

Biebel (2010) investigated the role of social support from coworkers and supervisors as mediators on the impact of substance abuse counselor's job frustration, burnout, and compassion fatigue. Participants were substance abuse counselors who worked in State Prisons or publicly funded community treatment centers. The author predicted that substance abuse counselors who were in recovery would report higher levels of frustration than those counselors not in recovery. Results found that this prediction could not be supported as counselors who were not in recovery reported higher levels of job stress than those in recovery.

### **Clinical Orientation: The Disease Concept of Addiction**

The dominant treatment model for addiction in the United States has been the disease concept of addiction. The model has been criticized for failure to use

scientifically endorsed methods and claims have been put forth that addiction counselors who endorse the disease concept of addiction are not open to new knowledge. Yalisove (1998) reported that the National Council on Alcoholism (NCA) included the following elements in the conceptual definition of the disease concept

(a) alcoholism is a disease, (b) alcoholics gradually develop ‘loss of control’ over drinking; once they begin drinking, they may be unable to stop, (c) alcoholism is a permanent and irreversible condition; alcoholics can never drink safely, and (d) alcoholism is a progressive disease, which if untreated can lead to insanity or death. (p. 470)

In addition to Yalisove’s definition, advocates of the disease concept also state alcoholism/drug addiction is rooted in “abnormalities of brain chemistry” and other biochemical anomalies that are genetically inherited. For cases where genetic vulnerability is absent, the disease can be acquired by intense and sustained exposure to alcohol or other drugs. The symptoms and order of stages of the disease are consistent and make possible clear and accurate diagnosis. The presence of “craving” and “loss of control” are prime indicators of the disease process and can prevent the individual from consistently refraining from use or controlling use once drinking or drug use has begun (White, 2001a, 2001b).

In contrast to the disease concept of addiction the “free-will model” proposes that addiction is a behavior that is voluntary and characterized by willfulness and responsibility. In an effort to explore the ability of demographic variables that may explain variance of addiction beliefs among treatment providers Schaler (1997) found five variables that were statistically significant:

1. membership in a treatment professional group,
2. gender,

3. current attendance of AA,
4. certification status as a provider of addiction treatment, and
5. amount or number of mood altering drugs or alcoholic drinks consumed per week (p. 377).

Results indicated that stronger belief in the disease concept of addiction was positively associated with professional membership, being female, current attendance of AA, and fewer drinks/mood altering drugs consumed per week. It may be that “current attendance of AA” also was an indicator of recovery status in that of the total sample 34.2% of participants reported attending AA now and 33.9% of the total sample also reported being in recovery.

Concerns regarding substance abuse counselors’ clinical theoretical orientations have been raised due to the impact of differing orientations on clinical decision making and treatment planning. With regards to the disease concept, Thombs and Osborn (2001) noted that, “Disease model practitioners may not be receptive to, nor adequately prepare to adopt new practices that deviate from their personal experience. Thus, there is a need for training programs that prepare practitioners for change” (p. 451). From a survey pool of 1,261 potential respondents, Thombs and Osborn identified three distinct clinical orientations of substance abuse counselors. The largest group Thombs and Osborn labeled as “uniform counselors.” These counselors “endorsed a simple moral-disease model with little interest in psychosocial interventions” (p. 79). A second group labeled as “multiform counselors” valued numerous treatment approaches and held an incongruent moral-disease psychosocial model of addiction. The final and smallest of the three groups (“client centered” counselors) were described as not completely endorsing

Alcoholics Anonymous (AA) principles, recognizing the presence of co-occurring disorders among substance disordered clients, and valuing non-coercive treatment. The authors note that the response rate from the survey yielded a modest 32.2% rate which limited the generalization and representativeness of their study but also noted that the response rate was similar to other mail surveys of this population.

Moyers and Miller (1993) found similar concerns regarding receptiveness to adopt new practices among clinicians who endorse the disease model. The authors conducted a survey in New Mexico of certified drug and alcohol treatment providers, therapists treating alcoholic patients, and drug and alcohol certification classes (N = 412). According to Moyers and Miller, those who responded positively to items endorsing disease beliefs were apt to say that alcoholics “(a) are liars who cannot be trusted, (b) cannot make good decisions for themselves, (c) have personality deficits that predate drinking, (d) have special spiritual deficits, and (e) need strong confrontation” (p. 243). It should be noted that Moyers and Miller stated the results of their survey be interpreted with caution as the study was providing initial psychometric data of a new instrument (Understanding of Alcoholism Scale) and also that portions of the respondent pool were self selected and may not have been representative of the larger population of treatment providers.

Schaler (1995) suggested that therapists and clients in addictions treatment be “matched,” thereby maximizing “consensual therapeutic relationships and minimizing coercive ones” (p. 131). In an effort to provide a method to match clients and treatment providers’ goals, style of treatment and temporal demands of treatment, Schaler developed the Addiction Belief Scale (ABS), an 18 item measurement assessing the

strength of belief in the disease concept of addiction versus the free-will model. A total of 511 surveys comprised of the ABS were mailed to various substance abuse treatment providers culminating in a final sample of 295 that were then analyzed. Results of the survey indicated three dimensions to the disease model controversy that are diametrically opposed. Schaler identified these dimensions as (a) power, (b) dichotomous thinking, and (c) a way of coping with life. The “power” dimension indicates the range of belief between “The most important step in overcoming an addiction is to acknowledge that you are powerless and can’t control it” (disease model) versus “You have to rely on yourself to overcome an addiction such as alcoholism” (free-will model). The “Dichotomous thinking” dimension points to the range of beliefs between the statements of “Physiology, not psychology, determines whether one drinker will become addicted to alcohol and another will not” (disease model) versus “Alcoholics and drug addicts can learn to moderate their drinking or cut down on their drug use” (free-will model). The dimension of “A way of coping with life” reflects only the free-will model represented by statements that include “Drug addiction is a way of life people rely on to cope with the world” and “People can stop relying on drugs or alcohol as they develop new ways to deal with life.” All three dimensions indicated conflictual understanding and acceptance of the disease concept of addiction:

That treatment providers hold contradictory points of view regarding the disease and willful nature of addiction supports Caetano’s (1987) findings that conceptions about alcoholism are ‘not entirely consistent in the public’s mind: the disease concept may be contradicted and supported at the same time.’ (Schaler, 1995, p. 126)

**Clinical orientation and recovery status.** Studies regarding counselor’s recovery status, defined as “being in recovery from alcohol or other drug abuse,” have



primarily focused on the relationship of recovery status and subsequent impact on clinical orientation and approach to treatment. Overall, these studies have suggested that counselors who identify themselves as “in recovery” are more likely to more strongly endorse the disease model of addiction compared to those who do not adhere to a more strict adherence to the disease model concept (Moyers & Miller, 1993; Osborn, 1997; Russell, Davies, & Hunter, 2011; Schaler, 1995, 1997; Shipko, 1992). Similar to Schaler’s (1997) findings, Moyers and Miller (1993) while developing a measure to assess substance abuse counselors beliefs regarding the nature and causes of alcoholism, suggested that their results indicated that counselor’s who identified themselves as in recovery were more likely to endorse disease model beliefs more strongly than those not in recovery. In addition, Moyers and Miller concluded that counselors who were in recovery tended to be less flexible in their treatment goals.

Toriello and Leierer (2005) investigated the relationship between clinical orientation and differences in clinical decision making of substance abuse counselors in recovery and counselors not in recovery. Counselors were divided into two groups of orientation “clusters.” “Cluster one” counselors were most likely to endorse statements such as: (a) help clients accept disease and commit to AA/NA (Alcoholics Anonymous/Narcotics Anonymous), (b) substance use causes addiction, (c) addicts lie about their use, (d) addiction is a spiritual issue, and (e) addiction is a disease. In addition, these counselors were less likely to endorse the use of psychotropic medications or use behavioral modification techniques. Counselors falling into the category of “cluster two” were most likely to endorse items such as: (a) support the use of medications, (b) use behavioral techniques, (c) consider reducing the use of substances as

a treatment goal as opposed to abstinence being the only goal, (d) underlying psychological issues can cause addiction, and (e) addiction is not a spiritual issue. Least likely to be supported by cluster two counselors were statements such as: (a) help clients accept disease and commit to AA/NA, (b) substance use is the cause of addiction, and (c) addiction is largely a spiritual issue (Toriello & Leierer, 2005, p. 80). Somewhat counter to Moyers and Miller's (1993) conclusion, results indicated that rather than a distinct dichotomy between the two cluster groups, counselors from both groups may have moved away from a rigid adherence to the traditional, pure disease model clinical orientation to a more contemporary range of interventions (p. 82). Evidence of this movement was shown in that counselors who identified themselves as "in recovery" were members of both cluster groups. In addition, there was only a relatively small difference between the percentage of counselors who identified as in recovery within each group and those who did not identify as in recovery (54.1% and 50.2% respectively).

Stöffelmayr, Mavis, Sherry, and Chiu (1999) examined the influence of education and recovery status compared to counselor's range of treatment techniques and treatment goals. Prior studies according to Stöffelmayr et al., suggested that counselors who were in recovery were more likely to rely on 12-step principles and adhere more to the rationale of abstinence as a primary treatment goal compared to those with a higher education level who were deemed to be more flexible in their treatment approach and hold a wider range of treatment goals. Results indicated level of education predicted neither treatment techniques or treatment goals. In addition, being in recovery denoted a wider range of practices and goals compared to those who did not identify as in recovery. Interestingly, endorsement of 12-step principles which was linked with recovery status

was only minimally important regarding treatment goals and not at all important regarding treatment techniques. In other words, being in recovery was associated with a wider range of treatment techniques and a broader range of treatment goals independent of endorsement of 12-step principles.

Humphreys, Noke, and Moos (1996) investigated recovering substance abuse staff's beliefs about addiction at 15 Veterans Affairs (VA) hospitals. Of the total of 329 participants in the study, 47 (14.4%) identified themselves as in recovery from alcohol or other drugs. Results indicated that recovering staff were not significantly different compared to non-recovering staff on race or type of educational degree. In addition, while recovering staff tended to work in programs where the goals and activities were more consistent with a 12-step approach compared to a more cognitive-behavioral approach, endorsement of recovering staff of the disease model was not significant.

Humphreys et al. concluded that:

Contrary to arguments that recovering staff are rigid adherents of the disease model, recovery status did not affect disease model beliefs when other factors were taken into account. When considered in the context of other variables in a multivariate analysis, recovery status was significantly positively related to higher scores on the eclectic orientations scale, indicating that recovering staff are less likely than non-recovering staff to view substance abuse patients as a homogenous population for whom a uniform treatment approach is appropriate. (p. 77)

### **Statement of the Problem**

Prior research to date has consistently identified several recurring factors as possible contributors to both counselor turnover intention and burnout. Specific to turnover intention, factors associated with job retention include: (a) counselor level of perceived job autonomy, (b) age, (c) length working in the field, (d) working in a public funded agency versus a private institution, (e) the presence and quality of clinical

supervision, (f) performance-based rewards, (g) level of support for job creativity, (h) counselor recovery status, and (i) level of experience of agency directors.

Investigations into sources of burnout among substance abuse counseling staff have often noted the relationship of emotional exhaustion and depersonalization specific to case load size. However, this relationship has been found not to be consistent among treatment programs. In addition to the size of caseloads, variability of the types and severity of the needs of clients assigned to caseloads has also been observed as a mediating factor of burnout. Furthermore, results of previous studies regarding the relationship between counselor personal characteristics and burnout have been mixed. Various studies have shown both a positive and negative relationship between counselor characteristics such as age, gender, educational level, recovery status, and emotional exhaustion. Greater emotional exhaustion has been associated with being male, Caucasian, younger, and holding a master's degree or higher. On the other hand, gender and level of education has also been shown not to be a significant factor in predicting burnout. Interestingly, level of education, specifically having a master's degree or higher, has been linked with greater intention to quit regardless of gender.

Though results of prior studies have sometimes provided conflicting results, none the less, recurring relationships among variables associated with turnover intention and burnout have been explored extensively. What remains to be explored, however, is how substance abuse counselor's clinical orientation, specifically counselor's strength of belief in the disease concept of addiction, may contribute to counselor's vulnerability to burnout.

### **Purpose of the Study**

The purpose of this survey study was to investigate the relationship between substance abuse counselor's strength of belief in the disease concept of addiction (clinical orientation) and burnout. Participants of the study were counselors who were certified Chemical Dependency Professionals (CDPs) or Chemical Dependency Profession Trainees (CDPTs) who were currently employed in a state certified substance use disorder outpatient treatment facility. Strength of belief in the disease concept of addiction was assessed by scores on the Addiction Belief Scale with higher scores indicating a stronger belief in the disease concept of addiction (Schaler, 1995). Level of burnout was measured by the three subscales of the Maslach Burnout Inventory, emotional exhaustion, depersonalization, and personal accomplishment (Maslach et al., 2001). Demographic information including counselor recovery status defined as having a prior substance abuse history, "yes" or "no," was also examined in relation to strength of belief in the disease concept of addiction as well as burnout.

### **Research Questions and Hypotheses**

This study asked three questions. The first question asked, "Is there a relationship between substance abuse counselor's strength of belief in the disease concept of addiction and burnout?" Prior studies have indicated counselors who strongly adhere to the disease model of addiction are more likely to have attitudes towards their clients that are cynical and deterministic (Moyers & Miller, 1993). In addition, stronger belief in the disease concept has been associated with an unwillingness to negotiate treatment goals and reluctance to endorse more contemporary treatment strategies. It may be that this combination of cynicism towards clients and deterministic/inflexible stance regarding

treatment practices may lead to: (a) increase levels of counselor's sense of emotional exhaustion, (b) increased cynicism towards clients, (c) a decreased sense of potency and accomplishment in one's work, and (d) a general increase in levels of burnout.

