Published in final edited form as:
J Psychoactive Drugs. 2013 ; 45(1): 17–27.

Causes, Consequences, and Prevention of Burnout among Substance Abuse Treatment Counselors: A Rural versus Urban Comparison

Carrie B. Oser, PhD[1], **Elizabeth P. Biebel, PhD**[2], **Erin Pullen, MA**[3], and **Kathi LH Harp, MA**[4]

Elizabeth P. Biebel: e.biebel@moreheadstate.edu; Erin Pullen: erinpullen@gmail.com; Kathi LH Harp: kathi.harp@gmail.com

[2]Assistant Professor, Morehead State University, Department of Sociology, Social Work, & Criminology, 150 University Blvd., Morehead, KY 40351, USA, Phone: (606-783-5386); Fax: (606)783-5070

[3]Study Director, University of Kentucky, Department of Sociology, Center on Drug & Alcohol Research, 1531 Patterson Office Tower, Lexington, KY 40508, USA, Phone: (859)257-6890; Fax: (859)323-0272

[4]Doctoral Candidate, University of Kentucky, Department of Sociology, Center on Drug & Alcohol Research, 1531 Patterson Office Tower, Lexington, KY 40508, USA, Phone: (859)257-6890; Fax: (859)323-0272

Abstract

Substance abuse counselors are vulnerable to burnout, which has negative repercussions for the counselor, employing organization, and clients. However, little is known about differences in counselor burnout from the counselors' perspective in rural versus urban treatment centers. In 2008, focus group data from 28 rural and urban counselors in a southern state was analyzed, revealing three burnout themes across all counselors: causes, consequences, and prevention. However, there were various differences between rural and urban counselors in sub-themes with only rural counselors citing office politics and low occupational prestige as causes of burnout. Only urban counselors reported responses endorsing the sub-themes of role reversal, clients trying to choose their counselors, and changing jobs as consequences of burnout. All counselors cited co-worker support, clinical supervision, and self-care as important strategies for managing burnout. In sum, context clearly matters as rural counselors cited more causes of burnout; yet, the implications of burnout are universal in that they often lead to poor quality clinical care. There is a continued need for greater understanding of addiction as a disease, which would reduce stigma, especially in rural areas, as well as increase the prestige and earning potential of the substance abuse counseling occupation.

Keywords

counselor; burnout; rural; urban; client treatment outcomes; qualitative

1. Introduction

Substance abuse counselors are at high risk for burnout due to low wages and a lack of prestige in their job, combined with the fact that their clients many times deny their

[1]Corresponding Author: Associate Professor, University of Kentucky, Department of Sociology, Center on Drug & Alcohol Research, 1531 Patterson Office Tower, Lexington, KY 40508, USA, cboser0@uky.edu, Phone: (859)257-6890; Fax: (859)323-0272.

problems, lack the motivation to change, are homeless, relapse, are involved with the criminal justice system, have significant health problems such as HIV/AIDS, and many times have co-occurring mental health disorders (Covington 2007; Ducharme et al. 2007; McNulty et al. 2007; Garner, Knight & Simpson 2007). Burnout is a term commonly referred to by those in human service fields to describe the three-dimensional aspects of (1) emotional exhaustion (inability to feel compassion for clients), (2) depersonalization (detachment from the emotional needs of their client), and (3) lack of personal accomplishment (critical evaluation of oneself) (Shoptaw, Stein & Rawson 2000). Although burnout can occur in other occupations, it is most commonly seen in the human service industry due in part to the emotional aspect of the relationship between caregiver and client (Ducharme, Knudsen & Roman 2008). That emotional connection is what differentiates burnout from occupational stress according to Maslach and colleagues (1997), who state that burnout is tied to work that is demanding and involves emotional investment. A number of factors have been found to be associated with burnout. Some are personal – age, educational level, recovery status – while others are organizational characteristics – caseload, available resources, autonomy, and role expectations (Ducharme, Knudsen & Roman 2008; Knudsen, Ducharme & Roman 2008; McNulty et al. 2007; Broome et al. 2009).

Burnout can lead to consequences for the counselor, the organization, and the client. Counselors suffering from burnout have more stress-related illness and mental health issues including depression, anxiety, and decreased self-esteem, as well as increased rates of physical health problems such as insomnia, headaches, and a general increase in overall illness (Ducharme, Knudsen & Roman 2008; Garner, Knight & Simpson 2007; Cherniss & Krantz 1983; Pines & Maslach 1978). In general, those suffering from burnout typically have a lower quality of life.

The organization faces high rates of absenteeism and turnover due to burnout, which is monetarily draining to the organization, in addition to expending necessary financial resources to recruit, hire, and train new staff (Knight, Becan & Flynn 2012; Eby & Rothrauff-Laschober 2012; Maslach, Jackson & Leiter 1997). Furthermore, counselors suffering from burnout have low productivity, are less effective, and have more interpersonal conflicts than those counselors who are not suffering from burnout.

Clients are also affected when their counselor is experiencing burnout since high rates of staff absenteeism and a lack in continuity of counselor care have been linked to clients prematurely withdrawing from treatment (McKay 2009; Schaefer et al. 2005; Bowen & Twemlow 1978; McCaul & Svikis 1991). Furthermore, there is a reduction in client satisfaction when widespread burnout within a health care setting occurs (Landrum, Knight & Flynn 2012; Garman, Corrigan & Morris 2002; Vahey et al. 2004). Conversely, research has shown that clients who have more positive therapeutic relationships with their counselors engage in less drinking and drug use, are abstinent for a longer period of time, and are more involved in their treatment than those with weaker alliances (McKay 2009; Connors et al. 1997; Simpson et al. 1997).

1.1. Burnout by Geographic Region

The majority of research suggests that there are minimal differences in rural and urban areas regarding the prevalence of drug abuse and dependence (Peen et al. 2009), although some studies suggest rural areas have significantly more serious substance abuse problems (Lambert, Gale & Hartley 2008; Warner & Leukefeld 2001). Thus, there is a substantial need for substance abuse treatment services in both rural and urban areas, and findings suggest that publicly funded treatment in rural areas is associated with reductions in both drug use and crime (Hiller et al. 2007), similar to findings from urban-based national outcome studies (Simpson, Joe & Brown 1997).

