University of Alberta

Addiction Counselling Self-Efficacy, Job Satisfaction, Motivation, and Burnout: A Mixed Methods Study

by

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Dedication

I would like begin by acknowledging the addiction counsellors who participated in this study. Your time and commitment to the profession is truly admirable. Every day your work with individuals struggling with addictive behaviours is felt exponentially by individuals, families, communities, and society as a whole. In addition, I would like to express my gratitude to each addiction treatment site manager who saw benefit in this study and opened the doors for counsellor participation. Many thanks to administration staff for distributing survey packages. I would also like to thank Alicia Wendler for providing me with information on the Addiction Counseling Self-Efficacy Scale.

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Abstract

Addiction counsellors provide the majority of treatment to individuals struggling with substance abuse and problem gambling behaviour and, therefore, compose an essential workforce for providing effective treatment to individuals with addictive behaviours. Given the growing body of research highlighting the effects of counsellors on client outcomes this study is among the first to use a mixed methods approach to study the job-related beliefs of addiction counsellors from Alberta, Canada. In Study 1, a quantitative survey was used to discover and describe 110 counsellors' self-appraisals of self-efficacy, job satisfaction, and burnout from three previously validated survey instruments. In Study 2, 10 individual interviews were conducted to add depth and support to the quantitative Study 1 findings and add details about counsellor job motivation. Results from Study 1 reveal that counsellors are less confident in their skills for treating clients with co-occurring disorders and providing group counsel, are more satisfied with the intrinsic aspects of their jobs, and occasionally experience a low level of burnout in the form of emotional exhaustion and negative work environment. Furthermore, results support that greater self-efficacy is associated with greater job satisfaction, which are both associated with lower levels of burnout. Results from mediation analysis indicate self-efficacy mediates the relationship between job satisfaction and incompetence. Results from Study 2 highlight the importance of clients, learning opportunities, and organizational factors on counsellor's job-related beliefs.

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CHAPTER 1

Introduction

Addictions counsellors are faced daily with clients for whom substance abuse and problem gambling behaviours are serious problems. Although substance abuse and problem gambling behaviours are recognizably different conditions the commonalities among these behaviours presents a situation in which addiction counsellors can use many of the same skills to treat either conditions. Substance abuse is described as the greatest preventable health problem in North America and is more prevalent than problem gambling behaviour. Canadian epidemiological estimates indicate that more than one in five (22.6%) adults who consume alcohol drink in excess, almost one in six (14.5%) report concurrent drug use, and almost one third of Canadians report experiencing harm as a result of someone else's drinking in the past year. Over 3% of Canadians experience moderate to severe harm related to their gambling activity (Ericson, 2001; Smith & Wynne, 2002; Adlaf, Begin, & Sawka, 2005). Estimates from the Province of Alberta indicate that during the 2006/2007 fiscal year the provincial government funded programs and services to more than 35, 000 clients seeking help with their alcohol, other drug, tobacco, and/or gambling behaviour (Canadian Centre on Substance Abuse, 2005a; Alberta Alcohol and Drug Abuse Commission, 2007). For many of these clients this was not their first attempt at seeking help from an organized treatment facility (Substance Abuse and Mental Health Administrators Office of Applied Studies, 2004). This suggests substance abuse and problem gambling behaviour are paramount challenges confronting society today (Ericson, 2001; Wendler, 2007).

A variety of professionals — nurses, social workers, physicians, psychiatrists, psychologists, spiritual leaders, and addiction counsellors — offer services to individuals and

families experiencing problems associated with alcohol, other drug, tobacco and/or gambling behaviours. Despite the variety of services available, however, the majority of addiction services are provided by addiction counsellors (Wendler, 2007). In Alberta, most addiction counsellors are employed at government-funded agencies or organizations which aim to provide research-based practice.

To date, addiction research examining the antecedents of client outcomes tends to focus on client characteristics such as demographic variables, stage of change, patterns of drug use, psychopathology, individual histories or the effect of different treatment types. Over the past decade, however, a growing body of literature has highlighted the importance of counsellor characteristics on client outcomes (Canadian Centre on Substance Abuse, 2005b; Health Canada, 2001; Gossop, Stewart, & Marsden, 2006; Grella et al., 2007). Findings from this counsellor-focused research suggest that counsellor characteristics such as attitude, background knowledge, experience, and counselling skills specific to addictions all contribute to effective addiction counselling and positive client outcomes (Health Canada, 2001). Furthermore, as Murdock, Wendler, and Nilsson (2005) suggest, counsellor qualities such as personality, interpersonal functioning, and professional beliefs have been found to account for more variance in client outcomes than do differences among pre-treatment client characteristics or between different types of treatments. These findings point to the importance of previously overlooked variables on client treatment outcomes and the need to further examine the effects of addiction counsellors on counselling and client outcomes (Carroll, 2001).

Among health professionals, motivation beliefs like self-efficacy have been associated with professional development, work motivation (i.e., the reasons for engaging in a particular

behaviour; Herzberg, Mausner, & Snyderman, 1993), acquisition of desired vocational goals, job satisfaction (i.e., the degree to which professionals enjoy their jobs; Spector, 1997), and overall well-being (Larson & Daniels, 1998; Pinquart, Juang, & Silbereisen, 2003; Perdue, Readon, & Petrson, 2007; Lubbers, 2004; Pajares, 2002). Self-efficacy beliefs (i.e., beliefs in one's capabilities to organize and perform specific actions in such a way that desired goals are achieved) are said to mitigate work-related stress and strain such that employees with higher self-efficacy are more productive, seek more opportunities to learn and use problem-centred coping compared to avoidant or 'wait and see' coping behaviours when job demands are high (Bandura, 1977, 2001; Salanova, Grau, & Martinez, 2006). Furthermore, quantitative studies examining self-efficacy suggest that these beliefs influence helping professional's motivation for professional development as well as job satisfaction, job retention, and ultimately job performance (Murdock et al., 2005; Tsigilis, Zachopoulou, & Grammatikopoulos, 2006; Yang, Kao, & Huang, 2007; Khaled et al., 2007). Specifically, survey analyses examining self-efficacy beliefs among helping professionals suggest that employees with high job-related self-efficacy are more likely to see themselves continuing in their current profession and are less likely to experience burnout (i.e., a professionals' level of discouragement in their occupation; Angerer, 2003) (Ellet, 2001; Evers, Tomic, & Brouwers, 2001).

To date little attention has been paid to the relationship between self-efficacy, job satisfaction, job motivation and burnout among addiction counsellors. As Murdock and colleagues (2005) suggest, this lack of research attention is perhaps due to the absence of universal competencies understood to be necessary for the effective practice of addiction counselling. Compounding the lack of overall research attention given to the relationship between self-efficacy, job satisfaction, job motivation, and burnout among addiction

counsellors is the absence of qualitative or mixed methods research. This presents a gap in the literature as quantitative questionnaire research has inherent weaknesses such as the misrepresentation of participant's views, confirmation bias, and lack of pragmatic application. Mixed methods studies, conversely, offer the advantages of capturing the trends and details of a situation by providing rich and meaningful data that reflects participant's views at a local level to develop concepts and theory or add insight to quantitative results (Bryman, 2004). Therefore, an opportunity exists to improve addiction counsellor professional development, staff retention, and morale, but these improvements require a research base to support the relationship between self-efficacy beliefs, job satisfaction, job motivation and burnout among addiction counsellors (Johnson & Onwuegbuzie, 2004).