The second question of this study asked, "Is there a relationship between substance abuse counselor's recovery status and burnout?" There has been a very limited number of studies of the relationship of counselor's recovery status and burnout and results have been contradictory. Davis (2008) noted that attendance to 12-step meetings (implying counselor's past history as a substance abuser) was associated with lower levels of burnout whereas Elman and Dowd (1997) found no significant differences in burnout between those who identified themselves as "in recovery" versus those who did not.

The third and final question of this study asked, "Is there a relationship between substance abuse counselor's recovery status and clinical orientation, that is, strength in the belief of the disease concept of addiction?" Prior studies have been ambiguous regarding the relationship of recovery status and strength of belief in the disease model. For instance, both Moyers and Miller (1993) as well as Schaler (1997) suggested that counselors who strongly adhere to the disease model of addiction were more likely to identify themselves as in recovery whereas Toriello and Leierer (2005) found little relationship between counselor's recovery status and adherence to the disease model of addiction.

As an exploratory investigation this study presents the following hypotheses:

H<sub>1</sub>: There will be a relationship between substance abuse counselor's strength in belief in the disease concept of addiction and burnout.

H<sub>2</sub>: There will be a relationship between counselor's self-identification as a recovering substance abuser and burnout.

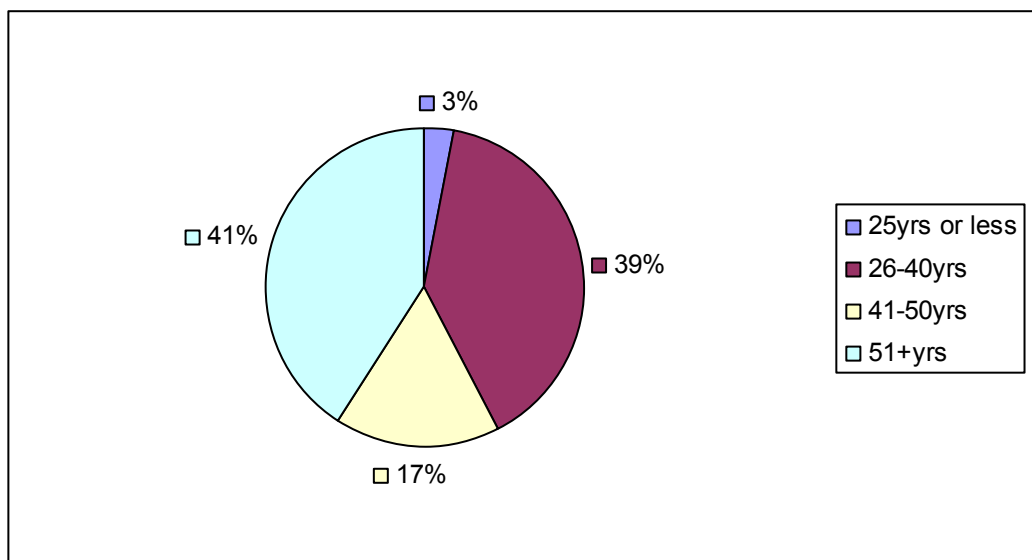
H<sub>3</sub>: There will be a relationship between counselor's self-identification as a recovering substance abuser and strength of belief in the disease concept of addiction.

## Chapter II: Methods

### Participants

Participants were recruited via a purposive survey sampling method consisting of counselors who were state certified Chemical Dependency Professionals (CDPs) or Chemical Dependency Profession Trainees (CDPTs) who were currently employed in a state certified substance use disorder outpatient treatment facility. In addition, in order to participate in the study, participants had to be providing face to face addiction counseling services and have an assigned case load. A total of 66 counselors participated the study.

**Age and gender.** Age of counselors ranged from less than 25 years (3%) to over 51 years of age (41%). Most counselors were in the age range of 41 years of age and over (57%) (see Figure 1).



*Figure 1.* Age of all counselors.

Females comprised the greatest proportion of counselors. There were 20 males (30%) and 45 females (68%). One participant declined to note their gender status. The



largest age cohort for male counselors was 51 years of age or older (45%). The largest age cohort for female counselors was the 26–40 years range (42%).

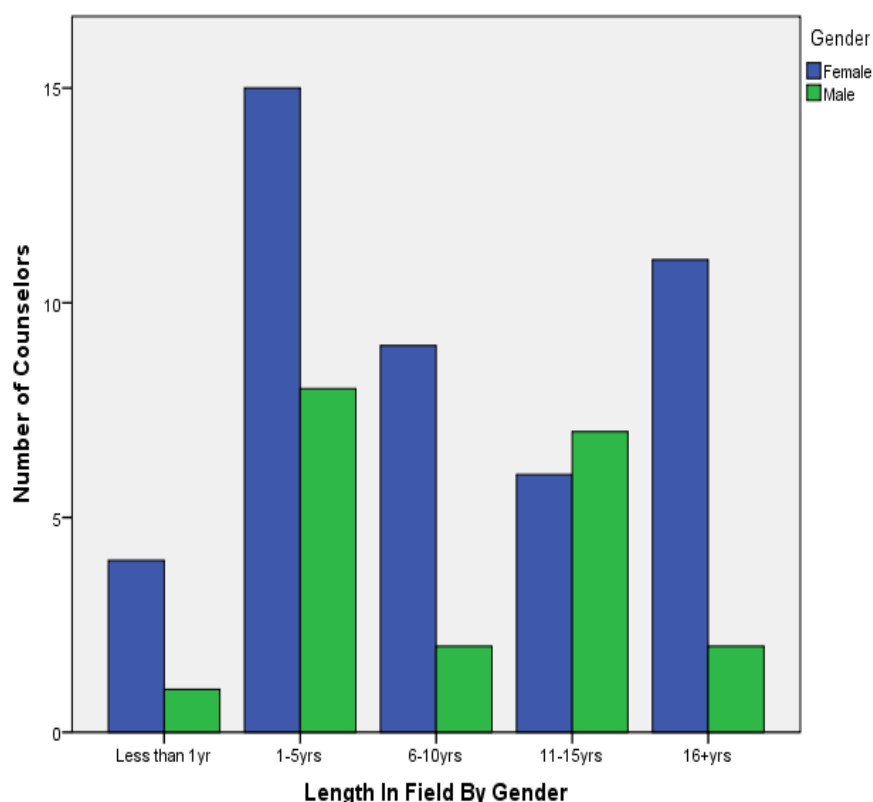
As shown in Table 1, the ratio of age compared to gender indicated that generally, this was a mature group of counselors who were most likely to be female and over 41 years of age and reflect similar findings by both national and regional surveys (ATTC, 2009; RMC Research Corporation, 2005).

Table 1

*Age and Gender*

Gender	Age			
	25yrs Or Less	26–40yrs	41–50yrs	51+yrs
Female	2	19	6	18
Male	0	7	4	9

**Length in field.** Fewer than 8% of counselors surveyed had less than one year of experience in the field. Counselors who had one to five years of experience comprised 35% of the sample. Counselors with at least 6 years experience accounted for 18% of the sample and those with 11 to 15 years accounted for 20%. Counselors with more than 16 years of experience accounted for the same percentage as those with 11 to 15 years experience (20%). As a whole, the majority of counselors (58%) had six or more years of experience. Those with 11 years or more experience in the addictions field accounted for nearly 40% of those surveyed and the majority of these were women. Similar to prior surveys (ATTC, 2009), this sample of substance abuse counselors appeared to be a well-seasoned group of professionals (see Figure 2).



*Figure 2.* Length in field less than one year through 16 years or greater by gender.

**Level of education and gender.** This was a well educated group of counselors as most had at least a four year degree. Those who had earned a four year degree or higher accounted for over 66% of the total sample. Counselors who had earned a four year degree comprised 46% of the sample and those with a masters degree comprised 20% of the sample. There were no Psy.D. or Ph.D. degreed counselors. The remaining 34% of counselors held an AA degree. Of the total of 13 counselors who had earned a master's degree, 12 were female and one was male. One participant declined to note their education level and one participant declined to note their gender (see Figure 3).

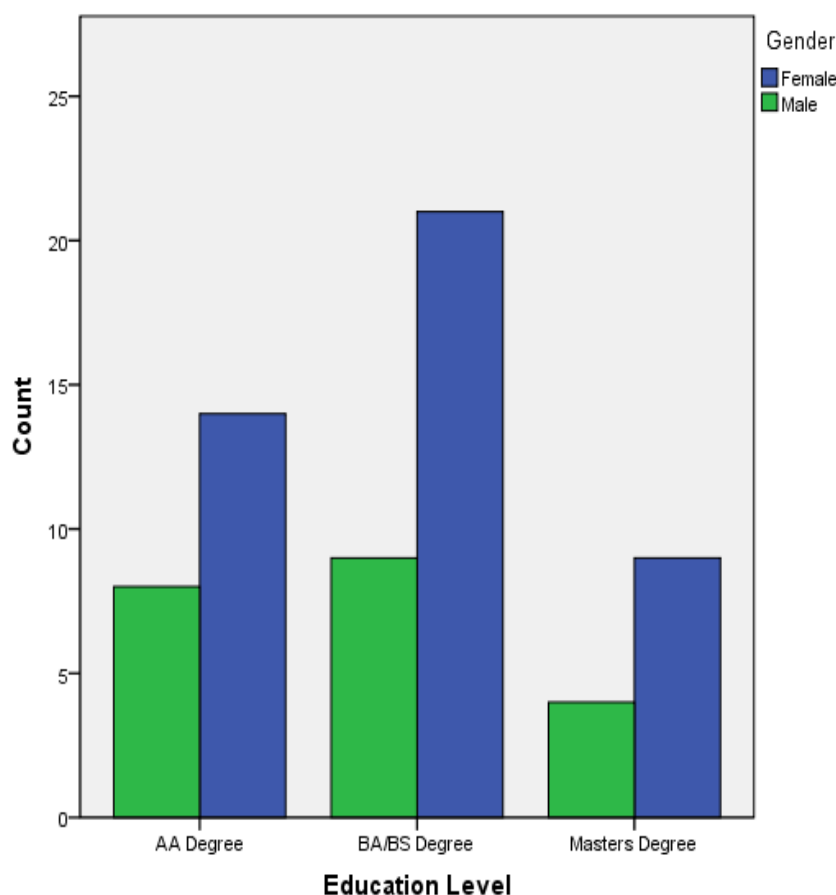
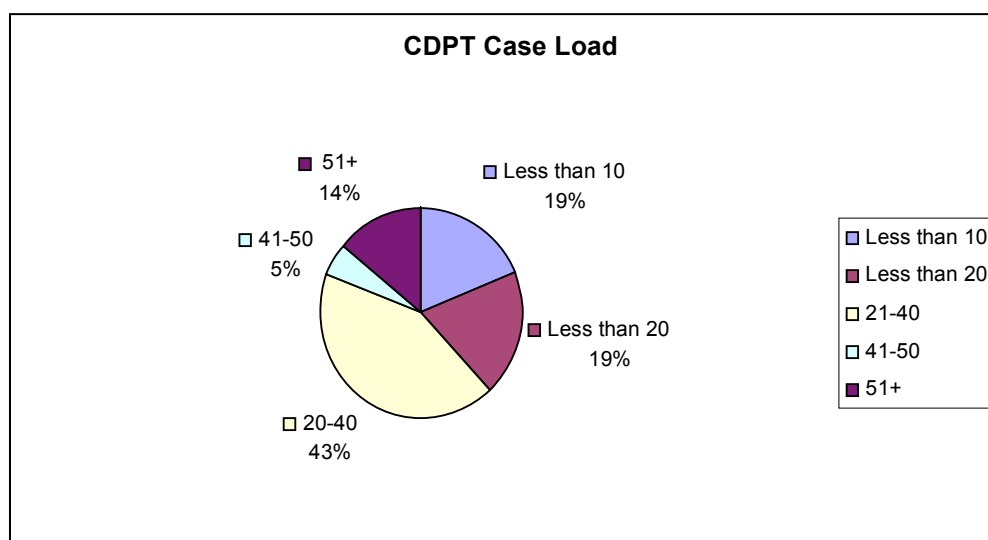
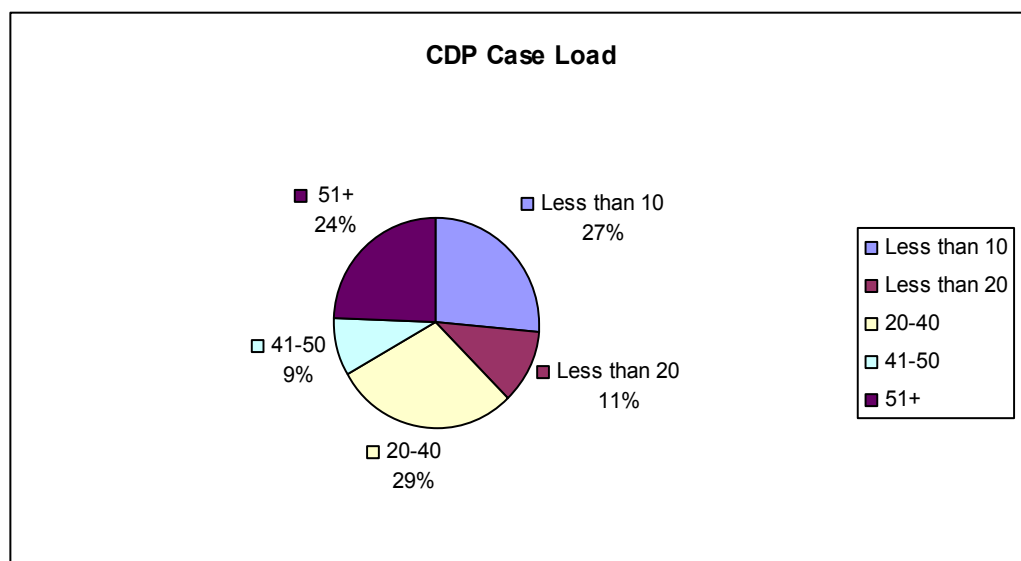


Figure 3. Level of education by gender.