One significant area of difference between rural and urban substance abuse counselors could be their level of burnout. Research shows that rural mental health counselors face more stress and have fewer resources to assist in coping with this stress (Hargrove & Curtin 2012; Kee, Johnson & Hunt 2002). Kee and colleagues (2002) found that rural mental health counselors were at significant risk for burnout, with 65% of their sample indicating a moderate or higher burnout level on the Maslach Burnout Inventory (Maslach, Jackson & Leiter 1997). The same sample of mental health counselors scored lower than average on the Social Provisions Scale, which examines the degree to which respondents' social relationships provide various dimensions of social support, indicating they were lacking in areas such as guidance, social integration, attachment, opportunity for nurturance, and reliable alliance. The authors state that the connection between high levels of reported burnout and low levels of reported social support suggests professional isolation may be largely to blame for the high rate of burnout in rural areas. It has also been well documented that rural counselors must also handle ethical situations pertaining to dual relationships (Hargrove 1986) as counselors are more likely to know their client and their families personally from residing in a low population density area (Sexton et al. 2008).

Since substance abuse treatment counselor burnout has the potential to negatively impact client treatment outcomes and the employing treatment organization, it is important to develop a greater understanding of burnout for substance abuse counselors and any variations that may occur by geographic locale. The purpose of this study is to examine the differences between rural and urban counselor burnout and the counselors' perspective of how that burnout may affect clients' substance abuse treatment outcomes. As burnout is costly to clients, counselors, and organizations, it's imperative to use the qualitative methodological approach utilized in this study as it allows for an in-depth contextualization of burnout among counselors employed in both rural and urban treatment settings that may not have been revealed in using traditional survey methods. This is the first known study to examine these issues.

2. Materials and Methods

2.1. Participants

Data were collected from 28 substance abuse treatment counselors who participated in four focus groups. Participants were recruited from the Kentucky School of Alcohol and Other Drug Studies, sponsored by the Kentucky Division of Mental Health and Substance Abuse Services (http://www.ksaods.net/). This event is held annually to provide continuing education for drug prevention and treatment professionals from across Kentucky. Institutional Review Board (IRB) and Public Relations-approved recruitment flyers requesting participation in a focus group were distributed in continuing education sessions and displayed at an information booth.

Potential participants were screened for eligibility and the county in which they were employed. Eligibility included being employed as a counselor in a Kentucky state-funded substance abuse treatment program, and willingness to participate. Two focus groups were conducted with counselors practicing in urban counties and two focus groups were conducted with counselors practicing in rural counties. No additional focus groups were conducted as saturation was achieved and no new information was emerging by the fourth focus group. A county was operationalized as either rural or urban according to USDA's Economic Research Service (ERS) Rural-Urban Continuum Codes (RUCCs). The RUCCs designate counties on a range of one to nine based on a combination of their population size, degree of urbanization, and adjacency to a metro area. ERS's guidelines were followed when categorizing counties into a rural versus urban designation. Specifically, non-

metropolitan areas (i.e., RUCC 4 or greater) are categorized as rural and counties with a code of 1, 2, or 3 were classified as urban.

In the four focus groups, 10 participants were employed in rural counties and 18 were employed in urban counties. Three focus group participants were African American (11%) and the remaining 25 participants were white (89%), which is similar to Kentucky's racial distribution (U.S. Census Bureau 2008). Ten participants were male (36%). A majority of female participants was expected in this study, as estimates suggest that women comprise 50 to 70% of the clinical workforce in substance abuse treatment (Mulvey, Hubbard & Hayashi 2003; Knudsen, Johnson & Roman 2003; Kaplan 2003). It should be noted that quantitative data on detailed characteristics (e.g., years of education, age, etc.) were not collected from participants; however, additional qualitative details from this study on how rural and urban substance abuse treatment counselors' characteristics (e.g., education, experience in the field, recovery status) affect client outcomes are reported elsewhere (Oser, Biebel & Harp 2011).

2.2. Procedures

Each focus group lasted approximately 60 to 90 minutes and was conducted on-site at the Kentucky School of Alcohol and Other Drug Studies in a private room. Prior to the focus groups, informed consent was obtained by the focus group facilitator, who is the lead author. All counselors agreed to participate in the focus group and signed the IRB approved informed consent document.

After obtaining permission from all the focus group participants, each focus group was audio recorded. In addition, the first author moderated the focus group using a scripted protocol that introduced the study purpose, outlined the agenda, re-emphasized confidentiality, outlined the procedures for incentives, and provided the ground rules. The second author took detailed notes. Focus groups were conducted in July 2008. Each counselor received $50 for participating in a focus group and food was provided.

2.3. Focus Group Questions

The focus group protocol included questions which were developed to gather in-depth, qualitative data on the factors impacting client behavioral treatment outcomes from a provider perspective on a variety of topics including counselor characteristics, burnout, views of medication-assisted treatment and other innovative treatment techniques. Approximately a quarter to a third of the focus group time was spent discussing issues related to burnout. Feedback on the focus group questions was obtained from two experts in the substance abuse treatment field and revisions were made to the focus group protocol. The questions were purposefully open-ended and vague in order to elicit a fruitful unstructured discussion; however, focus group facilitator prompts were used when necessary. The focus group questions examined in this paper included:

> Do you or counselors you know ever feel "burned out"?
>
> How do you think this impacts clients' substance abuse treatment outcomes?

The purpose of this study is to qualitatively examine the differences between rural and urban counselor burnout and the counselors' perspective of how that burnout may affect clients' substance abuse treatment outcomes.

2.4. Content Analysis

The audio recordings of the four focus groups were immediately transcribed by the second author. Individual research participants were not identified on the transcripts. A two-phase

content analysis approach was used to develop themes from the transcripts of the qualitative focus group data (e.g., Hall, Baldwin & Prendergast 2001) using a grounded theory methodological approach (Glaser & Strauss 1967). Three raters independently used a line-byline coding scheme of each focus group transcript. First, initial coding, also known as open coding, was used to condense and categorize the data (Strauss & Corbin 1990). Second, focused coding took place to build upon the initial coding (Lofland et al. 2006). Throughout the process of both initial and focused coding, memo writing occurred. Memo writing has been defined as the step between coding and the first draft of the completed data analysis (Charmaz 2001). Memo writing leads to a more in-depth descriptive examination of the codes. It also allows for the exploration of how initial codes may be related; and thus, fit into larger categories. Moreover, the use of memo writing allowed for theoretical extension and refinement of the existing literature on substance abuse treatment outcomes from a counselor's perspective. From this analytic approach a consensus was reached and there was 100% agreement between the three raters resulting in the completed data analysis. Using this approach, three themes emerged related to counselor burnout that did not differ across rural and urban counselors. However, various sub-themes were identified during the content analysis that differed among the rural and urban counselors. Each theme and sub-theme is supported by selected illustrative quotes from the focus group transcripts.