Counselling Self-Efficacy Scales

There are currently two measures available for assessing the self-efficacy of addiction counselling knowledge and skills. Kranz (2003) developed the Alcohol and Other Drug Self-Efficacy Scale for assessing social worker's confidence in the effective practice of addiction counselling. Psychometric properties of this scale indicate high internal reliability; however, the use of this scale is limited as social workers were the normative sample and no further publications examining this scale are available. In 2005, with funding from the Substance Abuse and Mental Health Services Administration (SAMHSA), Murdock et al. (2005) developed and provided initial validation of a new scale measuring self-efficacy among addiction counsellors working with substance abusing clients. Titled the Addiction Counseling Self-Efficacy Scale (ACSES), the ACSES was created from addiction counsellor competencies outlined by the Centre for Substance Abuse Treatment (2006a). Since its inception, several reliability and validity studies have examined the use of this scale to assess

five essential competency areas deemed necessary for the effective treatment of addiction clients (Wendler, 2007). Specifically, the ACSES measures self-efficacy for (a) addiction counselling and recovery skills; (b) assessment, treatment planning, and referral skills; (c) skills for working with clients with substance abuse and concurrent mental health problems; (d) group counselling skills; and (e) basic counselling skills. Based on psychometric testing, the ACSES is supported as an "accurate and reliable measurement for addiction counsellor self-efficacy beliefs" (Wendler, 2007, p.iii). Therefore, this scale provides a strong foundation to further both the research and practice of addiction counselling.

Summary and Focus of Research

Little qualitative or mixed methods research has addressed the job-related beliefs of addiction counsellors. The purpose of this mixed method study was to discover and describe the relationship of self-efficacy beliefs with job satisfaction, job motivation, and burnout among adult addiction treatment counsellors working in government-funded substance abuse and problem gambling treatment facilities across Alberta. By combining data from quantitative measures of self-efficacy, job satisfaction, and burnout, with qualitative data gathered from individual interviews with addiction counsellors (which includes information on job motivation), an understanding of the relationship of these job-related variables can be developed.

CHAPTER 2

Review of the Literature

This chapter begins with a brief overview of substance abuse, problem-gambling behaviour, and the goals of provincially-funded addiction treatment services in Alberta. Subsequently, self-efficacy theory is discussed in relation to mental health and addiction counselling, along with current research on self-efficacy beliefs as they relate to job satisfaction and burnout. The lack of research on job motivation is discussed and the development and validation of the Addiction Counseling Self-Efficacy Scale (ACSES) is described. Then the benefits of using a mixed methodology are presented. Lastly, support is provided for using a mixed methodology research design to explore the relationship between self-efficacy, job satisfaction, job motivation, and burnout among addiction counsellors practicing in provincially-funded treatment centres across Alberta.

Substance Abuse, Problem Gambling Behaviour, and Addiction Treatment in Alberta

Negative Sequelae of Addictive Behaviours

Substance abuse and problem gambling adversely affect individuals with these behaviours and also negatively affect society as a whole. Substance abuse is the recurring and excessive use of alcohol, tobacco, and/or other drugs, which negatively affects various life domains. Problem gambling is similarly characterized by the loss of control over gambling activity and the continuation of gambling behaviour despite adverse consequences (Topp et al., 1998; American Psychiatric Association, 2000). Both substance abuse and problem gambling can be classified as addictive behaviours that occur along a continuum of severity from minor problematic behaviour to a chronic state of psychological and physiological

dependence, which are the main features required for a diagnosis of addiction (Herie, Godden, Shenfeld, & Kelly, 2007; Alberta Alcohol and Drug Abuse Commission, 2006).

In Western society, the abuse of alcohol, tobacco, and other drugs has been said to cause more deaths, illnesses and disabilities than any other preventable health concern (Schneider Institute for Health Policy, 2001). Socially, addictive behaviours disrupt relationships, families, and, on a broader social scale, entire communities by contributing to increased crime rates and decreased job productivity. Furthermore, estimates indicate that the avoidable costs associated with substance abuse in Canada exceed 40 billion dollars annually when considering the costs of healthcare, law enforcement, and loss of job productivity (Canadian Centre on Substance Abuse, 2006). This suggests that reduction of addictive behaviours would inevitably result in significant health, social and economic improvements.

Studies examining the treatment-seeking behaviour of individuals struggling with alcohol, tobacco, other drug and gambling activity indicate that not everyone with these types of problems seeks formal treatment. The majority who do seek treatment, however, tend to have more severe problems and are more frequently diagnosed with addictions. Due to the high rate of relapse, addictions frequently require multiple entries into treatment to maintain reduction or abstinence (SAMSA Office of Applied Studies, 2004; National Institute of Drug Abuse, 2008). This suggests individuals confronting addictive behaviours require access to a continuum of services that are provided by well-trained and effective service providers.

Addiction Services in Alberta

Commencing April 2009, the Alberta Health Services Board (which will fund and oversee the majority of addictive behaviour treatment services in Alberta) will unite all previously separated health regions and provincially-funded organizations operating across

Alberta. Following the standard of research-based practice, the goal of this new organization is to improve access, efficiency and effectiveness of the Alberta health care system (Alberta Health Services – Alberta Alcohol and drug Abuse Commission, 2008). To achieve this goal, the Alberta Health Services Board recognizes the value of adopting a tiered model of service delivery that provides coordinated services for individuals struggling with addictive behaviours (both with and without co-occurring and mental health problems) and the pursuit of research-based practice.

In providing health services to a heterogeneous group of people, research-based practice recommends that service providers adopt a tiered model of service delivery that is coordinated to meet the unique multidimensional needs of those being served (Canadian Centre on Substance Abuse, 2008; Alberta Health Services–Alberta Alcohol and Drug Abuse Commission, 2008; Whittinghill, Whittinghill & Loesch, 2000). Typically composed of five tiers, each level represents supports and services that are similar in their availability, accessibility, and intensity. For example, the foundation of the tiered system is designed to consist of a broad base of primary health care and community groups that are widely available, highly accessible, and provide the least intensive form of treatment to the greatest number of people. As tiers increase, services are designed to meet the needs of fewer people, who require more intense treatments for more severe problems. In the tiered system, addiction counsellors provide services ranging from the broad base of brief intervention to more intense residential treatment programs.

Over the past two decades, findings from research have highlighted the high incidence of mental health problems among individuals seeking help for their addictions compared to the general population (Skinner, O'Grady, Bartha, & Parker, 2004). According to Health

Canada (2001), addictive behaviours and mental health problems are so interrelated that addictive behaviour is a common reason for relapse into mental illness, and untreated mental illness is a significant factor for recurrence of addictive behaviours. Therefore, there is a clear need for well-trained addiction counsellors and health professionals who are confident in their abilities to provide addiction treatment services to clients with and without co-occurring addictive behaviours and mental health problems.