**Certification level and case load size.** Certified Chemical Dependency Professionals (CDPs) accounted for 68% of all participants compared to 32% for Chemical Dependency Professional Trainees (CDPTs). For client case load sizes equal to or greater than 20 clients, CDPTs and CDPs were nearly identical (63% and 62% respectively). CDPs with caseloads of 41 to 50 clients totaled 7% where those with caseloads of 51 clients or greater totaled 24%. Compared to CDPs, CDPTs had a smaller rate of case load size of 41 to 50 clients (5%) and a smaller rate of caseloads of 51 or more clients (14%). None the less, in a practical sense, trainees (CDPTs) appeared to be managing similar sized caseloads compared to their CDP counterparts (see Figure 4).



*Figure 4.* Percentage of case load size by certification level.

**Number of groups facilitated weekly.** Weekly groups were primarily facilitated by CDPs (68%). CDPTs accounted for the remainder of groups facilitated (32%). The most frequent range of groups facilitated weekly was the 1–3 groups per week range. Within the weekly group range of 1–3 groups, CDPs facilitated 75% of these groups whereas CDPTs facilitated 25%. For the range of 4–6 groups per week, CDPs facilitated

53% and CDPTs 47%. The maximum number of groups facilitated weekly was reported as 7–9 groups per week. CDPs facilitated 60% of these groups while 40% were facilitated by CDPTs. Specific to counselor duties such as group facilitation, the NFATTC (RMC RESEARCH CORPORATION, 2005) noted that substance abuse trainees and certified counselors are often doing similar levels of work. A review between this sample of CDPs versus CDPTs indicates this sample appears consistent with the NFATTC conclusions (see Figure 5).

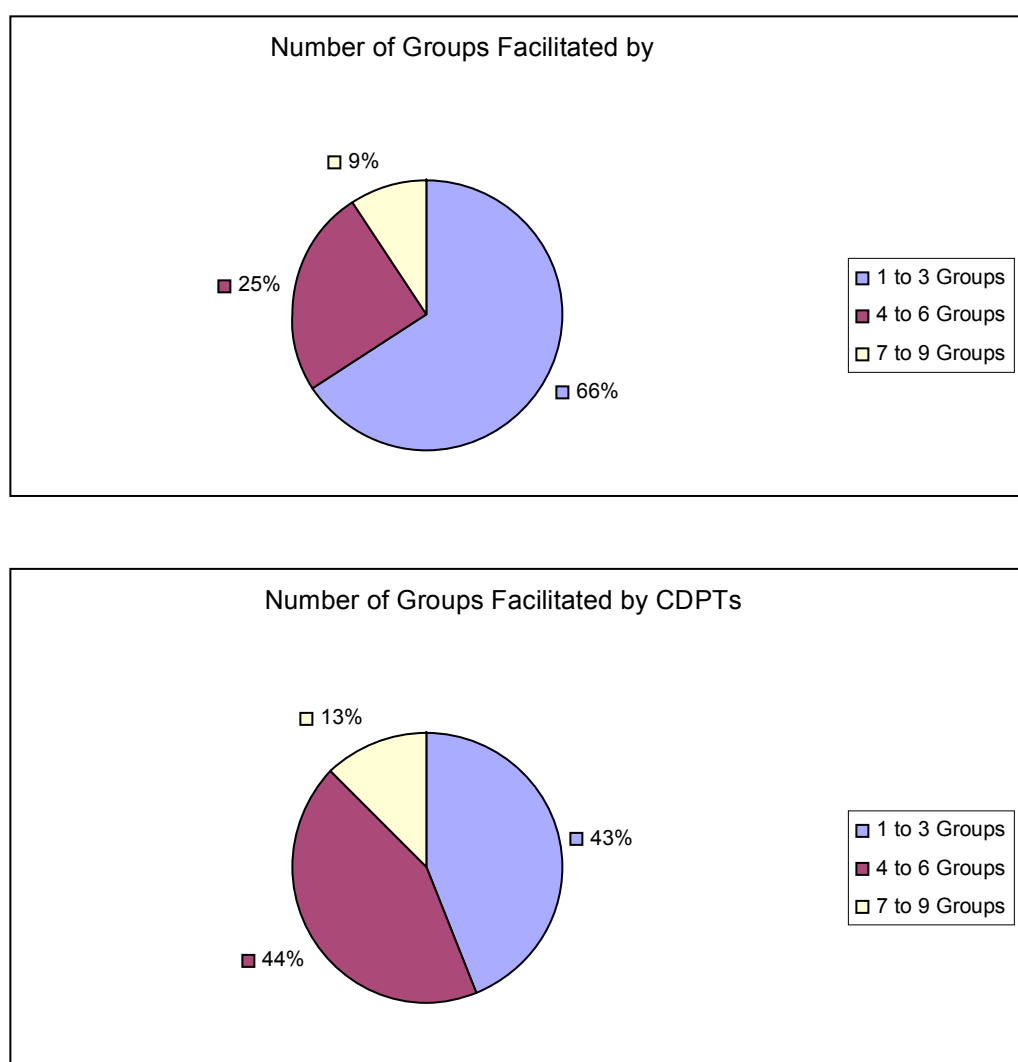


Figure 5. Number of group psychotherapy facilitated by certification level.

**Recovery status and education level.** Participants who identified themselves as “In recovery from alcohol or other drugs” accounted for a total of 29 of the 66 participants or 44% of the sample (one participant did not identify their recovery status). Of those who self identified as “in recovery,” women accounted for a smaller percentage (35%) compared to men (65%). Of those who had earned a BA degree or greater, those who did not self-identify as in recovery had obtained a higher level of education overall; (a) 47.2% had completed their four year degree, and (b) 27.8% had earned their master’s degree (see Table 2).

Table 2

*Level of Education and Recovery Status*

		Education Level		
		AA	BA/BS	Master
Recovery Status	*Yes	44.8%	44%	10.3%
	No	25%	47.2%	27.8%

*Note.* \*One participant declined to note educational level.

**12-step meeting attendance.** A total of 24 or 35% of counselors reported attending 12-step support meetings. Counselors who self identified as in recovery accounted for 92% of those who attended 12-step support meetings. Two counselors who did not report as in recovery from alcohol or other drugs also reported attending 12-step support meetings. Of the 29 counselors who identified as in recovery, seven reported not attending 12-step support meetings.

## Measures

Three measures were included in this survey: (a) Addiction Belief Scale (ABS), (b) Maslach Burnout Out Inventory – Human Services Survey (MBI-HSS), and (c) counselor demographic data.

**Addiction Belief Scale.** The Addiction Belief Scale (ABS) is intended to reflect two conflicting models that contribute to the “disease model controversy” (Schaler, 1995). These two models are known as the *disease concept* of addiction and the *free will* model of addiction. Schaler defined the disease concept of addiction as involuntary behavior that is characterized by *loss of control* and the free will model of addiction as being characterized by *willfulness and responsibility*. The ABS is an 18 item questionnaire comprised of nine items that reflect the disease concept of addiction and nine items that reflect the free will model of addiction. An example of an item that reflects the disease concept of addiction is *Most addicts don't know they have a problem and must be forced to recognize they are addicts*. An example of a free will item is *People often outgrow drug and alcohol addiction*. Items are scored on a five point Likert scale ranging between *strongly agree* to *strongly disagree*. The stronger the belief in the disease concept of addiction the higher the total score. The highest possible score is 90. There are no suggested cutoff points such as low, average, or high belief in either the disease concept or the free will concept though the conceptual median of the entire scale is 54. Prior analysis has indicated strong internal consistency ( $\alpha = .91$ ) and high construct validity which was evidenced by strong, negative correlation with the two recovery beliefs, disease concept versus free will model, ( $r = -.67, p = .01$ ). The mean participant's ABS score for this study was 59.41 ( $SD = 8.67$ ).

**Maslach Burnout Inventory—Human Services Survey (MBI-HSS).** The current version of the MBI-HSS measures the frequency of occurrences within three dimensions or subscales: Emotional Exhaustion (EE), Depersonalization (DP), and Personal Accomplishment (PA) (Maslach et al., 1996). Emotional exhaustion is the key aspect and primary foundational aspect of the burnout construct (Kalliath, Driscoll, Gillespie, & Bluedorn, 2000; Maslach & Jackson, 1981; Wright & Cropanzano, 1998). It is evidenced by feelings by the worker that they are no longer able to give of themselves psychologically to the demands of their work. The emotional exhaustion subscale then assesses feelings of being emotionally over-extended and exhausted by one's work. Depersonalization is positively correlated with emotional exhaustion and characterized by negative, often cynical attitudes and feelings about the recipients of one's work. This subscale measures unfeeling and impersonal responses towards recipients of one's efforts of service, care, treatment or instruction. Personal accomplishment is related to workers' feelings about themselves and their satisfaction with their accomplishments regarding their job. The personal accomplishment subscale therefore accesses feelings of competence and the perceived level of successful accomplishment regarding one's work with people. In addition, personal accomplishment is inversely correlated with emotional exhaustion and depersonalization. In other words, high levels of personal accomplishment are associated with low levels of emotional exhaustion and depersonalization.

The degree of burnout is conceptualized as a continuous variable ranging from low to high among the three subscales. A high degree of burnout is indicated by higher scores in emotional exhaustion and depersonalization and lower scores in personal



accomplishment. A moderate degree of burnout is reflected by average scores across all three subscales. A low degree of burnout is indicated by lower scores on both emotional exhaustion and depersonalization and higher scores on personal accomplishment.

Convergent validity of the MBI-HSS has been demonstrated by (a) reports from family and co-workers, (b) correlated with job characteristics expected to contribute to burnout, and (c) correlations of MBI-HSS scores have been significant with measures of various outcomes that have been hypothesized to be related with burnout. Discriminant validity indicating that the MBI-HSS is distinct from other measures of psychological constructs such as depression and occupational distress, has shown that burnout is not a clinical syndrome but rather a crisis in one's relationship with work. In addition, burnout, unlike depression, is specifically related to work and the relationship with those that are the focus of work, whereas depression is global, permeating all aspects of one's life (Maslach et al., 1996). Internal consistency has been standardized on over 11,000 samples of professionals that include teaching ( $n = 4,163$ ), post secondary educators ( $n = 635$ ), social workers ( $n = 1,538$ ), medical workers ( $n = 1,104$ ), mental health workers ( $n = 730$ ), and others that include attorneys, law enforcement, probations officers, ministers, librarians, and agency administrators ( $n = 2,897$ ). Reliability coefficients for each subscale of the MBI based on Chronbach's alpha were as follows: .90 for Emotional Exhaustion, .79 for Depersonalization, and .71 for Personal accomplishment (Maslach et al., 1996).

The MBI-HSS is comprised of 22 questions that are distributed across the three subscales (emotional exhaustion, depersonalization, and personal accomplishment). Each question of the three subscales is scored on a seven point frequency scale ranging from

*never to everyday*. An example of questions that comprise the emotional exhaustion scale is *I feel emotionally drained from my work*. An example of questions of the depersonalization scale is *I feel I treat some clients as if they were impersonal objects*. An example of a personal accomplishment scale question is *I can easily understand how my clients feel about things*. Cut off scores for low, average and high levels of burnout have been established for various occupations, that is, teaching, social services, medicine, mental health workers, and others. This study used the cut off points for Mental Health Workers as displayed in Table 3 (Maslach et al., 1996).

Table 3

*MBI Cut Off Scores for Mental Health Workers*

MBI Subscales	Range of Experienced Burnout		
	Low	Average	High
Emotional Exhaustion (EE)	$\leq 13$	14–20	$\geq 21$
Depersonalization (DP)	$\leq 4$	5–7	$\geq 8$
Personal Accomplishment (PA)	$\geq 34$	33–29	$\leq 28$

**Counselor demographic questionnaire.** The counselor demographic questionnaire solicited the following characteristics of the study participants: (a) age, (b) gender, (c) length of time in the field, (d) level of education, (e) substance abuse counselor credential status, (f) case load size, (g) primary client population served, (h) number of group psychotherapy sessions performed weekly, (i) recovery status, (j) current attendance of 12-step support group meetings, and (k) number of 12-step meetings attended. The category of “primary client population served” was removed

from analysis due to obvious confusion indicated by multiple responses by several individual participants. Demographic variables were categorically coded for analysis as displayed in Appendix A.