3. Results

The three main burnout themes that emerged from the focus groups were causes, consequences, and prevention of burnout. It should be noted that there were no differences between rural and urban counselors in the identification of three themes; however, the sub-themes of the causes, consequences, and prevention of burnout did differ based on rural versus urban locale. Table 1 depicts the themes and sub-themes that emerged from the analyses also denoting which were rural only, urban only, or discussed among both rural and urban counselors.

First, multiple sub-themes related to the causes of burnout emerged from the counselor focus group data, including clients who are difficult to treat, high caseloads, massive amounts of paperwork, office politics, and the low level of prestige associated with the counseling occupation. One sub-theme that was identified by both rural and urban counselors as a cause of burnout was providing services to clients who are difficult to treat. Oftentimes clients with substance use disorders present with co-occurring mental health problems and issues with their physical health. These clients also are challenging to treat because they may face myriad other social problems such as employment difficulties, lack of housing, minimal social support, and/or no childcare. Thus, it's not surprising that this theme emerged from all the focus group transcripts as the clientele of counselors all have substance use disorders, regardless of if they are receiving treatment in rural or urban areas. One urban counselor discussed how this could be overwhelming and could potentially lead to burnout by stating

> I mean, I have been in it 10 years now, and I am happy not to do a group, or not to do an education program now. I really am, because the stuff that comes out… sometimes, so I take them out of the readings and say "We are not going to do this today, it's just too much." And you throw in their co-occurring disorders, the anti-social stuff and it's like no…

This sentiment was also brought up by a counselor in a rural focus group who said: "In all of the jobs that I have been in, and that have brought this to the table, recidivism is a biggie for burnout. I can see it sending me on the road to burnout quicker than any other job could. Sometimes you wonder – are my efforts doing anything?" Another rural counselor discussed recidivism and its relationship to criminal involvement and violence. This counselors said "You know when you graduate a client, and you feel like 'wow, this person's really got it,'

which is a trap they tell us not to get into, but we get into that, and then 3 days later you see them on the news where they have robbed a store and were shot to death. That can be down heartening…"

High caseloads resulting in volumes of paperwork, presumably as a result of managed care stipulations, has also lead to burnout. This sub-theme was identified by both rural and urban counselors. An urban counselor said "…that managerial stuff, gosh I hate that stuff sometimes." Likewise, a rural counselor in response to a question about what leads to burnout stated:

> High caseloads and a lot of paperwork, and when I am time-challenged…. When I am time-challenged and I have several people coming in I tend not to clear my head and really be there with the person, and I can tell a big difference. And sometimes that is unavoidable, there are just bad days.

The remaining two sub-themes emerged from the rural counselors only. Frustration with colleagues and management was a form of office politics that was discussed in both of the rural groups. Oftentimes, rural facilities employ fewer full-time equivalent employees and more part-time staff. Thus, if workplace conflicts occur, there are fewer co-workers to turn to for support and counselors will have to continue working with co-workers who are the cause of frustration on a daily basis. As one rural counselor expressed:

> I believe the whole dynamic of the office setting and the political powers that be in a job situation are linked to burnout as much as the actual job itself. I think the politics of it all…the people you work with and the drama that is going on behind the scenes and, actually, it is a relief sometimes to go to a counseling session and step outside of that for awhile. All of it can lead to burnout.

The lack of prestige or value in being a substance abuse counselor was also discussed as a cause of burnout among rural counselors only. For example, one rural counselor discussed a strategy that he used where he tried to emphasize that he was a Certified Alcohol and Drug Counselor (CADC) and that this was more important than traditional educational degrees. Specifically, this counselor stated:

> This is another piece of what I am saying about this profession is not valued. And, that goes with it all the way up to the top. One of the things that I do pro-forma is I write my signature CADC, MSW. I know what comes first, and I do that as protest. I am not going the other direction, it's an "in your face" sort of thing.

This was the counselor's effort to bring prestige to the field and to emphasize what he thought was really critical to being an effective substance abuse treatment counselor. Another rural focus group participant stated "Why would a young person go to college to 'get a four year degree to make $18,000 a year?' They are not going to do it and I don't blame them, you know?" The low pay was indicative of limited extrinsic rewards and the lack of prestige associated with being employed in the addiction counseling field.

In addition to the causes of burnout theme, rural and urban counselors also discussed the consequences of burnout. Within this discussion of consequences of burnout, poor quality client-care was a sub-theme among all participants; however, effects of burnout that emerged from the urban focus group participants only included reversing roles (i.e., where the client takes on the counseling role to address the counselor's personal problems), clients trying to choose their counselor, and changing jobs.

An obvious effect of counselor burnout is that the client's recovery process may be slowed down or thwarted. Thus, it is not surprising that the sub-theme of poor quality clinical care was identified by all counselor participants regardless of geographic locale. Specifically,

each of the four focus groups mentioned that clients can tell when their counselor is not engaged and this effects counselor-client rapport. One urban counselor stated "Clients can tell if you are not there, if you are not engaged with them, they know. They can read people really well." In discussing his specific experience, one rural counselor stated "I would love to tell you that it has never happened to me, but I have had clients who have come out and said 'You look like you are having a bad day…is it ok?' I think 'No, it's not supposed to happen this way….'" Burnout can clearly disrupt rapport between the client and counselor, resulting in subpar clinical care.

Other sub-themes of the effects of burnout were mentioned by urban counselors only. A reversal of roles can occur when clients sense that their counselor is burned out. In this instance, the counseling session can become a therapy session for the counselor rather than the client, thereby disrupting the client's therapeutic process. Role reversals may often be sought out by clients for a variety of reasons including providing the client with a sense of self-worth, as a way to establish a relationship with their counselor, or as a strategy to avoid dealing with their substance use disorder(s). Regardless of the reason, the reversal of roles is problematic as it takes away time that should be devoted to addressing the client's issues. One urban counselor stated,

> On that emotional burnout piece as well, how it affects the client, sometimes I think there is a role reversal. And they are not paid to be the counselor - they are the client. And sometimes with that burnout, you hear counselors who are discussing their personal problems, going through divorce, or the dog died, or you know…and then the clients, they feed right into it, "Oh, well tell me about it." And they are ready to reverse that role anyway. And they want to do the counseling.