To support research-based practice of addictive behaviour treatment, a large amount of literature has been compiled on various aspects of addiction treatment and its effect on client outcomes. The majority of this literature, however, focuses on pre-treatment client characteristics or the effects of different treatment modalities. Few studies explore counsellor characteristics, which is surprising as counsellor characteristics have been shown to have a greater influence on addiction client outcomes than either client characteristics or treatment effects (Murdock et al., 2005; Wendler, 2007). According to Wendler (2007) and Carroll (2001), the study of addiction counsellor attributes on client outcomes is a timely and necessary activity as literature demonstrates that individual counsellor qualities such as personality, interpersonal development, and professional beliefs account for greater variance in client outcomes (Stoffelmayr, Mavis, Sherry, & Chiu, 1999; Siqueland et al., 2000). Huppert and colleagues' (2001) study similarly supports the notion that 'the therapist matters' when investigating the effect of counsellors on client outcomes. In their study, counsellors with equivalent levels of education and experience provided the same type of treatment to clients with similar problems. Results indicated that counsellor's level of competence was positively related to client level of recovery, thus highlighting the effect of counsellor variables on client outcomes (Huppert et al., 2001).

In summary, health services in Alberta are shifting toward a coordinated and integrated approach where research-based treatment is provided to clients with and without co-occurring addictive behaviour and mental health-related issues through a tiered model of service delivery (Centre for Substance Abuse Treatment, 2006b). The emphasis on research-based practice highlights the importance of examining a previously neglected area of inquiry with respect to counsellor qualities on client outcomes. This line of research has the potential to improve the lives of those suffering with addictive behaviours and ultimately reduce the adverse consequences of these behaviours on society. Research on addiction counsellor characteristics and work motivation is sorely lacking. In the next section, some possible theoretical frameworks underlying research on addiction counsellor motivation are explored.

Self-Efficacy Theory and Research

Social Cognitive Theory

Bandura's Social Cognitive Theory (SCT) provides one way of understanding the motivation beliefs of addiction counsellors. Social Cognitive Theory offers an "agentic" (Bandura, 2001, p. 3) perspective of learning and personality development whereby humans are understood as cognizant agents of their own lives who actively engage in their own development and intentionally create change throughout their lifetime (Pajares, 2002; Bandura, 1994). Central to SCT and human functioning are self-efficacy beliefs or one's beliefs or judgements about one's capabilities to effectively perform a specific course of action to meet the demands of a particular situation (Bandura, 1986). These powerful beliefs influence whether or not certain behaviours will be attempted and the magnitude of effort, perseverance, and resilience displayed when facing adversity (Brown, 1999; Dombeck & Wells-Moran, 2006; Holden, 1991; Stajkovic & Luthans, 1998). As Bandura (1997) states,

"people's level of motivation, affective states, and actions are based more in what they believe than what is objectively true" (p. 2). Following this theoretical framework, human behaviour may be better predicted by considering an individual's self-perceptions of her own capabilities (self-efficacy beliefs) rather than that individual's 'true' capability to accomplish a task (Pajares, 2002).

Sources of Self-Efficacy Information

Self-efficacy beliefs are acquired from four sources, namely enactive mastery, vicarious learning, social persuasion, and physiological arousal. The first source, enactive mastery, occurs when an individual performs a specific behaviour, interprets the results of that specific behaviour in conjunction with the outcome, and uses that interpretation to develop further beliefs (i.e., self-efficacy beliefs) about his or her capabilities in a future circumstance or activity. These self-efficacy beliefs then direct forthcoming choice and action and, according to Bandura (1986), may improve or diminish depending on how a person interprets the outcome (Pajares, 2002). Of all the sources of self-efficacy, it is suggested that enactive mastery has the greatest influence on improving or diminishing self-efficacy beliefs (Bandura, 1986; Sheu & Lent, 2007). For example, addiction counsellors who experience success when working with a client are more likely to presume similar future successes when working with similar types of clients. Conversely, counsellor self-efficacy to treat specific clients may diminish if the outcome is perceived as unsuccessful (Wendler, 2007).

Vicarious learning is the second source of self-efficacy beliefs and is especially helpful in the early stages of career development. Vicarious learning occurs when an individual observes, retains, recalls and replicates a model's performance on a specific task (Bandura, 1986). In practice, the effects of vicarious learning are greatest among individuals

who have limited experience at a task or among individuals who are undecided about their own capabilities to perform a task. For example, novice counsellors, with limited enactive mastery experiences, are more likely to rate their own self-efficacy for treating clients higher after observing models perform successful counselling sessions (Larson et al., 1999). Vicarious learning is also more effective when the observer relates to some attribute of the model, perceives the model as similar, and identifies the model's performance as indicative of his or her own, when performing a similar task (Pajares, 2002).

Social persuasion is the third source of self-efficacy. Social persuasion includes positive reinforcements such as effective words of encouragement that work to nurture self-efficacy beliefs and instil the sense that envisioned successes are possible. However, when unfounded social reinforcements are presented and an individual experiences failure, self-efficacy beliefs will decrease since the enactive mastery experience is considered a more credible source of information compared to the disconfirmed social persuasion. Social persuasions in the form of negative reinforcement and punishment may also serve to decrease self-efficacy beliefs and reinforce avoidance or abandonment of difficult tasks (Bandura, 1994).

Finally, self-efficacy beliefs are influenced by somatic and emotional states since physiological and emotional feedback are used to inform individuals about their personal competence for performing a task. For example, when faced with a challenging task, a positive mood may increase confidence in an individual's competence to perform the necessary actions to achieve success. Conversely, the presence of anxiety and/or negative mood may be interpreted as resulting from a lack of competence to perform a task and, therefore, decrease self-efficacy beliefs (Bandura, 1994).

In addition to describing the four sources of self-efficacy beliefs, Bandura provides a distinction between two components of self-efficacy: efficacy expectations and outcome expectations (Bandura, 1977). Efficacy expectations refer to the belief that individuals can successfully act to achieve a desired outcome. Highly influenced by verbal persuasions and vicarious learning, these expectations do not require self-knowledge to perform specific tasks. Efficacy expectations are generally more optimistic than outcome expectations, regardless of level of training (Sipps, Sugden, & Faiver, 1998). In contrast, outcome expectations refer to the cause-and-effect beliefs that individuals possess regarding their performance with respect to the corresponding outcomes. Unlike efficacy expectations, outcome expectations are developed from personal experience.

Measurement of Self-Efficacy Beliefs

Self-efficacy beliefs were originally measured by presenting a list of tasks and asking participants if they were able to perform them, with answers collected in a yes/no format (selecting direction). Then participants were asked to rate their confidence for performing those tasks on a "0 = No confidence" to "100 = Absolute confidence" scale (selecting strength). Recognizing the redundancy of measuring both direction and strength of these beliefs and their direct correlations, Lent and Hackett (1987) suggested measuring the magnitude of self-efficacy beliefs for both direction and strength with Likert-type scales (e.g., "1 = Not confident" to "5 = Highly confident"). This has since been deemed a more appropriate method for measuring the construct of task-specific self-efficacy (Mauer & Andrews, 2000).

Self-efficacy beliefs also differ in their level of abstraction: from a high level of abstraction that measures general and context-free competencies to low level of abstraction

that measures specific and context-dependent competencies (Kear, 2000). Bandura, however, recommends the study of self-efficacy beliefs be limited to specific cognitions for performing specific actions under specific circumstances, rather than general feelings of mastery (Lent et al., 2006; Jammison, Terry, & Callan, 2004). According to Bandura (1995), measures of self-efficacy must be: (a) task specific and contextually appropriate, (b) operationalized parsimoniously (i.e., clearly and comprehensively), (c) a representation of performance on a related and challenging set of skills, and (d) an assessment of current perceptions of capability. Further, Bandura purports that measures of self-efficacy beliefs reflect expert knowledge about what is necessary for achieving success or attaining a desired end (Sheu & Lent, 2007).