### **Procedure**

State certified outpatient substance use disorder agencies were contacted by phone and appropriate supervisory or research coordinator staff identified. A brief description of the survey was e-mailed to the appropriate staff member as well as a copy of the study's informed consent as an aid in explaining the purpose of the study (see Appendix B). Once agency approval to distribute the survey was obtained an appointment was set to briefly present the survey at a clinical staff meeting of counselors. During the clinical staff meeting a copy of the informed consent was given to those in attendance and used as a guide to explain the study. Surveys were distributed to all those in attendance. Those who chose not to participate were asked to either return the survey uncompleted or destroy the survey and envelope. A total of 130 surveys were distributed. Of the 130 distributed, 72 were returned for analysis giving a 55% response rate. There were no returns of surveys that were not completed.

As surveys were returned each survey and the accompanying envelope was stamped with an individual identification number. It should be noted that in an effort to enhance counselor's sense of confidence of anonymity and subsequent participation, the return address on envelopes was the same as the delivery address. This was done in an effort to increase confidence of counselors in that not only would their personal participation be anonymous but also the agency where the counselor was employed would remain unknown. In addition, a list of local county mental health crisis lines and

two licensed counselors were provided as referral resources for participants in the event that they experienced any psychological distress after completing the survey. The complete survey packet included, (a) the informed consent, (b) counselor demographic questionnaire, (c) the Maslach Burnout Inventory—Human Services Survey, (d) the Addiction Belief Scale, and (e) referral resources.

Surveys were scored and responses coded using a coded response form (see Appendix C). Individual scored surveys and the accompanying data response coding form were then stapled together in an effort to make retrieval of specific surveys as efficient as possible if needed. Initial screening of surveys resulted in removing a total of six surveys from the study. Four surveys were removed due to not “checking” the informed consent box showing that the participant understood the terms of the survey and giving consent to use their responses in the study. An additional two surveys were removed due to a high frequency of missed questions or insertion of written answers in lieu of circling response items.

Survey data were then entered into Microsoft Excel for Windows directly from the scored coding form for later statistical analysis. Two weeks following the last distribution of surveys, scores were once again checked from original survey packets, coding form, and the Excel data base in preparation for importing directly into the Statistical Package for the Social Sciences ([SPSS], 2010) for analysis.

### **Research Design**

This quantitative exploratory study utilized a purposive convenience sampling survey design (Kelly, Clark, Brown, & Sitzia, 2003). Certified substance abuse counselors or counselor trainees working in an outpatient substance use disorder

treatment facility were solicited to voluntarily complete a 51 item questionnaire. The majority of questions were Likert-like items such as *never* to *every day* and *strongly agree* to *strongly disagree*. Other questions were specific to participant's demographic characteristics. A total of 130 surveys were distributed of which 72 were returned for analysis giving a 55% response rate.

Analysis of data included non-parametric statistical methods that included Spearman rank order correlation, Chi-square Test for Independence, and Fisher's Exact Test. In addition independent-sample t-tests and Kruskal-Wallis tests were used as indicated. All analyses were performed using an alpha level of .05 (two tailed).

### **Ethical Considerations**

In survey research two important ethical issues to adhere to are informed consent and confidentiality (Kelly et al., 2003). To address informed consent, an informed consent letter was provided to all participants explaining the purpose and nature of the study, risks of participation, and that participation was voluntary (see Appendix B). There were no incentives offered for participation as participation was voluntary.

Efforts to ensure confidentiality of study participants included not asking for or making reference to personal identifiers such as participant's name, social security number, date of birth, race, or place of employment. In a further step to ensure confidentiality, all "hard copies" of surveys and associated documentation were stored in a locked electronic database was password protected and only the researcher had access to the password.

Ethics literature dealing with the practice of social surveys notes that for surveys it is standard practice to obtain verbal consent without a formal record (Martin & Marker,

2007). To ask participants for a signature may increase their perception that confidentiality and anonymity could be violated thereby giving reason to decline participation (Singer, 2004). Therefore, a “check box” in lieu of a signature was provided as evidence of understanding the purpose and guidelines of the study rather than requesting a signature.

The use of human subjects required submitting a request to the Institutional Review Board of Antioch University, Seattle. Written approval was obtained prior to making contact with participants and data collection.

### Chapter III: Results

#### Preliminary Analysis

Descriptive statistics of the Addiction Belief Scale (ABS) and the three subscales of Maslach Burnout Inventory (MBI) are shown in Table 4.

Table 4

#### *Univariate Analysis of MBI and ABS Scales*

	N	M	SD	Skewness	Kurtosis
Addiction Belief Scale (ABS)	66	59.41	8.67	-01.68	.023
Emotional Exhaustion (EE)	66	21.56	12.72	0.55	-0.42
Depersonalization (DP)	66	6.64	5.50	1.24	1.08
Personal Accomplishment (PA)	66	41.90	4.44	-0.96	0.934

As shown in Appendix D, histogram analysis revealed that two subscales of the MBI (Emotional Exhaustion and Depersonalization) were positively skewed. In addition, the Personal Accomplishment scale was severely negatively skewed. Finally, the Addiction Belief Scale was found to be negatively skewed as well. Initial Kolmogorov-Smirnov tests further verified non-normal distribution of the three MBI scales while the Addiction belief scale was within tolerable limits (see Table 5).

Table 5

*Initial Komogorov-Smirnov Test of MBI and ABS Scales*

	Kolmogorov-Smirnov		
	Statistic	Df	Sig.
Addiction Belief Scale (ABS)	.054	66	.200
Emotional Exhaustion (EE)	.110	66	.045
Depersonalization (DP)	.208	66	.000
Personal Accomplishment (PA)	.131	66	.007

Outliers were identified using box plot analysis and removed from further analysis. Transformation of the four scales using Square Root and Log transformation techniques were then used to determine if normality of distribution of the scales could be attained. As shown in Table 6, final Komogorov-Smirnov test results indicated that normality of distribution was untenable for the scales of Emotional Exhaustion, Depersonalization, and Personal Accomplishment. Hence, non-parametric tests that included previously removed outliers were used for hypothesis testing that included the scales of the MBI (Field, 2005).



Table 6

*Final Kolmogorov-Smirnov Test of MBI and ABS Scales*

	Kolmogorov-Smirnov		
	Statistic	Df	Sig.
Addiction Belief Scale (ABS)	.054	65	.200
Emotional Exhaustion (EE)	.110	66	.045
Depersonalization (DP)	.208	63	.000
Personal Accomplishment (PA)	.131	64	.033

Because of the anomalies of distribution of the three burnout scales (Emotional Exhaustion, Depersonalization, and Personal Accomplishment) all three scales of the MBI were collapsed into categorical variables. Each category was coded as low, average, and high using the cut off points established for mental health workers (see Table 3). For analyses that included both the scales of the MBI and the ABS continuous scale, the ABS scale was collapsed into the categorical variable low/high using the conceptual median of 54 as the cut off point (Russell et al., 2011). Scores falling below the median of 54 indicated a lower degree of strength in the belief of the disease concept and scores equal to or greater than the median of 54 indicated a higher degree of belief in the disease concept of addiction.

### **Descriptive Analyses**

**Counselor demographics.** The number of participants for this study was 66 substance abuse counselors. The descriptive statistics for counselor characteristics are shown in Appendix E and reflect similar demographic characteristics reported in prior

studies (Knudsen & RMC Research Corporation, 2006; RMC Research Corporation, 2005). The majority of counselors were female (68.2%) and the largest age cohort was 41 years of age or older (57%). Years of experience in the field ranged from less than one year to 16 years or more with the largest number of counselors (58%) having at least six or more years service in the field. Most counselors had obtained a BA degree or higher (65.2%) and of those, 19.7% had obtained a master's degree.

Specific to "recovery status," twenty nine counselors (36.4%) identified themselves as "in recovery" and the majority of these were men (65%). Non-recovering counselors had a higher educational degree status compared to those in recovery in that 27.8% of non-recovering counselors had obtained a master's degree compared to 10.3% of those who identified as in recovery. Regarding years of experience, counselors with six or more years in the field were more likely to be those in recovery (62.1%). Finally, recovering counselors were older in age compared to their non-recovering colleagues as they comprised 72.4% of those 41 years of age older.

Strength of belief in the disease concept. The Addiction Belief Scale (ABS) was designed to measure two conflicting models that contribute to the "disease model controversy" (Schaler, 1995). These two models are known as the "disease concept model" and the "free will model." Of the total of 18 items of the ABS, nine items pertain to disease model beliefs with item scores ranging from one to five higher scores indicating a stronger belief in the disease model. The remaining nine items reflect free will model beliefs and range from one to five as well, with higher scores indicating a greater belief in the free will model of addiction.

The overall mean score of the ABS for all counselors was 59.41 ( $SD = 8.67$ ). The mean score for the group of counselors with the strongest belief in the disease concept of addiction was 62.61 ( $SD = 6.34$ ). In addition, these counselors agreed most often with the following three statements: (a) The most important step in overcoming an addiction is to acknowledge that you are powerless and can't control it ( $M = 4.22$ ,  $SD = .88$ ), (b) Abstinence is the only way to control alcoholism/drug addiction ( $M = 3.90$ ,  $SD = 1.15$ ), and (c) People who are drug addicted can never outgrow addiction and are always in danger of relapsing ( $M = 3.78$ ,  $SD = 1.12$ ).

The mean score of the group of counselors with the strongest belief in the free will model of addiction was 47.50 ( $SD = 4.94$ ). Three statements agreed to most often for this group of counselors were: (a) The best way to overcome addiction is by relying on your own willpower ( $M = 4.33$ ,  $SD = .62$ ), (b) People become addicted to alcohol/drugs when life is going badly for them ( $M = 3.60$ ,  $SD = .91$ ), and (c) You have to rely on yourself to overcome an addiction such as alcoholism ( $M = 3.20$ ,  $SD = 1.21$ ). Appendix F provides the means and standard deviations of all data for the two groups—counselors with the strongest belief in the disease model versus counselors with the strongest belief in the free will model counselors. An independent samples t-test was conducted of the two groups of counselors which indicated a significant difference in scores for disease model advocates ( $M = 62.61$ ,  $SD = 6.34$ ) and free will advocates,  $M = 47.50$ ,  $SD = 4.94$ ;  $t(64) = 8.25$ ,  $p < .001$  (two tailed). The magnitude of the differences in the means (mean difference = -15.11, 95% CI: -11.45 to -18.77) was very large (eta squared = .80).

**Burnout levels.** Study participants' level of burn out was determined by the Maslach Burnout Inventory—HSS (MBI) (Maslach et al., 1996). Mean scores of the MBI

subscales of emotional exhaustion, depersonalization, and personal accomplishment of the normative sample of mental health workers compared to this study's participant mean scores are shown in Table 7.

Table 7

*Average MBI Scores of Mental Health Workers and Study Participants*

Scale	<i>M</i>	<i>SD</i>
Mental Health Workers ( <i>N</i> = 730)		
Emotional Exhaustion	16.89	8.90
Depersonalization	5.72	4.62
Personal Accomplishment	30.87	6.37
Study Participants ( <i>N</i> = 66)		
Emotional Exhaustion	21.56	12.72
Depersonalization	6.64	5.50
Personal Accomplishment	41.91	4.44

Table 8 provides the percentages of study participants who fell within the cutoff ranges of low, average, and high burnout for the three subscales, that is, emotional exhaustion (EE), depersonalization (DP), and personal accomplishment (PA).

Table 8

*Percentage of Study Participants Within Each of the Three Subscales of the MBI*

MBI Subscales	Range of Experienced Burnout		
	Low	Average	High
Emotional Exhaustion (EE)	29%	24%	47%
Depersonalization (DP)	44%	24%	32%
Personal Accomplishment (PA)	92%	5%	3%

As shown in Table 8, nearly one half of study participants (47%) scored high in Emotional Exhaustion and approximately one third (32%) scored high in Depersonalization. Nonetheless, the majority of scores in the Personal Accomplishment subscale indicated a high level of sense of personal accomplishment (as a reminder, scores of the Personal Accomplishment scale are opposite of the Emotional Exhaustion and Depersonalization scales in that higher raw scores on the PA scale correspond to lower degrees of burnout).

### **Correlational Analyses**

Correlation coefficients of counselor characteristics among the ABS and MBI subscales were determined using Spearman's rank order correlation coefficient (two tailed). For the Addiction Belief Scale (ABS) there was a small positive correlation with counselor age,  $r_s = .25$ ,  $n = 66$ ,  $p = .047$  with higher strength of belief in the disease model of addiction associated with older counselors. In addition, there was a small positive association with number of groups facilitated weekly indicating counselors with a stronger belief in the disease concept were more likely to facilitate a greater number of weekly groups ( $r_s = -.25$ ,  $n = 66$ ,  $p = .031$ ).

For the MBI subscale of emotional exhaustion there was a small negative correlation with length in field,  $r_s = .25$ ,  $n = 66$ ,  $p = .044$  with greater emotional exhaustion associated with less time in the field. For the subscale of depersonalization there was a medium negative association with age,  $r_s = -.33$ ,  $n = 66$ ,  $p = .007$ , indicating greater depersonalization was associated with younger counselors. Also, there was a small negative association between depersonalization and case load size suggesting smaller case load size was associated with greater levels of depersonalization  $r_s = .28$ ,

$n = 66, p = .025$  . Finally, there were no correlations between counselor characteristics and the MBI subscale of personal accomplishment.

Spearman's rank order correlations between counselor's strength of belief in the disease concept of addiction (ABS) and the three subscales of the MBI are shown in Table 9.