Another sub-theme that emerged from the urban focus group data was that burnout can lead to clients trying to select their counselor. The reasons for clients requesting specific counselors can range from difficulties in establishing rapport with certain counselors (e.g., because they are burned out) to selecting a counselor because he or she will not force the client to focus on the difficult personal issues they have been avoiding. One urban counselor said

> Like someone else was saying, "Well I want that counselor versus this one. Well if I go to that group she's just going to talk about her car and her cats." And that's not what we are there for. It's to help facilitate them to the next step, or to be the pilgrim on the journey to help move them forward."

Requesting counselors leads to difficulties in discerning the difference between a client who is not engaged in the recovery process versus a counselor who is really burned out and is not therapeutically effective. This clearly demonstrates the difficulties in allowing clients to select who they work with while in substance abuse treatment.

Changing jobs was the final sub-theme of the consequences of burnout mentioned by the urban counselors only. When counselors in urban areas discussed the effects of burnout, they mentioned "just a little change up with your job would help." Because of the high prevalence of co-occurring disorders, counselors could change their positions to focus on (and bill for) mental health treatment. Changing positions within the same organization may occur more frequently in urban community mental health centers, which are larger and may offer more employment opportunities. Other counselors mentioned leaving the field completely which is a significant cost to the treatment organization. One urban counselor said "Two years. I have seen a lot, burnout in 2 years. Change jobs in 2 years." In response, another counselor in this urban focus group said "I think they've done studies that counselors burnout after 2 years" and a third counselor confirmed this by saying "That's not

unusual." This discussion provides support for the perception of high turnover in the counseling field in urban areas.

The final theme that emerged from both the rural and urban focus groups was that burnout could be prevented, through the sub-themes of co-worker support, clinical supervision, and self-care. There were no differences between rural and urban counselors regarding the prevention of burnout. All counselors believed that support from other substance abuse treatment counselors was useful because co-workers could point out the signs of burnout as well as offer suggestions for how to combat burnout. It was emphasized that co-workers are down in the trenches and are able to recognize signs of burnout, perhaps because they have experience burnout symptoms themselves. One participant working in an urban treatment facility stated,

> … It's just as important with our administrators that our colleagues do the check and balance. If I work with you on a daily basis, the supervisor may come out of their tower once a week, once a month, you know, that's what I understood when I finished my schooling, that's a professional respect. You should be able to go to your colleague and bounce ideas about this client, you should also be open to your colleague coming to you and saying "Hey, the way you reacted…the way I noticed you handle your client…hey, you might want to take a vacation…" And I know that is not going on where I am, but it's necessary, because again, that undermines our program. It just takes the client away.

Another counselor in the same urban focus group said "Sometimes I will go in and say 'Is everything ok? Do you need a break? Why don't we do a meditation?' Cause you need that…you at least need that among your peers and your workgroup." Coping strategies, including a sympathetic ear and accountability were seen as being needed but sometimes not received, by co-workers.

In addition to support from colleagues, the need for clinical supervision as a protective factor from burnout was mentioned by both rural and urban counselors. Several insightful statements made by urban counselors were that "counselors need counseling" and "supervisors need supervision, because they burnout too." One rural counselor's quote depicts the need for clinical supervision:

> Sometimes you get to help out one of the other counselors and sometimes they have to help you out. But I think that is where the clinical team comes into play and that is where the clinical director who is really our supervisor…or whoever is in charge of the agency doesn't really carry a caseload because us counselors are their caseload. So they watch out for our mental health and we try to watch out for each other. But can it happen, yes, frequently.

In addition, counselors in one urban focus group brought up supervisor accountability and dissatisfaction with supervisors. For example, the notion that burnout is contagious was addressed as well as the notion that administrators rarely step in to manage their counselors' burnout symptoms. As one counselor remarked,

> Theoretically speaking, it would be nice if you had administrators who also thought about systems care, and if they had a counselor who was burned out and infecting the whole place, that they could take that person and say "Maybe this isn't where you should be right now. Maybe you need to let go of the substance abuse element and work on something else." If they see that kind of infection going on…

On the whole, counselors seemed satisfied with the level of clinical supervision they received; however, some counselors expressed the concern that administrators were detached from what occurred in everyday clinical care settings.

Finally, self-care was discussed by both rural and urban counselors as a prevention tool for burnout. Self-care included meditation, taking a vacation, taking the time to debrief with a co-worker, or just engaging in other tasks besides therapy. For example when asked about experiencing burnout, one urban group participant stated “Yes, that’s why God invented vacations.” Another rural counselor stated “So, you have to be mindful of when you are tired or burned out or need that vacation, or you need to go debrief with a co-worker, so that you can give your clients the attention they deserve because that is what they are there for.” Self-care, in addition to co-worker and supervisor support, was cited as an important protective factor against both rural and urban counselor burnout.

4. Discussion

These findings provide a rich qualitative demonstration that substance abuse treatment counselors in rural and urban contexts experience significant challenges which contribute to occupational burnout. The causes, consequences, and prevention of burnout emerged as themes among all counselors. However, there were geographic differences in the sub-themes related to the causes and consequences of burnout; but all of the sub-themes related to the prevention of burnout emerged from both the rural and urban counselors.