Research on Counsellor Self-Efficacy

The following section explores self-efficacy beliefs as they relate to counsellors. Defined as “one's beliefs or judgments about her or his capabilities to effectively counsel a client in the near future” (Larson & Daniels, 1998, p. 180) counselling self-efficacy has been associated with the development, training and provision of effective counselling skills. Over the past two decades, counsellor self-efficacy research has tended to focus on the self-efficacy beliefs among novice counsellors; the relationship of self-efficacy beliefs on training, supervision, and counsellor performance; and interventions targeting self-efficacy beliefs.

Self-efficacy research with novice counsellors has become an important area of research for the training and development of various counselling skills. For example, Barbee, Scherer, and Combs (2003) examined the effect of service learning (enactive mastery experiences) on pre-practicum undergraduate counselling students with various levels of counselling coursework and training. As defined in this study, service learning required students to complete community service hours in the field of counselling and incorporate and

reflect on their field experience as it related to their academic work. Findings revealed that pre-practicum students with limited work experience in the counselling field received the greatest benefits from service learning as their ratings of counsellor self-efficacy significantly improved and their anxiety for working with clients decreased. In another study examining the effects of enactive mastery on counselling self-efficacy among pre-practicum master level and doctoral level counselling students, Lent and colleagues (2006) found that counselling self-efficacy significantly improved in as little as four counselling sessions. Interestingly, students in this study who rated themselves as more self-efficacious in their counselling skills were also more likely to have greater congruence with their clients in rating the quality of their counselling sessions (Lent et al., 2006).

In an additional study, Larson and colleagues (1999) examined the effect of vicarious learning (observation of a successful counselling session) and enactive mastery (role play with mock clients) training interventions on counselling self-efficacy among novice counselling students. By administering a counselling self-efficacy scale both before and after students received either training intervention (vicarious learning or enactive mastery opportunities), the authors found that vicarious learning experiences consistently improved counsellor self-efficacy. The effects of enactive mastery on self-efficacy, however, depended on the student's perception of his or her own performance. Students who perceived their mock session as going well rated themselves as more self-efficacious, whereas students who perceived their mock session as not going well rated themselves as less self-efficacious (Larson et al., 1999).

Studies examining counselling self-efficacy have investigated the relationship of these motivational beliefs on counsellor training, supervisory outcomes, and counsellor performance. Results from these studies emphasize the correlational, and perhaps reciprocal,

relationship of high counselling self-efficacy on career development and effectiveness as a counsellor (Lent et al., 2006; Sipps et al., 1998; Larson et al., 1992; Leach, Stoltenberg, McNeill, & Eichenfield, 1997; Pajares, 2002; Barnes, 2004). This makes sense as counselling self-efficacy has been positively related to level of counsellor training, amount of counselling experience, presence of supervision, and professional development (Cashwell & Dooley, 2001; Whittaker, 2007). Novice counsellors with high self-efficacy for various aspects of counsellor training and development, regardless of prior training or experience, have been found to be more open to and satisfied with supervisors' advice and evaluation (Friedlander & Snyder, 1983). Furthermore, according to SCT, counsellors who possess stronger counselling self-efficacy beliefs and who have at least an adequate level of counselling ability are more likely to generate helpful responses, expend greater effort and take more risks when encountering clinical impasses. These individuals also tend to show greater persistence and resilience when faced with adversity and appear more poised during clinical sessions (Lent et al., 2006).

One goal of counsellor educators is to assist those in training to become more effective counsellors. This can be done through interventions targeting self-efficacy beliefs. In an experimental study among graduate level counsellors, Larson and Daniels (2001) examined the effects of unfounded verbal persuasions (both positive and negative) on counsellor self-efficacy and anxiety after mock counselling sessions (enactive mastery experiences). By comparing counsellor ratings of self-efficacy and anxiety both pre and post unfounded performance feedback, the authors found that counsellors altered their self-efficacy beliefs and anxiety ratings in response to the type of feedback that was received. Specifically, unfounded positive feedback significantly increased counsellor self-efficacy, especially among less

experienced counsellors, and decreased anxiety. Unfounded negative feedback, conversely, significantly decreased counsellor self-efficacy and increased anxiety. Based on these results, counsellor educators are encouraged to provide honest feedback that enhances positive counsellor self-efficacy and decreases anxiety, but still conveys the necessary areas of improvement.

Research on Addiction Counselling Self-Efficacy

Research examining self-efficacy beliefs among addiction service providers is an understudied topic. Of the limited literature available, research in this area suggests that (a) novice addiction service providers tend to overestimate their true ability (Adams & Gallon, 1997), (b) addiction workers with specific training in addiction behaviour treatment tend to rate themselves as more competent or self-efficacious and take on more clients struggling with addictions (Amadeo & Fassler , 2001), and (c) healthcare workers with higher levels of self-efficacy and outcome expectations for treating addictive behaviour clients are more likely to determine if substance use problems exist and provide subsequent counselling sessions, rather than referring to outside sources (Gottlieb, Mullen, & McAlister ,1987).

To investigate the consistency between self-perceived capabilities and 'actual' competence for addiction counselling, Adams and Gallon (1997) gathered national sample (n = 776) of addiction counsellors and social workers employed across 17 American states. Using a survey design, addiction counsellors and social workers rated their perceived capabilities for working with addiction clients across several relevant domains [e.g., (a) clinical evaluation, (b) treatment planning, (c) referral, (d) case management, (e) counselling, (f) client/family/community education, (g) documentation, and (h) professional and/or ethical responsibilities]. To triangulate ratings, counsellor's immediate supervisors completed the

same form, rating the individual's competence for addiction counselling. Upon first evaluation, findings revealed that the self-perception of addiction counsellor competencies significantly differed from their supervisors' perceptions on all but one of the 121 competency items. On closer examination, however, Adams and Gallon found that counsellors newer to the profession rated themselves as significantly more capable as did their corresponding supervisors. More congruent levels of perceived proficiency were witnessed among the ratings of addiction counsellors and supervisors as the level of counsellor experience increased. Similar findings have been published in additional literature (Anderson, 2000; Steward, 1998; Sipps et al., 1998; Heppner, O'Brien, Hinkleman, & Flores, 1996).

The effect of professional development (e.g., post-graduate training) on patterns of practice and competency for working with addiction clients, among social workers, was measured by Amadeo and Fassler (2001). Using a matched subject design, these authors compared social workers (n = 23) who completed a nine-month intensive addiction training program with comparison social workers (n = 22) who did not receive this training. Both groups completed a caseload form indicating the types of clients (by diagnosis) they were currently treating and rated their competence in their ability to assess, intervene, and treat their clients with substance abuse issues (with and without co-occurring mental health problems). Social workers who completed intensive training had significantly more clients in their caseload who were diagnosed with substance abuse disorders (both with and without co-occurring mental health problems), and rated themselves as more competent in their intervention strategies when working with substance abusing clients. As Wendler (2007) suggests, perhaps trainee social workers took on more clients because they perceived they

were more prepared to successfully work with this type of clientele and had a stronger sense of addiction counsellor self-efficacy.