Table 9

*Spearman Rank Order Correlations Among the MBI Subscales and Addiction Belief Scale*

Scale	1	2	3	4
1. Addiction Belief	-	-.315*	-	-
2. Emotional Exhaustion		-	.568**	-.306*
3. Depersonalization			-	-.365**
4. Personal Accomplishment				-

*Note.* \*Correlation is significant at the 0.05 level (2-tailed)

\*\*Correlation is significant at the 0.01 level (2-tailed)

There was a medium negative correlation between the Addiction Belief Scale and Emotional Exhaustion,  $r_s = -.31, p = .010$ , with greater strength in the belief of the disease concept of addiction associated with lower levels of emotional exhaustion. In addition, there was (a) a strong positive correlation between emotional exhaustion and depersonalization,  $r_s = .57, p < .001$ , indicating greater depersonalization was associated with greater levels of emotional exhaustion, and (b) a medium negative correlation between the Emotional Exhaustion Scale and Personal Accomplishment,  $r_s = -.31, p = .013$ , indicating higher levels of emotional exhaustion were associated with lower

levels of personal accomplishment. Lastly, there was a medium negative association between personal accomplishment and depersonalization,  $r_s = -.36, p = .003$ , indicating greater depersonalization was associated with lower levels of personal accomplishment.

### **Tests of Hypotheses**

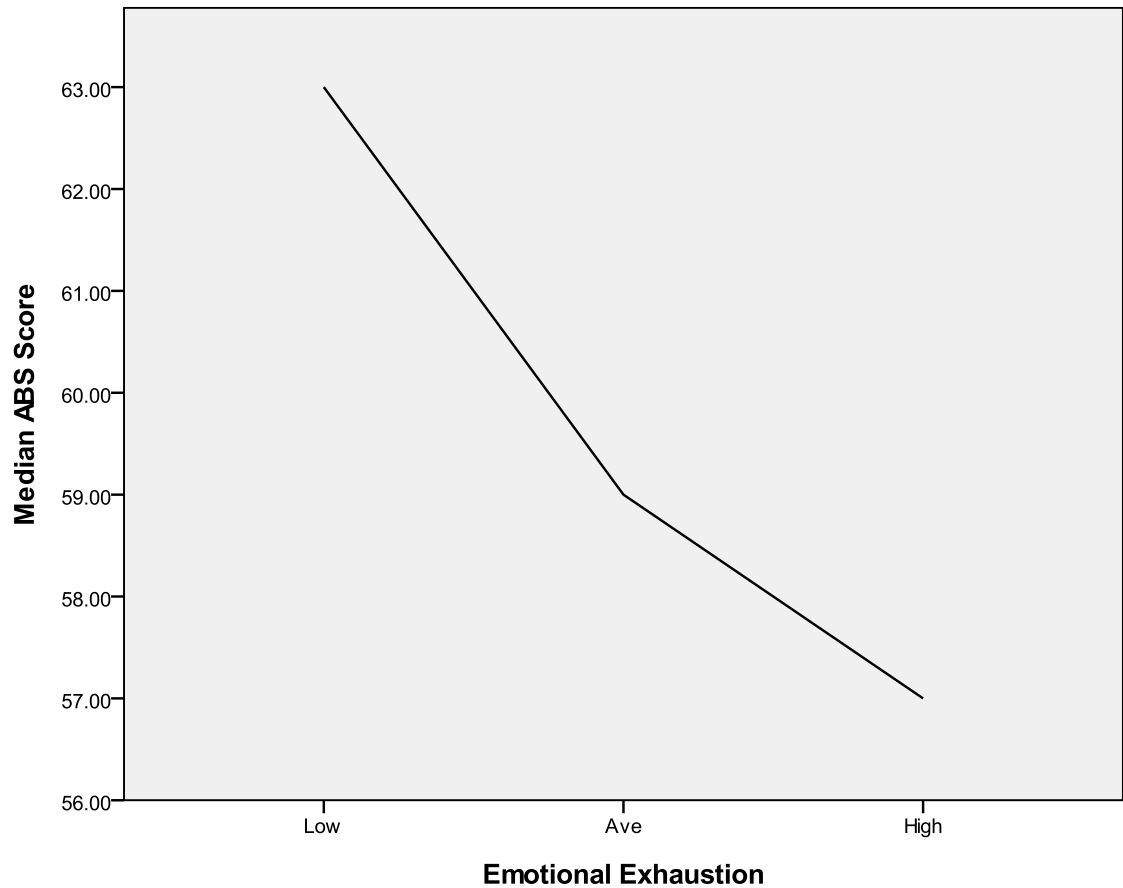
**Hypothesis one.**  $H_1$ : There will be a relationship between substance abuse counselor's strength of belief in the disease concept of addiction and burnout.

To examine the association between counselor's strength of belief in the disease concept of addiction and burnout the chi-square test for independence was used as it is a non-parametric test and is used to explore the relationship between two categorical variables having two or more categories each. Observed frequencies of cases that occur in each category are compared to the frequencies that would be expected if there were no association. Counselor's strength of belief in the disease concept as measured by the ABS was collapsed into the categorical variable low/high using the conceptual median of 54 as the cut off point (Russell et al., 2011). Scores falling below the median of 54 indicated a lower degree of strength in the belief of the disease concept and scores equal to or greater than the median of 54 indicated a higher degree of belief in the disease concept of addiction. As shown in Table 2, scores for each of the three subscales of the MBI, that is, emotional exhaustion, depersonalization, and personal accomplishment were divided into the categories of low, average, and high using the cut off points established for mental health workers (Maslach et al., 1996).

Initial chi-square results indicated that all scales of the MBI violated the assumption that the lowest expected frequency in any cell should be five or more (Field, 2005). Because of this violation Fisher's Exact Test was calculated rather than the

chi-squared statistic as the Fisher's Exact Test has no such assumption and can be performed regardless of how small the expected frequency is (Bower, 2003). Results indicated that hypothesis one was only partially tenable as Fisher's Exact Test was significant only for the emotional exhaustion scale ( $p < .001$ ). Contingency table analysis indicated that of counselors who scored above the conceptual median of the ABS (indicating a stronger belief in the disease concept of addiction) none scored high in emotional exhaustion. Results for the subscales of depersonalization and personal accomplishment were non-significant. A graphical representation of the association between emotional exhaustion and strength of belief in the disease concept of addiction (ABS) is shown in Figure 6. Caution should be observed in this representation as the median scale range of the ABS and the subsequent difference from low emotional exhaustion to high emotional exhaustion is only a range of eight points.





*Figure 6.* Graphical median representation of association between emotional exhaustion and strength of belief in the disease concept of addiction.

**Hypothesis two.**  $H_2$ : There will be a relationship between counselor's self-identification as a recovering substance abuser and burnout.

To examine the association between counselor's self-identification as a recovering substance abuser and burnout the chi-square test for independence was used once again as it is a non-parametric test and is used to explore the relationship between two categorical variables having two or more categories each. Observed frequencies of

cases that occur in each category are compared to the frequencies that would be expected if there were no association.

Counselor's self identification of recovery status was divided into the categories of "yes/no." Each of the three subscales of the MBI, that is, emotional exhaustion, depersonalization, and personal accomplishment were divided into the categories of low, average, and high using the cut off points established for mental health workers (see Table 2).

Results indicated no significant association between counselor's self identification as a recovering substance abuser and level of burnout among the scales of emotional exhaustion and depersonalization. Results for the scale of personal accomplishment were untenable due to the violation of the Chi-square assumption that the lowest frequency in any cell should be five or more. In this analysis, four cells had less than the expected count of five (see Appendix G for comparison of counselor characteristics and mean MBI burnout scores). Fisher's Exact Test confirmed no significant findings for all scales of the MBI, hence, the null hypothesis for hypothesis two was retained.

**Hypothesis three.**  $H_3$ : There will be a relationship between counselor's self-identification as a recovering substance abuser and strength of belief in the disease concept of addiction.

To explore the relationship between counselor's self-identification as a recovering substance abuser and strength of belief in the disease concept of addiction the independent-samples *t*-test was used. The independent-samples *t*-test compares the means of two different groups. In this analysis, the continuous measure was the Addiction Belief Scale, the two groups were the counselor categorical variable of recovering substance

abuser “yes” and recovery substance abuser “no.” Results indicated that on average, counselors who identified their recovery status “yes” ( $M = 61.2$ ,  $SD = 9.45$ ) had a stronger belief in the disease concept compared to counselors who identified their recovery status “no” ( $M = 58.0$ ,  $SD = 7.85$ ;  $t [64] = 1.50$ ) though the difference was not significant ( $p = .137$ , two tailed). The magnitude of the differences in the means (mean difference = 3.21, CI: -1.05 to 7.46) was very small (eta squared = .034). Hence the null hypothesis was retained (see Appendix H for comparison of counselor characteristics and mean scores of the Addiction Belief Scale).

## Chapter IV: Discussion

The primary purpose of this exploratory study was to investigate the relationship of substances abuse counselor's strength of belief in the disease concept of addiction and level of burnout. Participants in this study completed, (a) the Maslach Burnout Inventory, MBI-HSS (Maslach et al., 1996) to assess level of burnout, (b) the Addiction Belief Scale (Schaler, 1995) to determine counselor's strength of belief in the disease concept of addiction, and (c) a demographic questionnaire that included counselor's recovery status defined as "being in recovery from alcohol or other drug abuse." It was predicted that there would be a relationship between counselors level of burnout and (a) counselor's strength of belief in the disease concept of addiction, and (b) counselor's self identified recovery status and burnout. In addition, it was predicted there would be a relationship between counselor's strength of belief in the disease concept of addiction and counselor's recovery status.

### Hypothesis One

*H<sub>1</sub>*: There will be a relationship between substance abuse counselor's strength of belief in the disease concept of addiction and burnout.

Results for hypothesis one was only partially tenable in that of the three burnout scales of (a) emotional exhaustion, (b) depersonalization, and (c) personal accomplishment, only the emotional exhaustion scale indicated a significant relationship between counselor's strength of belief in the disease concept and burnout. This relationship indicated that greater strength of belief in the disease concept of addiction was associated with lower levels of emotional exhaustion.

There are a number of possible explanations for this result. One possible explanation for the significant negative relationship between emotional exhaustion and strength of belief in the disease concept of addiction may be that those counselors with the stronger belief in the disease concept view the disease concept of addiction as providing an organizing, pragmatic, and effective construct. From this prospective, counselors may view the disease model as assisting both the counselor and client to conceptualize and understand: (a) the problem (disease), (b) the manifestations of the problem (symptoms), (c) the potential causes (etiology), (d) the evolution of the problem (course), and (e) interventions to treat the problem (treatment options) and the likely outcome of interventions (prognosis) (White, 2001a, 2001b). The subsequent belief in the utility to this approach may then increase the counselor's confidence and belief that she or he is more able to send a clear and unambiguous message to clients about what addiction is and what it is not (Russell et al., 2011). This increase in confidence in the ability to send a clear and unambiguous message to clients may then also assist the counselor by limiting the emotional draining stress experienced by the counselor in work that is often charged with feelings of anger, embarrassment, fear or despair (Maslach & Jackson, 1981).

A second possible explanation for the finding that greater strength of belief in the disease concept of addiction is associated with lower levels of emotional exhaustion may be counselor's attributions towards their clients. Attribution theory suggests that people infer causality by two main causes—dispositional causes and situational causes. Dispositional causes are attributed to internal causes, that is, personality traits, motives, mood, intent, and values. Situational causes are external causes such as circumstances,

roles, laws, rules, and social norms (Myers, 2004). In most cases, neither dispositional or situational causes are considered irresistible. None the less, both can exert enormous influence on an individual when determining the cause for their own or others' behavior (Fiske, 2004). Haynes and Ayliffe (1991) suggested "disease" as an example of an external causal factor that is often associated with external attribution:

the process by which personal change is linked to certain causal factors: if the individual believes that they have caused the change then this is usually referred to as internal attributions; if, however, an external factor is thought to have caused the change, such as disease, or a prescribed drug, then this would be an example external attribution. (p. 1112)

Unfortunately, accurately determining dispositional versus situational causes for personal or other's behavior is frequently inaccurate. Research has shown that when trying to determine the causes for others' behaviors individuals are apt to underestimate situational influences and overestimate dispositional characteristics. This tendency is often referred to as the "fundamental attribution error" (Myers, 2004).

In regards to how strength of belief in the disease concept of addiction may influence substance abuse counselor's attributions towards their clients, it may be that counselors with a stronger belief in the disease model are less likely to make the "fundamental attribution error" and more likely to attribute the cause of their client's symptoms and sometimes difficult behavior to external causes, that is, *the disease*. The importance of this may be supported anecdotally in that a common phrase known within the substance abuse treatment community is, "Keep your eye on the disease, not the behavior." This phrase may be an example of how counselors with a stronger belief in the disease concept make use of their attribution causality style, that is, external attribution

(the *disease*), to manage their emotional draining stress that is so often a part of their interactions with their clients.

The conflicting results of the personal accomplishment scale in this study warrants discussion as counselor's sense of personal accomplishment appeared to remain high regardless of the level of emotional exhaustion or level of depersonalization. According to Maslach et al. (1996), the subscale personal accomplishment is negatively correlated with both the subscales of emotional exhaustion and depersonalization. In other words, as levels of counselor's emotional exhaustion and depersonalization increase, their sense of personal accomplishment decreases. In this study levels of personal accomplishment remained high regardless of counselor's level of emotional exhaustion or depersonalization. This finding is consistent with prior studies of burnout among substance abuse counselors (Aksamit, 1997; Elman & Dowd, 1997; Price & Spence, 1994) who noted that despite showing high levels of emotional exhaustion, counselor's scores of the personal accomplishment scale remained high indicating a high sense of personal efficacy in their work.