Several of the causes of burnout transcend locale such that both rural and urban substance abuse counselors struggle with a variety of similar factors. For example, as the results of this research indicate, the nature of addiction itself presents considerable difficulties to counselors which can result in burnout (Vilardaga et al. 2011; Najavits, Crits-Christoph & Dierberger 2000). Substance use disorders are chronic conditions (McLellan 2002; McLellan et al. 2000) that involve periods of recovery and relapse and can take a toll on clients and counselors alike (McNulty et al. 2007; Lundgren, Sullivan & Amodeo 2006; Oser et al. 2009). Research indicates that clients dropping out of treatment and dealing with a dual diagnosis (i.e., mental health disorders in addition to a substance use disorder) also exacerbate challenges in the treatment process (Palmer et al 2009; Back, Waldrop, & Brady 2009; Brown et al 2011; Najavits, Crits-Christoph & Dierberger 2000). Moreover, in addition to their substance use disorders, clients in treatment often present with a myriad of problems including mental health issues, housing needs, employment difficulties, and physical health problems (Oser et al. 2009). While retaining clients was voiced as a concern across the focus groups – specifically, the difficulty of doing so with few available wrap-around services – counselors also connected burnout to the chronic nature of addiction and the fragility of recovery. Supporting past research regarding client dropout and the effect of client co-morbidities on burnout rates (Back, Waldrop & Brady 2009; Brown et al. 2011; Najavits, Crits-Christoph & Dierberger 2000; Crits-Christoph & Siqueland 1996; Regier et al. 1990), both rural and urban counselors directly cited these as considerable factors leading up to substance abuse treatment counselor burnout. While the focus group questions did not specifically ask about the three dimensions of burnout (i.e., emotional exhaustion, depersonalization, and lack of personal accomplishment), evidence that emerged from the focus group research suggests that all three aspects are relevant for many of the counselors working to provide clinical services to challenging clients. For example, this is articulated by the rural counselor who said “Sometimes you wonder – are my efforts doing anything.” This quote suggests that the counselor is critically evaluating him/herself and may be experiencing a lack of personal accomplishment, and subsequent burnout.

As noted by all counselors in the focus groups informing this research, clients need a holistic treatment approach which is challenging to deliver when limited resources and organizational factors such as heavy caseloads and excessive administrative responsibilities can foster feelings of occupational fatigue. While these conclusions may seem obvious, past research has been mixed on the influence of some of these factors. One study focusing on

burnout among corrections-based substance abuse counselors found that caseload size was not significantly associated with burnout, except for male counselors who experienced increased rates of burnout given heavy caseloads (Garner, Knight & Simpson 2007). Another study reported that heavy counselor caseloads were correlated with lower reported occupational satisfaction, which may predict burnout (Broome et al. 2009). The findings of the current study add further support to the notion that heavy caseloads, and the resulting mounds of paperwork, can contribute to the stress precipitating burnout.

Two causes of burnout emerged as themes among the rural focus group participants only. Managing office politics, or frustration with colleagues and management, was a stressful experience that they saw as contributing to burnout among those in their occupation. This may be a more salient concern for rural counselors than those in urban settings because rural facilities may have fewer total staff available to deliver treatment services (Bouffard & Smith 2005), thereby requiring more workplace collaboration. While additional research is needed, these preliminary findings suggest that rural counselors experience more points of contact with colleagues and clients, both within and outside of the professional setting, and the friction caused by these interactions may affect the rate of counselor burnout. Additionally, because rural counselors must overcome other considerable strains associated with working in a rural locale – such as fewer client resources (e.g., public transportation and housing that is available in urban contexts) and treatment options, the stress of these factors may exacerbate already tenuous interpersonal relations with colleagues.

The social stigma associated with substance abuse and dependence taints both the clients who experience substance use disorders and the counselors who treat this considerable health concern. This sub-theme only emerged in the rural focus groups, as the medicalization of substance use disorders may be less likely to be embraced in these rural areas. Rural communities may continue to see individuals struggling from substance use disorders as suffering from a moral character inferiority, rather than a medical problem. As substance abuse remains socially stigmatized, providing treatment to individuals with substance use disorders is both a low prestige and low paying occupation in rural areas. Though the counselors in this study did not directly tie burnout to the social stigma that remains attached to those with substance use disorders, rural counselors did cite frustration with the lack of prestige and resulting low level of compensation associated with their profession which is consistent with Shoptaw and colleagues' (2000) lack of personal accomplishment dimension of burnout.

A second major theme that emerged from the qualitative analysis for all counselors was that burnout had consequences. This research makes evident the belief held by both rural and urban counselors that burnout affects not only oneself and other counselors, but also clients and their outcomes. As the existing literature suggests, counselors experiencing burnout are characterized as emotionally exhausted and detached from the therapeutic process, both of which contribute to negative client outcomes (Landrum, Knight & Flynn 2012; Vilardaga et al 2011; Shoptaw, Stein & Rawson 2000). It is not surprising that the participating counselors identified a link between the symptoms of burnout (namely counselor detachment) and negative outcomes. With past research emphasizing the importance of good client-counselor relationships, the apathy associated with counselor detachment presents a serious threat to the therapeutic process – regardless of rural or urban context (Joe, Simpson & Rowan-Szal 2009; Luborsky et al. 1997). Given the problems that occupational burnout poses for substance abuse counselors, the concluding remarks will present recommendations for future research and the implications of these findings.

In addition to the poor quality client care, the sub-themes of reversing roles, trying to choose counselors, and changing jobs emerged among urban counselors only. Again, urban

substance abuse treatment centers may employ more counselors, as compared to their rural counterparts (Bouffard & Smith 2005). In these larger urban facilities, other counselors and supervisors may be able to witness the role reversal phenomenon; whereas, rural organizations employ fewer counselors who may be experiencing professional isolation as their job duties may not overlap. Moreover, a larger counselor base provides more options for clients if they are trying to choose their counselor. Finally, there are fewer rural employment opportunities because urban/suburban development is favored, which results in a limited number of jobs and increased job competition (Flora & Christenson 1991). This may decrease even dissatisfied rural counselors' intentions to quit.

Despite the many challenges that substance abuse counselors in rural and urban contexts voiced and the impact that burnout can have on client outcomes, the focus group participants also universally recognized that burnout is not an inevitable outcome of their work. While the environment of substance abuse treatment facilities can admittedly place strain on counselors in rural and urban contexts, compounding the many other challenges the counselors participating in the focus groups identified, a positive working atmosphere can also help counselors to cope with these strains, thereby protecting them from burnout. Importantly, both rural and urban counselors identified prevention from burnout as a major theme and cite the importance of self-care, encouraging support from colleagues, and adequate clinical supervision for their occupational satisfaction and longevity. These three sub-themes findings mirror some past research which suggests that organizational structure can influence substance abuse counselor turnover, such that treatment centers with a more participatory management structure have better counselor retention rates – likely reflecting lower rates of burnout (Garner et al. 2007; McNulty et al. 2007). Past research also indicates that support from coworkers and a supervisor is beneficial in combating occupational fatigue and burnout (Broome et al. 2009; Ducharme, Knudsen & Roman 2008; Shoptaw, Stein & Rawson 2000). As some of the counselors in this study indicate, this protective support can be as seemingly insignificant as asking about a colleague's state of mind or as considerable as providing opportunities for counselors themselves to be counseled. Regardless of how this support manifests in treatment contexts, findings across rural and urban contexts universally indicate the need for organizations to nurture opportunities for counselor self-care and the prevention of burnout.