In a study examining self-efficacy and outcome expectations among primary care physicians to treat patients with tobacco, alcohol, and other drug related problems, Gottlieb, Mullen, and McAlister (1987) surveyed 422 general, family and internal practitioners. To measure self-efficacy beliefs, physicians were asked to rate how certain they were in their ability to convey appropriate information and provide helpful skills to improve their patients' non-substance using behaviour across a variety of scenarios. Outcome expectations were measured by having physicians rate, for each scenario, the following question, "Given that you feel that you could convey appropriate information and skills to your patients, how certain are you that the average patient will, in fact, follow through?" (p. 25). It was found that physicians with higher levels of self-efficacy, as it related to treating substance using patients, were more likely to be engaged and dedicated to achieving positive results with their addictive behaviour patients. Specifically, physicians with high levels of self-efficacy were more likely to incorporate questions regarding substance use when taking their patient's history, provide individual counselling sessions to patients who reported substance use problems, and were less likely to refer substance using patients to other care providers.

In summary, SCT provides an established theoretical framework for the study of self-efficacy beliefs. Developed from four major sources, self-efficacy beliefs affect several aspects of human behaviour. Research on counsellor self-efficacy has been integrated into the mental health field and has implications for novice counsellors, training and supervision, interventions, and counsellor performance. However, little is known about the influence of self-efficacy of addiction counsellors with a range of practical experience (i.e., not only novice

addiction counsellors, but those with more experience as well) or, more specifically the effect of addiction counsellor self-efficacy on addiction client outcomes. Although literature from the mental health field may be extrapolated, the skills and competencies required of addiction workers are unique and, therefore, require further study. This highlights a disparity in research, suggesting a further need to study self-efficacy theory as it relates to addiction counselling.

Applying Self-efficacy Theory to Occupational Psychology: Research Examining Self-Efficacy, Job Satisfaction, Motivation, and Burnout

Not only have studies of self-efficacy belief s been helpful in the examination of counsellor training, development, and performance, but they have also been significantly correlated with and found to predict several work-related outcomes such as stressors and strains (e.g., job satisfaction and burnout) as well as job turnover (Wendler, 2007). As Bandura (1977) explains, self-efficacy beliefs affect people's motivation, feelings, thoughts and behaviours. Highly self-efficacious individuals approach and carry out tasks more efficiently and persevere in the face of obstacles. This often leads to further opportunities to experience work-related accomplishments and success. In contrast, individuals with low self-efficacy tend to give up or avoid tasks when job demands are high. These individuals tend to harbour pessimistic thoughts about their performance and personal development, which are more likely to result in reduced opportunity for the realization of work-related success (Grau, Salanova, & Peiro, 2001).

Studies examining work-related self-efficacy, job satisfaction, and burnout are widely available and generally produce similar results across a variety of occupations. For example, Jex and Bliese (1999) surveyed over 2000 United States Army soldiers on their self-efficacy beliefs and found that soldiers with high levels of job self-efficacy reported higher levels of

job satisfaction. Furthermore, soldiers with higher levels of self-efficacy reported lower levels of psychological and physical strain when experiencing long work hours and work overload. These soldiers also remained highly committed to the army despite work overload. Soldiers with lower levels of self-efficacy, in contrast, reported decreasing organizational commitment (e.g., employee's identification with and loyalty for working in an organization; Knudsen, Johnson, & Roman, 2003) with the increases in work overload.

Another study examining the relationship among self-efficacy beliefs (both generalized and specific) on occupational stressors and strains was conducted by Grau et al. (2001). Survey results from 140 participants working with telecommunication technologies showed that high levels of generalized self-efficacy predicted low amounts of stress and strain (e.g., job dissatisfaction and burnout) regardless of level of autonomy or role conflict. High levels of task-specific self-efficacy, however, only predicted less strain (e.g., burnout and organizational non-commitment). In contrast, employees with low levels of generalized self-efficacy experienced greater amounts of burnout as level of autonomy increased or as role conflict increased. Employees with low levels of task-specific self-efficacy reported greater strain (burnout and organizational non-commitment) when routine in tasks or role conflict was high.

In addition, a meta-analysis of 274 published and unpublished correlational studies examining the relationship of self-evaluations (including generalized self-efficacy) on job satisfaction and performance indicates that high generalized self-efficacy strongly predicts both job satisfaction and performance across a range of professions, and is a stronger predictor of job satisfaction than self-esteem, locus of control, or narcissism (Judge & Bono, 2001). More recently, Schwarzer and Hallum (2008) conducted a longitudinal study examining high

self-efficacy as protective resource against strain and burnout among teachers new to the profession. These authors found that novice teachers with low teaching self-efficacy reported significantly higher symptoms of burnout. This supports Fillion et al. (2007) findings that low self-efficacy is one of the best predictors of emotional distress for healthcare professionals working in residential treatment facilities.

Research on Job Satisfaction, Job Motivation and Burnout among Addiction Counsellors

From an organizational perspective, the study of job satisfaction and burnout among addiction counsellors requires research attention as it provides insight for one of the major challenges facing addiction treatment agencies. This is because both job satisfaction and burnout have been shown to affect organizational commitment and turnover intention, both of which ultimately influence staff retention (Griffeth, Hom, & Gaertnew, 2000). Indeed, staff turnover in addiction treatment agencies is a legitimate concern as studies indicate that voluntary staff turnover among addiction counsellors ranges from 25% to 49% per year, which is higher than several other helping professions such as teaching and nursing (Oyefeso, Clancy, & Farmer, 2008; Gallon, Gabriel, & Knudsen, 2003).

High staff turnover in the field of addictions is problematic, and is perhaps due to the intrinsic nature of the clientele being served (Shoptaw, Stein, & Rawson, 2000). Clients with addictive behaviours have been described as an inherently difficult population to work with because they are emotionally taxing, show more severe addictive behaviour then those not seeking formal treatment, are often recidivists who require higher levels of coordinated services, occasionally put service providers at risk for blood-born pathogens such as Hepatitis or HIV/AIDS, and due to their unpredictable behaviour (especially among stimulant users) threaten the personal safety of addiction counsellors

(Levin, Culkin, & Perrotto, 2002). Another potential factor influencing staff turnover is the hierarchical organizational structure of addiction treatment services. The consequences of high staff turnover include threatening the quality of client care, more extensive/intensive program management, lowered staff morale, and increased costs for attracting, hiring, and training additional counselling staff (Knudsen, Ducharme, & Roman, 2006; Barak, Nissly, & Levin, 2001).

Job satisfaction. Literature examining self-efficacy beliefs and job satisfaction among addiction counsellors is limited, with scant research published over the last half-century. Results from a measure of job satisfaction (i.e., Minnesota Satisfaction Questionnaire; Weiss, Dawis, England, & Lofquist, 1967) among certified addiction counsellors (n = 231) revealed that these counsellors were generally satisfied with their jobs; however, over three quarters (76%) expected to leave their position with their current organization within the next five years and 17% indicated they expected to leave the profession of addiction counselling altogether. Participants in this group were most satisfied with the opportunity addiction counselling provided for helping others and were least satisfied with the opportunities for advancement and rates of pay (Evans & Hohenshil, 1997). These findings were replicated by Gallon and colleagues (2003) (n = 469) who further showed that addiction counsellors from their study were less satisfied with their employee benefits and opportunities for career growth. Moreover, Ogborne, Braun, and Schmidt (1998) examined a Canadian sample of addiction counsellors (n = 925) and their commitment to stay in the addictions field. Findings from this study support a positive association between intentions to remain in the field and job satisfaction. Finally, Wendler and Murdock (2005) (n = 393) examined addiction counselling self-efficacy and its relationship to job satisfaction and counsellor demographic and work

environment variables. Positive counsellor self-efficacy and supportive, less stressful work environments were found to predict higher levels of job satisfaction. Furthermore, level of education moderated this relationship. In particular, novice addiction counsellors (with less than graduate level training) were more satisfied with their jobs if they had mastery experiences in general addiction counselling and in the screening, assessing, and referring of addiction clients.