One possible explanation for the lack of relationship between counselor's strength of belief in the disease concept of addiction and the scales of depersonalization and personal accomplishment may be that counselors responded to negative questions in a socially desirable manner regarding how they think of their clients and their own sense of personal efficacy in their work. This may not necessarily mean that counselors were purposefully attempting to be deceptive in an effort to portray themselves in the most positive light. Instead, counselors may have answered questions in a manner that was

most congruent with a positive self image regarding their relationship with their clients and sense of personal potency in their work.

Another possible explanation for the lack of relationship between counselor's strength of belief in the disease concept of addiction and the scales of depersonalization and personal accomplishment is reflected in the literature regarding the sensitivity of these two MBI subscales. Wright and Cropanzano (1998) noted that while all three scales of the MBI are potentially important, there has been a growing consensus that "emotional exhaustion is the key dimension of burnout" (p. 487). In addition, Wright and Cropanzano pointed to prior research by Shirom in 1989 who concluded that the 'core meaning' of burnout is best found in the physical and psychological depletion that characterizes emotional exhaustion and that burnout as emotional exhaustion assists in distinguishing it from other social science concepts (p. 487). In addition, Kalliath et al. (2000) while investigating the factor structure of the Maslach Burnout Inventory in a study of burnout among health care workers found that, "Emotional exhaustion was the most robust of the MBI's factors, followed by depersonalization, while the personal accomplishment factor performed weakly" (p. 35). Kalliath et al. also noted that past findings (Koeske & Koeske, 1993; Lee & Ashforth, 1996; Reilly, 1994) were consistent with arguments that emotional exhaustion is the essence of burnout.

## **Hypothesis Two**

*H<sub>2</sub>*: There will be a relationship between counselor's self-identification as a recovering substance abuser and burnout.

Results for hypothesis two indicated no significant association between counselor's self identification as a recovering substance abuser and level of burnout. This



result is counter to Rubington's (1984) findings that proposed recovering counselors were at greater risk of burnout compared to non-recovering staff. On the other hand, results of this study are consistent with more recent studies such as Elman and Dowd (1997), Davis (2008) and Biebel (2010). These three studies all proposed that one possible explanation for the lack of relationship between recovery status and burnout was that recovering counselors, compared to their non-recovering colleagues, make use of additional social support that most often includes participation in community based 12-step fellowship support groups which helps to minimize and protect against burnout.

This researcher suggests another possible explanation for the lack of relationship between recovery status and burnout. It may also be the case that recovering counselors may be more likely to adhere to a "compensatory model" of helping (Brickman, Rabinowitz, Coates, Cohn, & Kidder, 1982). According to Brickman et al., the compensatory model of helping acknowledges that recipients of help are not responsible for problems (hence, they are then deserving of help) but also acknowledges the importance of leaving recipients of help with a sense of control over their lives in that it is they who choose how best to use help in finding a solution to their problem (their "disease"). This approach to helping is also in agreement with the fundamental supposition of the substance abuse treatment community that states, "Once alcoholics/addicts are made aware of the nature of their condition and the steps than can be taken for its resolution, they become responsible for initiating and managing their own recovery" (White, 2001b, p. 45). Recovering counselors may, by their own experience of addiction, place greater emphasis on their clients' taking personal responsibility for their recovery. This greater emphasis on personal responsibility may then help the recovering counselor avoid over

commitment and unrealistic expectations of the outcome of their work resulting in fewer feelings of emotional exhaustion and a greater sense of personal efficacy in their work.

### **Hypothesis Three**

*H<sub>3</sub>*: There will be a relationship between counselor's self-identification as a recovering substance abuser and strength of belief in the disease concept of addiction.

Results for hypothesis three indicated no significant relationship between counselor's recovery status and strength of belief in the disease concept of addiction. This finding is contradictory to previous studies but consistent with others. Contrary to this study, Moyers and Miller (1993) found that counselors with a personal history of alcohol or other drug abuse showed a significantly greater adherence to disease model beliefs compared to counselors with no personal history of alcohol or other drug abuse. In addition, Schaler (1997) found that current attendance of Alcoholics Anonymous meetings and being female was positively associated with stronger belief in the disease model of addiction.

Studies consistent with the results of this study such as Humphreys et al. (1996) found that contrary to past studies, recovering counselors were not "rigid adherents to disease model beliefs" (p. 77), and that caution should be taken in attributing specific beliefs to recovering staff members. Thombs and Osborn (2001) also found little support for a relationship between recovery status and adherence to disease model beliefs. In their study, three distinct clinical orientations were identified in a sample of 406 chemical dependency counselors. Strength of belief in the disease concept of addiction varied by group membership. The authors found it noteworthy that results indicated that counselors in recovery were not concentrated in any of the three groups.

One possible factor that may contribute to past conflicting results regarding recovering counselors adherence to the disease model of addiction may be that recovering counselors may fall within two distinct groups—counselors who have experienced formal substance abuse treatment as part of their initial recovery efforts versus counselors who have only been exposed to the guidance and support of the 12-step community such as Alcoholics Anonymous and others. It would seem a reasonable hypothesis that counselors who have participated in formal substance abuse treatment have been exposed to a more eclectic range of treatment options compared to those who have never experienced formal substance abuse treatment. This initial “training” by those with prior formal treatment experience may prepare this group of recovering counselors to be more accepting of a wider range of treatment/recovery strategies.

### **Limitations of the Study**

There are several limitations to this study. First, caution regarding the generalization of findings should be considered. The sample of counselors of this study was a sample of convenience and therefore may not be representative of substance abuse counselors in other geographical locations. Future studies should include other geographical locations so as to be more reflective of substance abuse counselors throughout the profession. In addition, the sample of counselors in this study were all working in a non-profit designated substance abuse outpatient treatment facility. Future research should include substance abuse counselors working in a variety of settings that include both non-profit and for profit organizations, substance abuse treatment inpatient settings, and mental health inpatient and outpatient settings. Finally, generalization of

findings may be limited by self selection bias in that counselors who were experiencing a high level of burnout may have chosen not to or been unable to participate in the survey.

Another possible limitation of this study is that the measures of this study were instruments that relied solely on self-report. As noted previously, participants may have responded to negative questions in a socially desirable manner that was most congruent with a positive self image regarding their relationship with their clients and sense of personal commitment to both their clients and their work. Future research might include some type of impression or social desirability measurement to determine if participants' responses correlate with social desirability.

An additional possible limitation to this study is that data was gathered using a cross sectional sampling method. This limits the ability to identify change in participant's theoretical orientation as well as level of burnout. Future research might consider using longitudinal designs in an effort to better determine factors that impact clinical orientation and burnout level over time.

There were also limitations related to statistical analysis involving the measure of burnout (MBI) due to non-normality of distribution of scores of the three subscales of MBI (emotional exhaustion, depersonalization, and personal accomplishment). Hence, statistical methods of analysis involving measurement of burnout was limited to non-parametric analysis. Previous studies of burnout have noted that the dimension of "emotional exhaustion" is the "core meaning" of burnout. In addition, it is the most robust of the MBI's three subscales, followed by depersonalization then personal accomplishment. Future researchers seeking to investigate burnout may find using a unidimensional measure of burnout more satisfactory as it requires less space on a

questionnaire and less time for administration and analysis (Maslach & Pines, 2005, p. 79).

### **Future Research**

Concern regarding substance abuse counselor turnover and retention rate and subsequent workforce shortage has gained national attention as demand for substance use disorder treatment continues to rise. Research thus far has identified several factors as possible contributors to counselor turnover and burnout. These factors include; the role of workplace management practices; counselor's personal characteristics such as age, gender, and education level, and counselor recovery status.

This study was an effort to expand the literature regarding contributing factors to counselor burnout by investigating the relationship between substance abuse counselor's clinical orientation, specifically counselor's strength of belief in the disease concept of addiction and burnout. To this writer's knowledge, this study was the first investigation of substance abuse counselors' clinical orientation and subsequent relationship with burnout. In addition, this study examined the relationship between counselor recovery status and burnout and the relationship between counselor recovery status and adherence to the disease model of addiction.

Future research should first determine if results of this study can be replicated. It may be that the sample of participants in this study do not represent the overall population of substance abuse practitioners.

Toriello and Leierer (2005) suggested that substance abuse counselors' clinical orientation development is not a static state. Individuals considering a career in the substance abuse field no doubt begin their training with a set of preconceived beliefs and

values regarding the causes and contributing factors that lead to addiction. One question of interest may be: Does early training and education alter these initial preconceived beliefs or are these idiosyncratic beliefs maintained following training? This question might be investigated via a repeated measure design by first identifying pre-training beliefs followed by post training assessment of individuals' adopted clinical orientation.

Brickman et al. (1982) suggests that a mismatch between helper's model of helping and attributions towards their clients will result in: (a) undermining the success of their very effort to help, and (b) have a negative impact on their self-esteem and involvement with their clients resulting eventually in burnout of the helper (p. 377). In addition, Lopez and Wokenstein (1990) noted that counselors' explanations for the causes of clients' problems can influence clinical decision making regarding diagnostic considerations, recognition of symptoms, and expected outcome. Another question of interest then would be: Is there a relationship between burnout and substance abuse counselors' dispositional versus situational attributions towards their client?

### **Conclusions and Implications**

The focus of this study was to investigate the association between counselor level of burnout and clinical orientation, that is, strength of belief in the disease concept of addiction. Results suggested that as strength in the belief in the disease concept of addiction increased vulnerability to burnout decreased. This study also examined the association between counselors' recovery status and vulnerability to burnout. In addition, recovery status and adherence to the disease model of addiction was investigated. Findings suggested that neither level of burnout or strength of belief in the disease concept was associated with recovery status.

Previous research investigating the prevalence and possible contributing factors of burnout and reasons for job turnover within the substance abuse treatment field have primarily focused on the personal characteristics of the individual (i.e., gender, age, personality type, recovery status) or the work environment (i.e., type of treatment setting, style of management, type and severity of client profiles served) as contributors to burnout (Aksamit, 1997; Broome et al., 2009; Davis, 2008; Eby et al., 2010; Elman & Dowd, 1997; Knudsen et al., 2006, 2008; Lacoursiere, 2001; Oyefeso et al., 2008; Price & Spence, 1994; Shoptaw et al., 2000; Vilardaga et al., 2011). White and Garner (2011) suggests that it may be beneficial for future research to shift its focus from why professionals are leaving the addiction field to why individuals remain working within the field. This writer would agree with such a shift in focus. This shift in focus could feasibly begin to develop a body of literature that could have a significant positive impact on the well being and work life of individuals working in the addictions' community. In addition, such a focus could also be instrumental in the improvement of the quality of addiction treatment provided.

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## Appendix A

### Counselor Demographic Questionnaire

1. What is your age?  
☐ 25 or under      ☐ 26–40      ☐ 41–50      ☐ 51 or older
2. What is your gender?  
☐ Female   ☐ Male
3. How long have you been working in the field of addictions?  
☐ Less than 1 year   ☐ 1–5 yrs      ☐ 6–10 yrs      ☐ 11–15 yrs      ☐ 16+ yrs
4. What is your current level of education?  
☐ AA degree      ☐ BA/BS degree      ☐ Masters degree      ☐ Psy.D/Ph.D
5. What are your current credentials? (Check all that apply)  
☐ CDP    ☐ CDPT      ☐ LMSW      ☐ LMHC      ☐ Other: \_\_\_\_\_
6. What is the size of your current case load?  
☐ Less than 10   ☐ Less than 20   ☐ 20 to 40   ☐ 41 to 50   ☐ Over 50
7. What is the primary client population that makes up your case load?  
☐ ADATSA    ☐ Drug Court      ☐ Co-occurring Disordered  
☐ No primary client population/Mixed Adult   ☐ Other: \_\_\_\_\_
8. How many group psychotherapy sessions do you co-facilitate/lead weekly?  
☐ None   ☐ 1–3 groups   ☐ 4–6 groups   ☐ 7–9 groups      ☐ 10+ groups
9. Do you identify yourself as “In recovery from alcohol or other drugs?”  
☐ Yes   ☐ No
10. a) If “yes” to the above do you attend “12-step” meetings?  
☐ Yes   ☐ No   ☐ N/A
10. b) If “yes” to the above, how often do you currently attend “12-step” meetings?  
☐ Monthly   ☐ Bi-monthly   ☐ Weekly   ☐ More than weekly   ☐ N/A

## Appendix B

### Informed Consent: Human Services Survey



### Informed Consent: Human Services Survey

Dear Colleague,

Concerns regarding recruitment and retention of Addictions Professionals in the workforce have been expressed at the state and national level as evidenced by NAADAC's (The Association for Addiction Professionals) statement in their publication, "Issue Brief: Current and Future Addiction Workforce."<sup>1</sup>

You are invited to participate in a research project to gain insight into how chemical dependency professionals view their job and the people with whom they work so closely. You are being asked to complete the attached questionnaire and return it using the enclosed self addressed postage paid envelope. Several alcohol/drug treatment agencies will participate in the survey. Your response will be anonymous and confidential as the survey does not ask for your name nor the agency you are currently employed by. It is hoped that the results of the survey will be useful for those in decision making positions in their efforts to best determine ways to enhance and support existing counseling staff and factors to consider in recruitment efforts. The results of the survey will be shared with the State of Washington's Division of Behavioral Health and Recovery (DBHR). There will also be an attempt to publish the results of the survey in a scientific journal.