4.1. Limitations

Despite the importance of this research examining counselor burnout among rural and urban substance abuse treatment counselors, several limitations must be noted. While the use of focus group data may provide a more in-depth contextual examination of substance abuse treatment counselor burnout, it may also limit generalizability. It is important to note that participants were counselors attending a continuing education workshop. Also, states differ in their requirements for substance abuse counselors, so the attitudes expressed by participants in the urban and rural focus groups, for example about paperwork and mandated educational requirements, may not be applicable to counselors in all states. Moreover, the questions asked of the focus group participants were purposely vague, opened-ended questions about if they have experienced or witnessed burnout and how that affects client outcomes; however, additional questions about the three dimensions of burnout (emotional exhaustion, depersonalization, and lack of personal accomplishment) while working in a rural versus an urban setting could provide more fruitful findings.

4.2. Future Directions

This research represents only an initial, qualitative foray into substance abuse counselors' perceptions of burnout and its impact on client outcomes in rural and urban contexts. Future research efforts should continue to investigate the differences between rural and urban

counselors, as mounting evidence, including this study, suggests that the context in which substance abuse counselors are located matters in important ways (Lenardson & Gale 2008; Beardsley et al. 2003; Fortney et al. 1995; Sullivan, Hasler & Otis 1993). This study found that rural substance abuse treatment counselors cited more causes of burnout (specifically office politics and low prestige) which is consistent with previous literature suggesting that rural mental health counselors must manage more stress (Hargrove & Curtin 2012; Kee et al. 2002). Counselors themselves are an important source for this information, and hearing their concerns, frustrations, and triumphs in day-to-day treatment settings is invaluable and must serve to inform funding and other decisions that affect their work.

As past research has already made clear, substance abuse counselor burnout can have important consequences. Namely, this study found that the impacts of this burnout have rippling effects among others involved in the substance abuse treatment process, often leading to poor quality clinical care, regardless of geographic locale. While poor client clinical care was the most commonly mentioned consequence sub-theme of burnout, three additional consequence sub-themes emerged from the urban counselor focus group transcripts only. For example, clients experiencing treatment dissatisfaction due to perceptions of counselor apathy may, as described by urban counselors in this study, attempt to select their counselor. Though the positive regard between counselor and client has been significantly linked to positive treatment outcomes, client selection of substance abuse counselors is arguably problematic for a variety of reasons (Luborsky et al. 1986; Luborsky et al. 1997). Moreover, counselor burnout leads to the costly negative effects of intentions to quit, and subsequent job turnover (Knudsen, Ducharme & Roman 2008; Knight, Becan & Flynn 2012; Maslach et al. 1997), which was a sub-theme espoused by the urban counselors only. Ultimately, given these and other adverse effects of counselor burnout on the treatment process and client outcomes, the importance of preventing – or at least minimizing – future substance abuse counselor burnout cannot be undersold. Since both rural and urban counselors cite the benefit of a collegial work atmosphere and self-care, efforts must be made at a local and regional level to foster an environment where these safeguards can be implemented (Lacoursiere 2001).

Though substance use disorders and their treatment have increasingly become medicalized and research regarding prevention and treatment have advanced considerably with the work of the National Institute on Drug Abuse (NIDA) and other institutes, the lack of prestige and low earning potential associated with the substance abuse counseling profession are indicative of the continued need for greater understanding of addiction as a disease (Fletcher, Tims & Brown 1997). This research suggests this is especially true in rural areas where both clients and counselors may experience stigma. As the general public and policymakers increasingly come to perceive substance use disorders as a medical condition, the important role that substance abuse counselors serve in ameliorating this major public health concern will become more apparent. Enhancing the prestige of the substance abuse counseling profession is essential if treatment organizations are to attract committed experts to the counseling profession, retain these clinicians, and reduce overall burnout of those in this occupation.

Acknowledgments

This research was supported by the National Institute on Drug Abuse (K01-DA21309, PI: Oser; F31-DA30061, PI: Harp). The authors would also like to thank Dr. Carl Leukefeld as well as the counselors who participated in this study.

References

Back SE, Waldrop AE, Brady KT. Treatment challenges associated with comorbid substance use and posttraumatic stress disorder: Clinician's perspective. The American Journal on Addictions. 2009; 18 (1):15–20. [PubMed: 19219661]

Beardsley K, Wish ED, Fitzelle DB, O'Grady K, Arria AM. Distance traveled to outpatient drug treatment and client retention. Journal of Substance Abuse Treatment. 2003; 25 (4):279–285. [PubMed: 14693257]

Bouffard JA, Smith S. Programmatic, Counselor and Client-level Comparison of Rural versus Urban Drug Court Treatment. Substance Use and Misuse. 2005; 40 (3):321–342. [PubMed: 15776980]

Bowen WT, Twemlow SW. Implications of staff absence for effective treatment. Social Casework. 1978; 59 (5):305–308.

Broome KM, Knight DK, Edwards JR, Flynn PM. Leadership, burnout, and job satisfaction in outpatient drug-free treatment programs. Journal of Substance Abuse Treatment. 2009; 37 (2):160–70. [PubMed: 19339143]

Brown CH, Bennett ME, Li L, Bellack AS. Predictors of initiation and engagement in substance abuse treatment among individuals with co-occurring serious mental illness and substance use disorders. Addictive Behaviors. 2011; 36 (5):439–447. [PubMed: 21196081]

Charmaz, K. Qualitative interviewing and grounded theory analysis. In: Denzin, N.; Lincoln, Y., editors. Handbook of qualitative research: Context and method. Thousand Oaks: Sage; 2001.

Cherniss, C.; Krantz, DL. The ideological community as an antidote to burnout in the human services. In: Farber, BA., editor. Stress and burnout in the human service professions. New York: Pergamon; 1983.