Job motivation. At an individual level, occupational motivation is defined as the intrinsic enthusiasm that promotes the continuous engagement in one's occupation or the "exceptional moments" (Csikszentmihalyi, 1997, p. 29) in one's career. Central to this definition is the notion that motivation involves voluntary actions that are goal directed (Halbeslem & Bowler, 2007). Associated with job engagement, happiness, personal growth and quality of life, job motivation has been documented in various occupations; however, to date, the study of job motivation among addiction counsellors has received little attention (Scheerer, Cahill, Kirby, & Lane, 2004; Graham, 2002; Dickie, 2003). Research investigating the occupational engagement of addiction counsellors has the potential to influence staff retention, a timely and necessary topic given the high staff turnover rates.

Burnout. Originally described by Maslach and Jackson (1981), job burnout has been operationalized across three individual parameters: which are (a) feelings of emotional and physical exhaustion, (b) depersonalization when working with others, and (c) negative feelings toward personal work accomplishments. Schaufeli and Peeters (2000) conceptualized burnout as a process (developing over time and circumstance) that ranges on a spectrum of severity. According to the authors, burnout has three stages: the first stage or onset of burnout is characterized by an imbalance of resources and demands, which leads to job stress. The

second stage occurs when emotional resources are depleted and negative attitudes and behaviours are developed, leading counsellors to treat clients in a detached and mechanical manner as a defence mechanism to reduce emotional exhaustion. This method of coping, however, is ineffective as the counsellor-client relationship and personal goal accomplishments are impeded, and feelings of incompetence and self-doubt are likely reinforced. The final stage in burnout is a reduction of personal accomplishment (Schaufeli & Peeters, 2000).

The study of job satisfaction and burnout among addiction counsellors has received considerable research attention over the past two decades. Using Maslach and Jackson's traditional burnout scale Oyefesco et al. (2008) found that addiction counsellors ($n = 200$) sampled from 48 organizations who experienced stress in the form of alienation (e.g., feelings of non-support from senior staff, isolation, and role ambiguity) and case complexity (e.g., working with demanding clients, conflicting job demands, lack of time to complete all tasks, and work overload) were more likely to experience emotional exhaustion. Similarly, Shoptaw et al. (2000) found that reports of emotional exhaustion were significantly higher among addiction counsellors who indicated less support from management and co-workers, and among addiction counsellors working in heavy caseload methadone clinics where clients were more often carriers of HIV. Additional studies suggest emotional exhaustion is a key component of burnout and is a precursor to actual turnover (Knudsen et al., 2006).

Another study examining the stress and strain associated with addiction counselling found that occupational and individual counsellor characteristics such as psychological maladjustment correlated with burnout (Elman & Dawd, 1997). Specifically, these authors found that counsellors with higher perceptions of social support and more

experience in the addiction field reported higher levels of personal accomplishment, but also reported greater depersonalization.

Further highlighting the relationship between burnout and organizational commitment is Knudsen et al.'s (2006) national study examining the predictive ability of management practices on burnout and turnover intention. Findings indicated a significant positive relationship between emotional exhaustion and intention to quit. Moreover, organizations with central and hierarchical decision-making practices for choices directly relevant to addiction counsellors (rather than decision-making practices that included addiction counsellors in choices that were relevant to their work) were more likely to have workforces that reported high levels of emotional exhaustion and turnover intention.

An investigation of addiction counsellor demographic variables on organizational commitment and turnover intention suggest that increases in age and longer treatment centre tenure are significantly related to organizational commitment (Knudsen et al. 2003). In fact, according to Oyefesco et al. (2008), age is a significant contributor to organizational commitment as addiction counsellors under the age of 25 were found to be seven times more likely to experience emotional exhaustion compared to counsellors over the age of 45. Increases in level of education, however, have been associated with decreases in organizational commitment of addiction counsellors (Knudsen et al., 2003).

Given the importance of organizational sources of burnout, Lee et al. (2007) recently designed and validated a measure to assess individual *and* organizational sources of burnout among counsellors. Along with providing a reliable score, these authors contend their Counselor Burnout Inventory (CBI) addresses several components of burnout not previously assessed in existing measures of burnout. For example, previous

studies examining addiction counselling job burnout have neglected to include items measuring the effect of work environment, personal life, and feelings of competency, which are according to Kesler (1990) fundamental contributors to burnout. This lack of previous measures examining these key contributors to burnout results in a further gap in the literature.

To summarize, research from a variety of occupations support a relationship between self-efficacy beliefs, job satisfaction, and burnout. Specifically, low self-efficacy and low job satisfaction are considered precursors to burnout. Furthermore, high self-efficacy is thought to act as a protective factor that may serve to mitigate job-dissatisfaction and physical/psychological burnout, which are described as precursors of organizational non-commitment, intention to quit, and actual job turnover. However, to date, similar studies have not been extended to the field of addiction counselling. Recognizing the need to address high job turnover rates, the investigation of self-efficacy beliefs and the work-related outcomes of job satisfaction, job motivation, and burnout provides a relevant line of inquiry that is currently under researched. It is conceivable that this lack of research attention may have been due to the absence of measures available to examine addiction counsellor self-efficacy. However, as the following section suggests, lack of measures should no longer limit this research endeavour as a promising scale is available that measures the skills necessary for the effective practice of addiction counselling.

Addiction Counselling Self-Efficacy Scales

Measurement of Addiction Counselling Self-Efficacy

Two measures of addiction workers' perceived capabilities to effectively work with substance abusing clients are reported in the literature. These are the Alcohol and Other Drug Self-Efficacy Scale (AODSES) (Kranz, 2003) and the Addiction Counselor Self-Efficacy Scale (ACSES) (Murdock et al., 2005).

The AODSES, which was grounded in SCT, was developed to provide a valid tool for measuring social workers' beliefs in their knowledge of substance abuse and competencies for treating addiction clients. Using a Likert-type scale, the AODSES includes 43 items and measures the competencies of assessment and treatment planning, referral, individual counselling, group counselling, documentation, and ethical responsibility. However, beyond its development and initial validation study, no further studies have been published using this scale. Criticisms of this scale include the limited generalizability of the normative sample, as the normative participants were social workers with graduate level of education, and the absence of survey items measuring the knowledge and skills required for working with clients with co-occurring addiction and mental health related issues, which is a relevant concern facing addiction treatment agencies across the nation (Substance Abuse and Mental Services Administration, 2000).