There is no known risks to you if you decide to participate in this survey other than it may bring back memories of difficult as well as meaningful experiences related to your professional work. If you experience any acute psychological distress after completing the survey you are encouraged to contact your local county mental health crisis line (see attached phone list). In addition, if you would like to talk with someone regarding your feelings after completing the survey a list of names and phone numbers of qualified mental health and social work professionals is also included with the crisis line county phone numbers. The research project will not provide funds for counseling and you would be responsible for any fees.

***Your participation is voluntary and there is certainly no penalty if you do not participate.*** Should you choose to complete the survey it should take you about 10 to 15 minutes to complete. ***You should not put your name or your agency's name on the questionnaire.***

This research project has been approved by the Internal Review Board at Antioch University of Seattle. Raw data will be maintained for seven years after its compilation. Thank you for any consideration you give to participating in this survey and your contribution of your valuable time and experience.

**By checking the box below labeled "Yes. I have read and understand the guidelines of participating in this survey" you are indicating you understand the potential risks involved and assume them voluntarily. Due to the efforts to protect the anonymity of surveys, once a survey is submitted it cannot be withdrawn from the study as there is no way to identify the individual who completed the survey.**

☐ **YES. I have read and understand the guidelines of participating in this survey.**

When you have completed the survey please return all documents in the attached postage paid self addressed envelope labeled "Survey."

Thank you again for your consideration and participation in this research project.

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<sup>1</sup> Issue Brief: Current and Future Addiction Workforce @ <http://www.naadac.org/documents/display.php?DocumentID=98>

## Appendix C

## Counselor Demographic Codes

## **Appendix D**

Frequency Distribution of Emotional Exhaustion, Depersonalization, Personal  
Accomplishment, and Addiction Belief Scales.

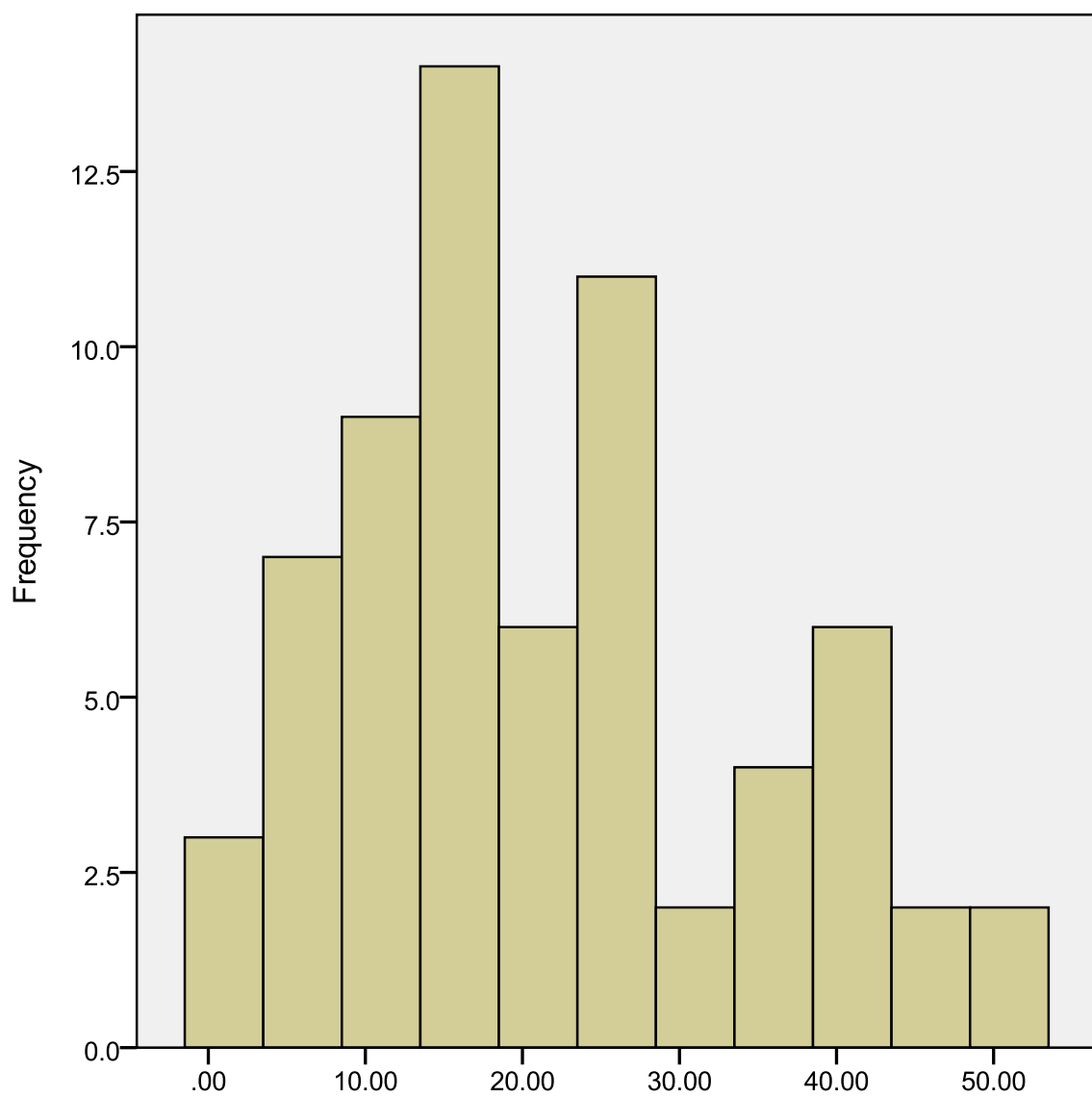
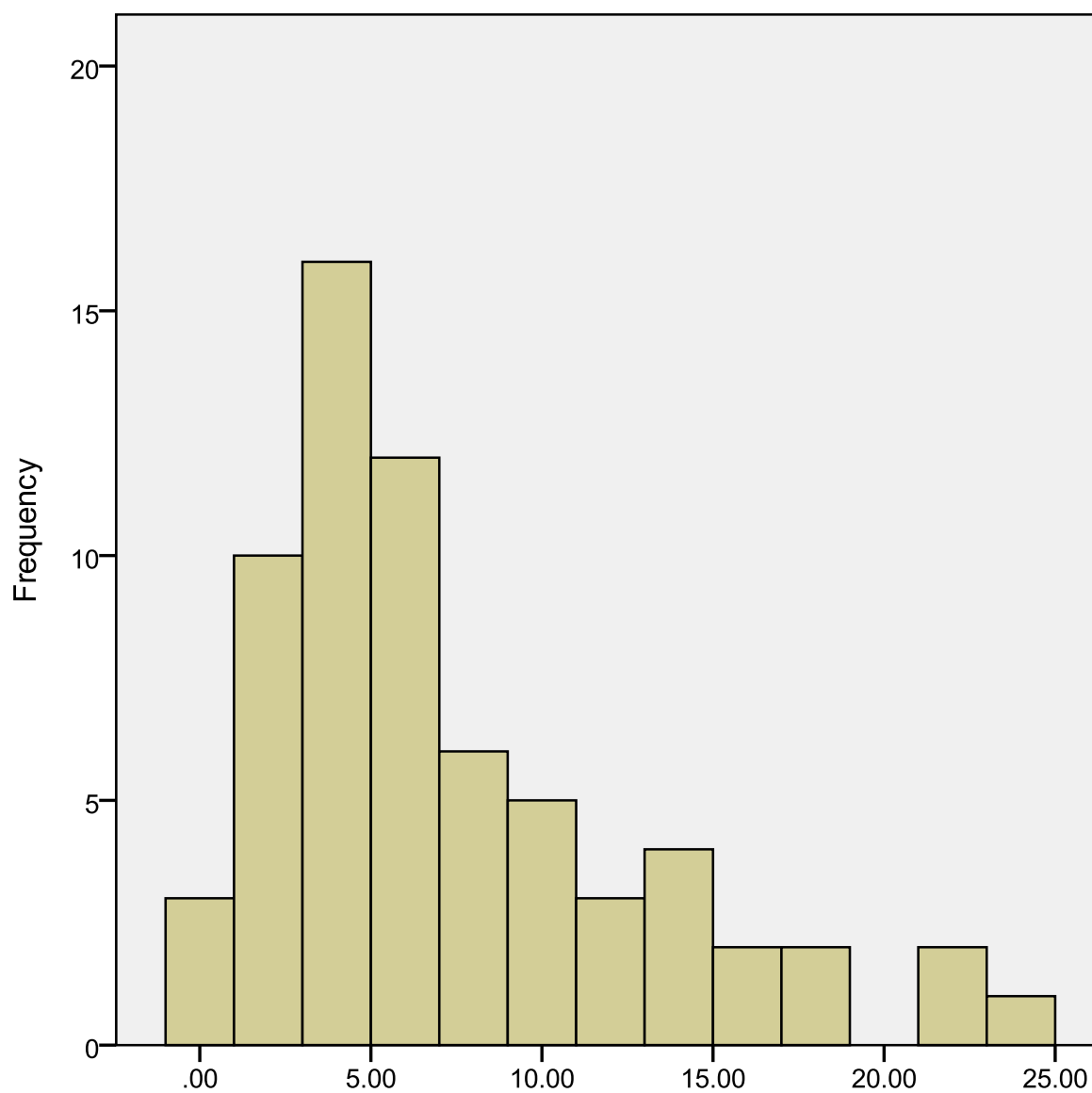
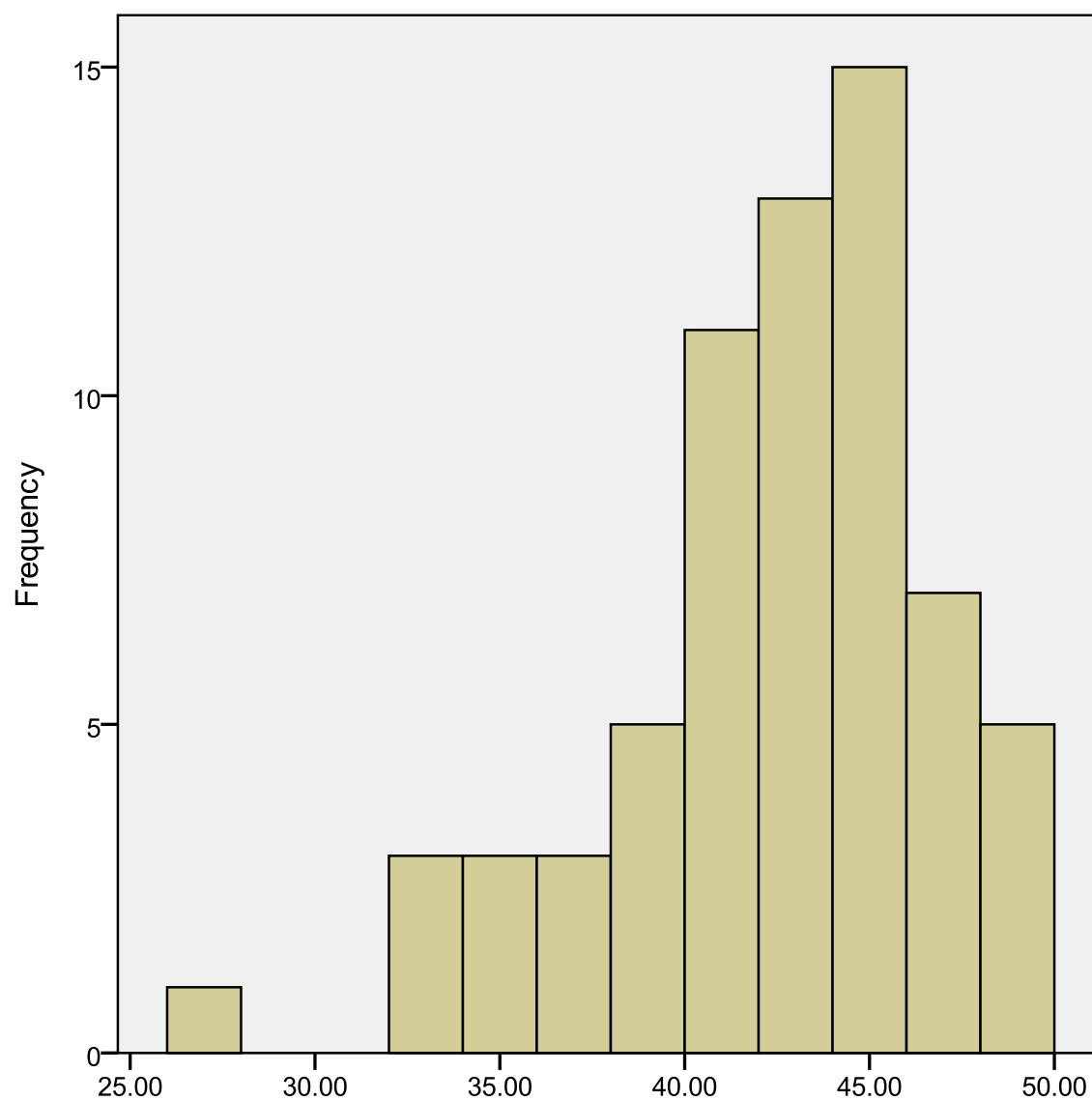