Connors G, Carrol K, DiClemente C, Longabaugh R, Donovan D. The therapeutic alliance and its relationship to alcoholism treatment participation and outcome. Journal of Consulting and Clinical Psychology. 1997; 65:588–598. [PubMed: 9256560]

Covington S. Working with substance abusing mothers: A trauma-informed, gender-responsive approach. The Source. 2007; 16 (1):1–11.

Crits-Christoph P, Siqueland L. Psychosocial treatment for drug abuse: A selected review and recommendation for national health care. Archives of General Psychiatry. 1996; 53:749–56. [PubMed: 8694688]

Ducharme LJ, Mello HL, Roman PM, Knudsen HK, Johnson AJ. Service delivery in substance abuse treatment: Reexamining "comprehensive" care. Journal of Behavioral Health Services and Research. 2007; 34 (2):121–136. [PubMed: 17390225]

Ducharme LJ, Knudsen HK, Roman PM. Emotional exhaustion and turnover intention in human service occupations: The protective role of coworker support. Sociological Spectrum. 2008; 28 (1): 81–104.

Eby LT, Rothrauff-Laschober TC. The relationship between perceptions of organizational functioning and voluntary counselor turnover: A four-wave longitudinal study. Journal of Substance Abuse Treatment. 2012; 42 (2):151–158. [PubMed: 22116013]

Fletcher BW, Tims FM, Brown BS. National treatment evaluations and the Drug Abuse Treatment Outcome Study (DATOS). Psychology of Addictive Behaviors. 1997; 11:216–229.

Flora, C.; Christenson, J. Rural Policies for the 1990s. Boulder: Westview Press; 1991.

Fortney JC, Booth BM, Blow FC, Bunn JY, Cook CAL. The effects of travel barriers and age on the utilization of alcoholism treatment aftercare. The American Journal of Drug and Alcohol Abuse. 1995; 21 (3):391–406. [PubMed: 7484987]

Garman AN, Corrigan PW, Morris S. Staff burnout and patient satisfaction: Evidence of relationships at the care unit level. Journal of Occupational Health Psychology. 2002; 7:235–241. [PubMed: 12148955]

Garner BR, Knight K, Simpson DD. Burnout among corrections-based drug treatment staff: Impact of individual and organizational factors. International Journal of Offender Therapy and Comparative Criminology. 2007; 51 (5):510–522. [PubMed: 17615435]

Glaser, BG.; Strauss, A. Discovery of grounded theory. Strategies for qualitative research. Piscataway: Aldine Transaction Press; 1967.

Hall EA, Baldwin DM, Prendergast ML. Women on parole: Barriers to success after substance abuse treatment. Human Organization. 2001; 60 (3):225–233.

Hargrove DS. Ethical issues in rural mental health practice. Professional Psychology: Research and Practice. 1986; 17 (1):20–23.

Hargrove, DS.; Curtin, L. Rural mental health practitioners: Their own mental health needs. In: Smalley, KB.; Warner, JC.; Rainer, JR., editors. Rural mental health: issues, policies, and best practices. New York: Springer; 2012.

Hiller ML, Leukefeld CG, Garrity TF, Godlaski T, Schoeneberger M, Townsend M, Hascal K. Client outcomes from rural substance abuse treatment. Journal of Psychoactive Drugs. 2007; 39 (1):59–68. [PubMed: 17523586]

Human J, Wasem C. Rural mental health in America. American Psychologist. 1991; 46 (3):232–239. [PubMed: 2035933]

Joe GW, Simpson DD, Rowan-Szal GA. Interaction of counseling rapport and topics discussed in sessions with methadone treatment clients. Substance Use & Misuse. 2009; 44(1):3–17. [PubMed: 19137479]

Kaplan, L. Report for US Department of Health and Human Services. Substance Abuse and Mental Health Services Administration (SAMHSA); 2003. Substance abuse treatment workforce environmental scan.

Kee JA, Johnson D, Hunt P. Burnout and social support in rural mental health counselors. Journal of Rural Community Psychology. 2002; 5:16.

Knight DK, Becan JE, Flynn PM. Organizational consequences of staff turnover in outpatient substance abuse programs. Journal of Substance Abuse Treatment. 2012; 42 (2):143–150. [PubMed: 22154028]

Knudsen HK, Ducharme LJ, Roman PM. Clinical supervision, emotional exhaustion, and turnover intention: A study of substance abuse treatment counselors in the Clinical Trials Network of the National Institute on Drug Abuse. Journal of Substance Abuse Treatment. 2008; 35:387–395. [PubMed: 18424048]

Knudsen HK, Johnson JA, Roman PM. Retaining counseling staff at substance abuse treatment centers: effects of management practices. Journal of Substance Abuse Treatment. 2003; 24:129–135. [PubMed: 12745030]

Lacoursiere RB. “Burnout” and substance user treatment: The phenomenon and the administrator-clinician’s experience. Substance Use & Misuse. 2001; 36 (13):1839–74. [PubMed: 11795582]

Lambert D, Gale JA, Hartley D. Substance abuse by youth and young adults in rural American. The Journal of Rural Health. 2008; 24 (3):221–228. [PubMed: 18643798]

Landrum B, Knight DK, Flynn PM. The impact of organizational stress and burnout on client engagement. Journal of Substance Abuse Treatment. 2012; 42 (2):222–230. [PubMed: 22154029]

Lenardson, J.; Gale, JA. Distribution of substance abuse treatment facilities across the rural – urban continuum. 2008. Retrieved March 23, 2012 from http://muskie.usm.maine.edu/Publications/rural/pb35bSubstAbuseTreatmentFacilities.pdf

Lofland, J.; Snow, DA.; Anderson, L.; Lofland, LH. Analyzing Social Settings: A Guide to Qualitative Observation and Analysis. 4. Belmont: Wadsworth; 2006.

Lundgren LM, Sullivan L, Amodeo M. How do treatment repeaters use the drug treatment system? An analysis of injection drug users in Massachusetts. Journal of Substance Abuse Treatment. 2006; 30:121–128. [PubMed: 16490675]

Luborsky L, Crits-Cristoph P, McLellan AT, Woody G, Piper W, Liberman B, Imber S, Pilkonis P. Do therapists vary much in their success? Findings from four outcome studies. American Journal of Orthopsychiatry. 1986; 56:501–512. [PubMed: 3789096]

Luborsky L, McLellan AT, Diguer L, Woody G, Seligman DA. The psychotherapist matters: Comparison of outcomes across twenty-two therapists and seven patient samples. Clinical Psychology: Science and Practice. 1997; 4:53–65.