Development and Validation of the Addiction Counsellor Self-efficacy Scale (ACSES)

Recognizing the need for a valid instrument to assess addiction counsellor self-efficacy beliefs, Murdock et al. (2005) developed and provided preliminary support for the feasibility and utility of the ACSES, in two published studies. Wendler (2007) then published a third validation study to support the 31-item ACSES in measuring addiction counsellor self-efficacy beliefs and the subscales of: specific addiction counselling skills; assessment, treatment, planning, and referral skills; co-occurring disorder skills; group

counselling skills; and basic counselling skills. To highlight the potential promise of the ACSES in the addiction field, Wendler (2007) recommended the use of the ACSES to further professional development and inform evidence-based practice for working with clients with addictive behaviour (with and without co-occurring mental health disorders), and to eventually (with research support) assist in improving client outcomes.

To summarize, the development and validation of the ACSES has provided a 31-item scale that shows tremendous promise for research, training, and the practice of addiction counselling. In its current state, the ACSES serves as a reliable and valid tool for measuring addiction counsellor self-efficacy as an overall construct as well as across five areas of competencies that have been deemed essential for the practice of addiction counselling. However, despite effort to develop and validate the ACSES, the need for research-based practice further highlights the importance of addressing the inherent weaknesses of quantitative research designs; that is, selection and response bias, misrepresentation of participant's views, confirmation bias, and lack of pragmatic application. Although the ACSES has been shown to be a reliable and valid measure, its quantitative approach may not paint a complete picture of addiction counsellor motivation.

Mixed Methods Research

Among the limited number of studies that explore addiction counsellor self-efficacy, few have used alternative research paradigms such as qualitative or mixed method research approaches. This omission is surprising because mixed methods research approaches offer several benefits compared to monomethod study designs (Johnson & Onwuebuzie, 2004; O'Cathain, Murphy, & Nicholl, 2008).

A major strength of mixed methods research is the integration of multiple strategies, approaches, and methods of data collection not found in single research techniques (Johnson & Onwuegbuzie, 2004). By combining quantitative data that captures trends from a large number of participants with qualitative data that is rich, meaningful, and reflects the local contexts, the level of inquiry may become broader, more comprehensive, and provide more insight than through the use of either approach alone (Bryman, 2004; Creswell & Plano Clark, 2007; O'Cathain, Murphy, & Nicholl, 2007).

Summary of Literature Review and Dissertation Objectives

The treatment of addictive behaviours is moving towards research-based practice. This move to evidence-based practice emphasizes the need for further research enquiry into the previously overlooked antecedents of client outcomes. Self-efficacy is a theoretically grounded construct that may be used to examine counsellors' perceptions of how confident they are to perform various tasks associated with working with addictive behaviour clients. Among mental health and healthcare providers self-efficacy beliefs have been associated with training, experience, and counsellor performance. Additional research suggests that self-efficacy beliefs are associated with both workplace stress and strain or job satisfaction and burnout. To date, minimal lines of inquiry have explored self-efficacy beliefs of addiction counsellors. Of the research that does exist, the majority use a quantitative approach through the collection of survey data. No studies to date have examined the constructs of self-efficacy, job satisfaction, job motivation and burnout as they relate to addiction counselling. Using the ACSES along with in-depth qualitative data will provide the opportunity to explore several of the existing gaps in addiction counselling self-efficacy research.

This study was designed to address six major gaps found in this literature review. First, little is known about the addiction counsellor self-efficacy beliefs. Second, research from other occupations supports the relationship between self-efficacy, job satisfaction and burnout, but similar findings have not been extended into the field of addiction counselling. Third, studies of addiction counsellor job motivation are literally non-existent, despite the potential to improve staff engagement and retention. Fourth, although research exists supporting both individual and organizational factors as contributors to burnout, studies of burnout among addiction counsellors have failed to use the CBI, which purports to assess burnout specifically related to counsellors and the environments in which they work. Fifth, despite the tremendous potential of the ACSES for assisting both research and practice of addiction counselling, this scale is relatively new and has not been used in Canadian settings. Lastly, studies on addiction counsellor self-efficacy have consisted primarily of quantitative questionnaire research, which like many monomethod approaches possesses inherent weaknesses. These weaknesses may be prevented by including a qualitative component in a mixed methods approach.

This study used a mixed methods design. For clarity, the quantitative and qualitative components are divided into Study 1 and Study 2. Study 1 involves the collection of quantitative survey data from addiction counsellors working at provincially funded addiction treatment agencies across Alberta. The survey instrument includes three previously developed and validated measures [i.e., ACSES (Wendler, 2007), Minnesota Satisfaction Questionnaire-Short Form (Weiss et al., 1967), and Counselor Burnout Inventory (Lee et al., 2007)] and a demographic form. Study 2 involves the collection of qualitative individual interview data from several addiction counsellors who also participated in Study 1.

Data from Study 1 provided statistical information on the previously understudied area of self-efficacy beliefs and its relationship with job satisfaction and burnout among addiction counsellors. Data from Study 2 was designed to enhance the understanding of results from Study 1 by adding depth and context to the quantitative information and providing details from a local context. In addition, Study 2 directly explored job motivation of addiction counsellors, which was not addressed in Study 1.

CHAPTER 3

Methodology

Overview of Study

This study uses a mixed methods, one-phase, embedded design with qualitative data collected to provide support and explanation for quantitative findings (Creswell & Plano Clark, 2007). Embedded designs mix different approaches, data sets, and results to examine a research problem and produce results that can be generalized but are indicative of the participants' local context (Creswell, 2007). Characterized as a QUAN + qual design, the major emphasis of this study is placed on the quantitative data collection, analysis, and interpretation whereas the minor emphasis is placed on the explanatory qualitative inquiry. For clarity, the quantitative component of this study is referred to as Study 1 and the qualitative component is referred to as Study 2.

The goal of this study is to explore and explain the relationship of addiction counsellor self-efficacy with job satisfaction, job motivation, and burnout. It is also anticipated that results from this study will provide further support for the use of the Addiction Counselor Self-Efficacy Scale (ACSES).

Study 1

Method

In Study 1 a quantitative survey was used to explore addiction counsellor self-efficacy, job satisfaction, and burnout among addiction counsellors from six government-funded treatment agencies that provide services to adults struggling with addictive behaviours. For Study 2 individual interviews were conducted among several of the counsellors from Study 1.

Participants

The majority of addiction counsellors in Study 1 were female (77.1%) and most identified themselves as Caucasian (87.2%), with 3.7% identifying as Aboriginal. The majority of counsellors reported completing undergraduate degrees (65.1%), 12% of whom indicated enrolment in graduate studies. Nearly one-fifth (16.6%) reported obtaining a college diploma and 13.8% indicated completion of a graduate program. The length of time counsellors were employed in the addiction treatment field ranged from less than 1 year to 32 years, with an average of 7.1 years. Similarly, the length of time counsellors had been employed as addiction counsellors ranged from less than 1 year to 32.8 years, with an average of 6.3 years. Most counsellors (62.5%) were not currently certified or registered with a professional association. Of those who were registered, the majority (75.6%) were Registered Social Workers. The majority of addiction counsellors (61.5%) reported receiving regular clinical supervision. Table 1 provides a summary of the demographic information for the addiction counsellor participants in Study 1.