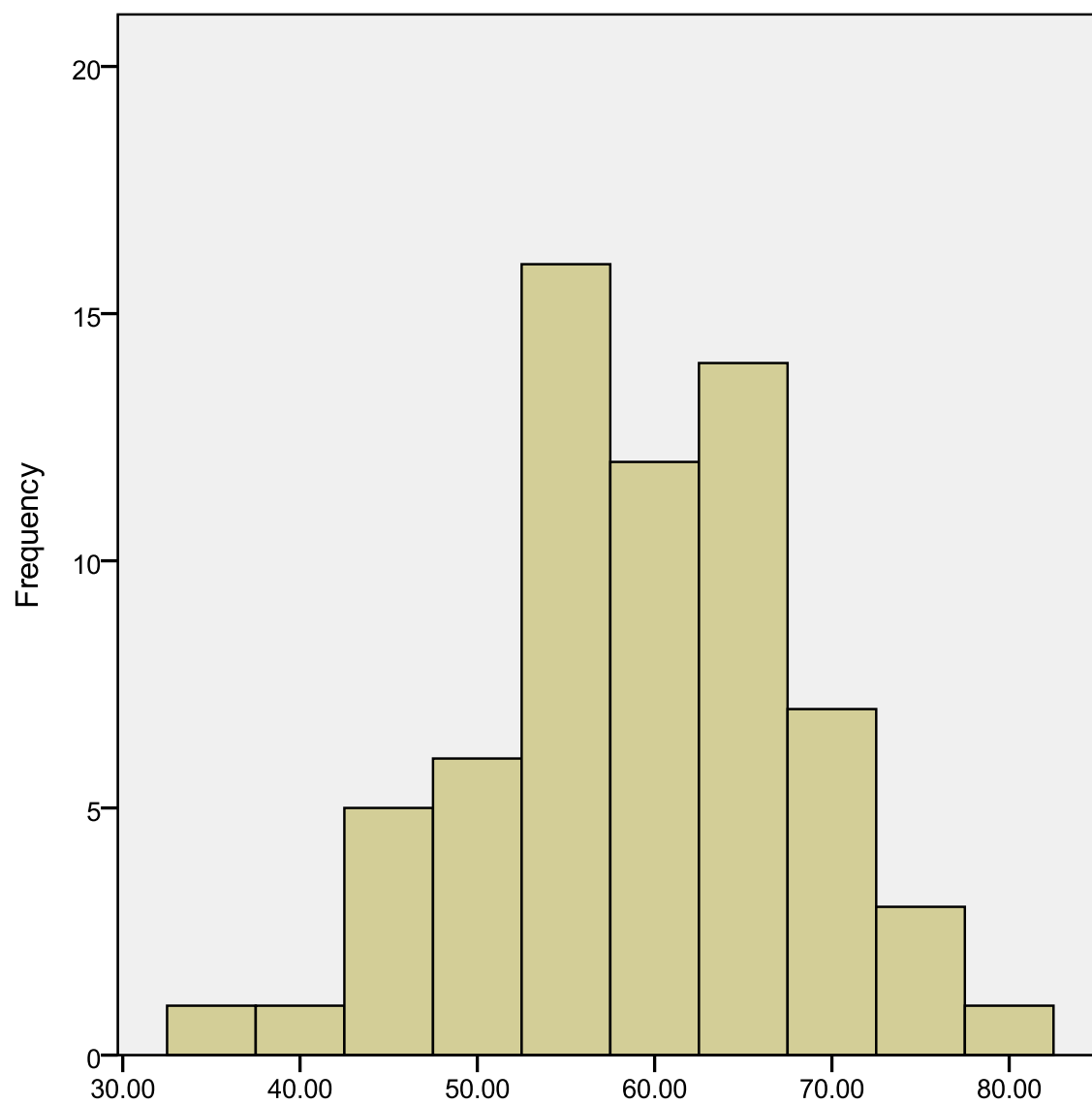
Figure E1. Frequency distribution of emotional exhaustion scale.



*Figure E2.* Frequency distribution of depersonalization scale.



*Figure E3.* Frequency distribution of personal accomplishment scale.



*Figure E4.* Frequency distribution of addiction belief scale.

## Appendix E

### Descriptive Statistics of Counselor Characteristics



*Descriptive Statistics of Counselor Characteristics*

Characteristic	<i>n</i>	%
Age		
≤25yrs	2	3.0
26–40yrs	26	39.4
41–50yrs	11	16.7
≥51yrs	27	40.9
Gender*		
Female	45	68.2
Male	20	30.3
Length in field		
<1yr	5	7.6
1–5yrs	23	34.8
6–10yrs	12	18.2
11–15yrs	13	19.7
≥16yrs	13	19.7
Education level**		
AA	22	33.3
BA	30	45.5
MA	13	19.7
Credential		
CDP	45	68.2
CDPT	21	31.8
Case load		
<10	16	24.2
10–19	10	15.2
20–40	22	33.3
41–50	4	6.1
≥51	14	21.2
Number weekly group		
No groups	18	27.3
1–3	28	42.4
4–6	15	22.7
7–9	5	7.6
Recovery status		
Yes	29	43.9
No	37	56.1
12-step attendance		
Yes	24	36.4
No	42	63.6

*Note.* \*One participant declined to note gender. \*\*One participant declined to note education level.

## **Appendix F**

Addiction Belief Scale (ABS) Statements Most Strongly Endorsed by  
Counselors With the Strongest Belief in the Disease Model  
and in the Free Will Model

ABS Statement	<i>M</i>	<i>SD</i>
Disease Model ( <i>n</i> = 51)		
1. The most important step in overcoming an addiction is to acknowledge that you are powerless and can't control it.	4.22	.88
2. Abstinence is the only way to control alcoholism/drug addiction.	3.90	1.15
3. People who are drug addicted can never outgrow addiction and are always in danger of relapsing.	3.78	1.12
4. The fact that alcoholism runs in families means that it is a genetic disease.	3.67	1.01
5. Addicts cannot control themselves when they drink or take drugs.	3.65	1.20
6. Addiction is an all-or-nothing disease: A person cannot be a temporary drug addict with a mild drinking or drug problem.	3.61	1.23
7. Physiology, not psychology, determines whether one drinker will become addicted to alcohol and another will not.	3.00	1.22
8. The only solution to drug addiction and/or alcoholism is treatment.	2.76	1.11
9. Most addicts don't know they have a problem and must be forced to recognize they are addicts.	2.14	.92

*Addiction Belief Scale (ABS) Statements Most Strongly Endorsed by Counselors With the Strongest Belief in the Free Will Model*

ABS Statement	<i>M</i>	<i>SD</i>
Free Will Model ( <i>n</i> = 15)		
1. The best way to overcome addiction is by relying on your own willpower.	4.33	.62
2. People become addicted to drugs/alcohol when life is going badly for them.	3.60	.91
3. You have to rely on yourself to overcome an addiction such as alcoholism.	3.20	1.21
4. People often outgrow drug and alcohol addiction.	3.13	1.06
5. Drug addicts and alcoholics can find their own ways out of addiction, without outside help given the opportunity.	3.00	1.00
6. Addiction has more to do with the environments people live in than the drugs they are addicted to.	2.73	1.16
7. Alcoholics and drug addicts can learn to moderate their drinking or cut down on their drug use.	2.67	1.11
8. Drug addiction is a way of life people rely on to cope with the world.	2.47	1.12
9. People can stop relying on drugs or alcohol as they develop new ways to deal with life.	1.73	.59

## Appendix G

### Descriptive Statistics of MBI Scores of Counselor Characteristics.

*Descriptive Statistics of MBI Scores of Counselor Characteristics*

	Emotional Exhaustion			Depersonalization			Personal Accomplishment		
	<i>M</i>	<i>SD</i>	<i>N</i>	<i>M</i>	<i>SD</i>	<i>N</i>	<i>M</i>	<i>SD</i>	<i>N</i>
MBI	21.56	12.72	66	6.64	5.50	66	41.90	4.44	66
Age									
≤25yrs	20.50	4.95	2	7.00	2.83	2	42.50	2.12	2
26–40yrs	24.46	12.42	26	8.88	6.44	26	40.85	4.40	26
41–50yrs	16.18	12.47	11	5.82	5.29	11	42.00	4.15	11
≥51yrs	21.04	13.21	27	4.78	3.95	27	42.85	4.67	27
Gender*									
Male	21.15	14.19	20	7.70	6.09	20	41.30	4.67	20
Female	21.62	12.31	45	6.02	5.18	45	42.17	4.59	45
Length In Field									
<1yr	18.80	5.54	5	6.00	4.12	5	41.20	4.20	5
1–5yrs	28.26	15.53	23	7.65	5.83	23	42.74	3.59	23
6–10yrs	19.17	10.78	12	5.50	4.70	12	41.33	5.05	12
11–15yrs	15.08	7.93	13	7.85	7.19	13	41.46	6.24	13
≥16yrs	19.46	10.48	13	4.92	3.97	13	41.69	3.59	13
Education Level**									
AA	20.32	13.13	22	6.18	5.36	22	42.45	4.55	22
BA/BS	18.57	10.06	30	6.20	5.82	30	41.17	4.25	30
MA	29.23	14.71	13	7.92	5.06	13	42.30	5.78	13
Credential									
CDP	19.89	10.48	45	6.75	5.78	45	41.53	4.57	45
CDPT	25.14	16.27	21	6.38	4.97	21	42.71	4.15	21
Case Load									
<10	20.06	11.15	16	9.12	7.40	16	41.44	4.73	16
10–19	25.90	12.57	10	8.40	4.32	10	40.90	5.40	10
20–40	20.18	10.45	22	5.32	4.17	22	42.36	3.24	22
41–50	15.75	13.35	4	4.75	3.59	4	40.25	8.84	4
≥51	24.00	17.38	14	5.14	5.24	14	42.93	3.77	14
Weekly Group									
No groups	22.11	12.34	18	7.11	6.92	18	42.05	4.09	18
1–3	21.39	13.86	28	6.5	4.89	28	41.36	4.46	14

4–6	19.93	12.89	15	5.20	4.89	15	42.20	5.36	15
7–9	25.40	8.71	5	10.00	4.72	5	42.05	4.09	5
Recovery Status									
Yes	20.76	13.26	29	5.59	4.51	29	42.62	4.32	29
No	22.13	12.43	37	7.46	6.10	37	41.35	4.52	37
12-step Attendance									
Yes	19.50	12.78	24	7.12	6.61	24	42.08	4.81	24
No	22.74	12.69	42	6.36	4.81	42	41.80	4.27	42

*Note.* \*One respondent declined to note their gender

\*\*One respondent declined to note their level of education

## Appendix H

### Descriptive Statistics of ABS Scores of Counselor Characteristics



*Descriptive Statistics of ABS Scores of Counselor Characteristics*

	<i>M</i>	<i>Mdn</i>	<i>SD</i>	<i>N</i>
ABS*	59.41	59.00	8.67	66
Age				
≤25yrs	65.00	65.00	15.56	2
26–40yrs	57.88	57.00	5.95	26
41–50yrs	57.55	57.00	5.77	11
≥51yrs	61.92	64.00	10.52	27
Gender**				
Male	60.05	60.00	11.51	20
Female	59.63	59.00	6.94	45
Length In Field				
<1yr	61.40	57.00	10.60	5
1–5yrs	56.68	57.00	9.09	23
6–10yrs	60.45	61.00	6.02	12
11–15yrs	62.08	63.00	7.90	13
≥16yrs	61.46	63.00	8.94	13
Education Level***				
AA	61.82	60.05	7.47	22
BA/BS	59.38	61.00	8.70	30
MA	57.15	59.00	9.62	13
Credential				
CDP	60.07	61.00	8.09	45
CDPT	59.10	58.50	9.62	21
Case Load				
<10	61.00	58.00	7.46	16
10–19	60.78	59.00	6.32	10
20–40	59.19	61.00	8.39	22
41–50	62.25	62.00	3.77	4
≥51	57.86	55.00	11.99	14
Weekly Group				
No groups	62.11	59.00	9.02	18
1–3	57.00	56.00	8.69	28
4–6	61.07	63.00	7.27	15
7–9	63.00	63.50	6.48	5
Recovery Status				
Yes	61.21	61.00	9.45	29
No	58.57	59.00	7.62	37
12-step Attendance				
Yes	60.25	59.00	8.64	24
No	58.47	60.00	8.57	42

*Note.* \*Highest score possible = 90. The higher the score, the stronger belief in the disease concept of addiction. Conceptual median = 54.

\*\*One participant declined to note gender status.

\*\*\*One participant declined to note education level.

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*Counselor Demographic Codes*


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Age	1 = $\leq 25$ yrs	2 = 26–40 yrs	3 = 41–50 yrs	4 = $\geq 51$ yrs	
Gender	1 = Female	2 = Male			
Length in field	1 = < 1 yr	2 = 1–5 yrs	3 = 6–10 yrs	4 = 11–15 yrs	5 = $\geq 16$ yrs
Level of education.	1 = AA	2 = BA/BS	3 = Masters	4 = PsyD/PhD	
Credentials	1 = CDP*	2 = CDPT**			
Caseload size	1 = < 10	2 = < 20	3 = 20–40	4 = 41–50	5 = $\geq 51$
No. of weekly groups	1 = none	2 = 1–3	3 = 4–6	4 = 7–9	5 = $\geq 10$
Recovery status	1 = Yes	2 = No			
Attend 12-step meetings	1 = Yes	2 = No			
Number of 12-step meetings	1 = Monthly	2 = Bi-monthly	3 = weekly	$\geq$ weekly	

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