Maslach, C.; Jackson, S.; Leiter, M. Maslach Burnout Inventory manual. 3. Palo Alto, CA: Consulting Psychologist; 1997.

McCaul M, Svikis D. Improving client compliance in outpatient treatment: Counselor-targeted interventions. NIDA Research Monograph. 1991; 106:204–215. [PubMed: 1922288]

McKay JR. Continuing care research: What we have learned and where we are going. Journal of Substance Abuse Treatment. 2009; 36 (3):131–145. [PubMed: 19161894]

McLellan AT. Have we evaluated addiction correctly? Implications from a chronic care perspective. Addiction. 2002; 97:249–252. [PubMed: 11964098]

McLellan AT, Lewis DC, O'Brien CP, Kleber HD. Drug dependence, a chronic medical illness: Implications for treatment, insurance, and outcome evaluation. Journal of the American Medical Association. 2000; 284 (13):1689–1695. [PubMed: 11015800]

McNulty T, Oser C, Johnson JA, Knudsen H, Roman P. Counselor turnover in substance abuse treatment centers: An organizational-level analysis. Sociological Inquiry. 2007; 77 (2):166–193.

Mulvey KP, Hubbard S, Hayashi S. A national study of the substance abuse treatment workforce. Journal of Substance Abuse Treatment. 2003; 24:51–57. [PubMed: 12646330]

Najavits LM, Crits-Christoph P, Dierberger A. Clinicians' impact on the quality of substance use disorder treatment. Substance Use & Misuse. 2000; 35:2161–90. [PubMed: 11138720]

National Association of Alcohol and Drug Addictions Counselors (NAADAC). Issue brief: Current and future addiction workforce. 2007. Retrieved December 14, 2008, from http://www.naadac.org/component/content/article/50-issues-briefs/297-pr123

Oser C, Biebel E, Harp K. The influence of rural and urban substance abuse treatment counselor characteristics on client outcomes. Journal of Social Service Research. 2011; 11 (1):1–13.

Oser C, Knudsen H, Staton-Tindall M, Leukefeld C. The adoption of wraparound services among substance abuse treatment organizations serving criminal offenders: The role of a women-specific program. Drug and Alcohol Dependence. 2009; 103S:S82–S90. [PubMed: 19181457]

Palmer RS, Murphy MK, Piselli A, Ball SA. Substance user treatment dropout from client and clinician perspectives: A pilot study. Substance Use & Misuse. 2009; 44 (7):1021–1038. [PubMed: 19938942]

Peen J, Schoebers RA, Beekman AT, Dekker J. The current status of urban-rural differences in psychiatric disorders. Acta Psychiatrica Scandinavica. 2010; 121 (2):84–93. [PubMed: 19624573]

Pines A, Maslach C. Characteristics of staff burnout in mental health settings. Hospital and Community Psychiatry. 1978; 29 (4):233–237. [PubMed: 631745]

Regier DA, Farmer ME, Rae DS, Locke BZ, Keith SJ, Judd LL, Goodwin FK. Co-morbidity of mental disorders with alcohol and other drug abuse: Results from the Epidemiologic Catchment Area (ECA) study. Journal of the American Medical Association. 1990; 264:2511–18. [PubMed: 2232018]

Schaefer JA, Ingudomnukul E, Harris AH, Cronkite RC. Continuity of care practices and substance use disorder pateints' engagement in continuing care. Medical Care. 2005; 43:1234–1241. [PubMed: 16299435]

Sexton RL, Carlson RG, Leukefeld CG, Booth BM. Barriers to formal drug abuse treatment in the rural South: A preliminary ethnographic assessment. Journal of Psychoactive Drugs. 2008; 40 (2): 121–129. [PubMed: 18720660]

Shoptaw S, Stein JA, Rawson RA. Burnout in substance abuse counselors: Impact of environment, attitudes, and clients with HIV. Journal of Substance Abuse Treatment. 2000; 19:117–126. [PubMed: 10963923]

Simpson DD, Joe GW, Brown BS. Treatment retention and follow-up outcomes in the Drug Abuse Treatment Outcome Study (DATOS). Psychology of Addictive Behaviors. 1997; 11:294–307.

Simpson D, Joe G, Rowan-Szal G, Greener J. Drug abuse treatment process components that improve retention. Journal of Substance Abuse Treatment. 1997; 14 (6):565–572. [PubMed: 9437628]

Strauss, A.; Corbin, J. Basics of qualitative research: Grounded theory, procedures, and techniques. Newbury Park: Sage; 1990.

Sullivan WP, Hasler MD, Otis AG. Rural mental health practice: Voices from the field, families in society. Journal of Contemporary Human Service. 1993; 74:493–502.

U.S. Census Bureau. State & County QuickFacts: Kentucky. 2008. Retrieved March 23, 2012, from http://quickfacts.census.gov/qfd/states/21000.html

Vahey DC, Aiken LH, Sloane DM, Clarke SP, Vargas D. Nurse burnout and patient satisfaction. Medical Care. 2004; 42(Suppl 2):57–66.

Vilardaga P, Luoma JB, Hayes SC, Pistorello J, Levin ME, Hildebrandt MJ, Kohlenberg B, Roget NA, Bond F. Burnout among the addiction counseling workforce: The differential roles of mindfulness and values-based processes and work-site factors. Journal of Substance Abuse Treatment. 2011; 40 (4):323–335. [PubMed: 21257281]

Warner BD, Leukefeld CG. Rural-urban differences in substance use and treatment utilization among prisoners. American Journal of Drug and Alcohol Abuse. 2001; 27 (2):265–280. [PubMed: 11417939]

Table 1

Burnout Themes and Sub-themes among Rural and Urban Counselors: Causes, Consequences, and Prevention

Themes:	Causes	Consequences	Prevention
Sub-themes:	Challenging–Clients B	Poor Client Care-B	Co-Worker Support–B
	Large Caseload–B	Reversing Roles–U	Clinical Supervision–B
	Paperwork–B	Clients Try Choosing Counselor–U	Self-Care–B
	Office Politics–R	Changing Jobs-U	
	Low Prestige–R		

NOTE: R=rural counselors only, U=urban counselors only, B=both rural and urban counselors