Table 1

Demographic Characteristics of Study 1 Participants (N = 110)

Variables	Addiction Counsellors
Age (Range)	22 – 65 years
Mean (Standard Deviation)	39.94 (13.35 years)
Gender (% Female)	77.1
Ethnicity (%)	
Caucasian	87.2
Aboriginal (e.g., First Nations, Métis)	3.7
African	1.8
Asian	1.8
Other	4.6
Level of Education (%)	
Less than Bachelor's Degree (e.g., College Diploma)	19.3
Bachelor's Degree	65.1
Master's Degree	13.8
Other	0.9
Certification/Licensure Status (%)	
Not Certified or Licensed	62.5
Licensed Social Worker	31.2
Licensed Psychologist	1.8
Licensed Provisional Psychologist	1.8
Other	2.8
Years Employed Experience in the Addiction Field	
Range	0.17 to 32 years
Mean (Standard Deviation)	7.1 (7.1)
Years Working as an Addiction Counsellor	
Range	0.17 to 32.8 years
Mean (Standard Deviation)	6.3 (6.7)
Counsellors who Receive Regular Supervision (% Yes)	61.5
Of those who report 'Yes', Range	0.2 to 365 days per year
Mean (Standard Deviation)	44.3 (72.2)

Materials/Instrumentation

The Study 1 instrument included three previously developed and validated surveys measuring the constructs of addiction counselling self-efficacy, job satisfaction, and burnout, as well as a demographic form that measures counsellor characteristics such as age, gender, ethnicity, education, years of experience, etc. (refer to Appendix A).

Measure of self-efficacy. The Addiction Counselor Self-Efficacy Scale or ACSES (Wendler, 2007) is a 31-item scale that purports to measure overall levels of addiction counselling self-efficacy as well as self-efficacy across five major areas of addiction counselling, which are (a) executing specific addiction counselling skills (e.g., "Help a client recognize what triggers her/his substance use"); (b) assessment, treatment planning, and referral skills (e.g., "Use assessment data to develop a treatment plan"); (c) working with co-occurring addictive behaviours and mental health issues (e.g., "Work effectively with a client who has both a substance use and anxiety disorder"); (d) group counselling skills (e.g., "Develop trust and cohesion among group members"); and (e) basic counselling micro skills (e.g., "Show empathy toward a client"). The instrument uses a 6-point Likert scale, anchored by "1 = No confidence" to "6 = Absolute confidence" and asks participants to rate their confidence in their ability to perform each listed skill. Instructions state that there are no right or wrong answers and participant responses are intended to reflect opinion. One composite and five subscales scores can be determined from the ACSES scale (refer to the major areas of addiction counselling described above). The composite score is calculated by summing the score on each of the 31-items and, therefore, an ACSES composite score may range from 31 to 180, with higher scores indicating stronger confidence in addiction counselling skills. Each of the five subscales is calculated by summing the mutually exclusive items into its corresponding addiction counselling skill.

Factor analyses of the ACSES support the validity of the ACSES composite score and the five ACSES subscale scores (Murdock et al., 2005; Wendler 2007). Psychometric properties of the ACSES suggest it is internally consistent (.84 to .95) and has stable test-retest

reliabilities (.88 to .98) over a three week period. Support for convergent, discriminant, and criterion validity has also been established (Wendler, 2007).

Measure of job satisfaction. The 20-item short form of the Minnesota Satisfaction Questionnaire (MSQ-Short Form; Weis et al., 1967) has been used in occupational research to measure overall job satisfaction as well as two distinct features of job satisfaction, which are intrinsic and extrinsic job satisfaction (Spector, 1997). MSQ intrinsic job satisfaction questions measure employee feelings toward their assigned job tasks (e.g., "The chance to do something that makes use of my abilities") and MSQ extrinsic job satisfaction questions measure employee feelings toward aspects of their work situation that are separate from job tasks or specific features of their work (e.g., "The way company policies are put into practice"). Instructions for the MSQ-Short Form indicate that participants are to use the 5-point Likert scale, ranging from "1 = Not satisfied" to "5 = Extremely satisfied", to rate satisfaction with various characteristics of a job. Composite scores on this scale are calculated by summing the score on each of the 20 items and may range from 20 to 100, with higher scores indicating stronger job satisfaction. The two subscales are calculated by summing intrinsic and extrinsic items, respectively.

Reliability studies indicate the MSQ-Short Form is internally consistent (.77 to .91) (Weiss et al., 1967). Studies examining the validity of this scale indicate it shows 'adequate' construct validity (Hirschifeld, 2000). Specifically, items measuring intrinsic job satisfaction are more strongly related to job involvement and have more of an emotional basis, compared to items measuring extrinsic job satisfaction (US Department of Health and Human Services & Office of Disability, Aging, and Long-Term Care Policy, 2005).

Measure of burnout. The Counselor Burnout Inventory or CBI (Lee et al., 2007) is a 20-item scale used to measure counsellor job burnout at an individual and organizational level. The instrument uses a 5-point Likert type scale ranging from “1 = Never true” to “5 = Always true” and provides an overall burnout score as well as burnout scores across the five subscales of negative work environment (e.g., “I feel frustrated with the system in my workplace”), devaluing clients (e.g., “I have little empathy for my clients”), deterioration of personal life (e.g., “I feel like I do not have enough time to engage in personal interests”), exhaustion (e.g., “I feel exhausted due to my work as a counsellor”), and incompetence (e.g., “I feel I am an incompetent counsellor”). The composite score on the CBI is calculated by summing each of the scores on the 20 items and may range from 20 to 100 with higher scores indicating greater levels of burnout. The five subscales are calculated by summing the four mutually exclusive items that correspond to the area of burnout.

When compared to the widely used Maslach Burnout Inventory – Human Services Survey or MBI-HSS (Maslach & Jackson, 1981), CBI reliabilities are found to be equivalent or superior. The internal consistency of the CBI is adequate (ranging from .73 to .94) and the test-retest reliabilities are said to be good (ranging from .72 to .85) over a six-week period. Validity studies indicate that the CBI positively correlates with the MBI-HSS measures of emotional exhaustion and depersonalization and negatively correlates with personal accomplishment. As well, the CBI negatively correlates with job satisfaction and self-esteem (Lee et al., 2007).

Recruitment and Procedure

Prior to conducting Study 1 and Study 2, the quantitative survey was pilot tested with two addiction counsellors working at government-funded treatment agencies in urban and

rural Alberta and the qualitative survey was pilot tested with another addiction counsellor working in an urban government-funded treatment centre. Permission to conduct the research was obtained from the University of Alberta's Faculty of Educational Extension and Augustana Research Ethics Board (Appendix B). Also, a Proposal to Conduct Third Party Research with provincially-funded employees was submitted and approved by the necessary parties. Then an email was sent to the managers of each treatment centre including an information letter describing the purpose and methodology of this mixed methods study (see Appendix C). One week later, the researcher telephoned the manager of each treatment site to further explain the study and answer any relevant questions. At the request of one treatment site manager, the researcher attended a staff meeting to provide addiction counsellors employed at that site a brief overview of the study. This 10-minute presentation took place August 6, 2008. On August 11, 2008 survey packets containing an Information/Consent Form for Addiction Counsellors (Appendix D), ACSES, MSQ-Short Form, CBI, Demographic Form and a return addressed, stamped envelope were mailed to addiction counsellors at five of the six treatment centres (due to staffing issues survey distribution was delayed at one treatment site). Following Krannich and Humphrey's (1986) suggestion to improve response rates, all envelopes containing survey packets were personally addressed. On August 27, 2008 addiction counsellors at the five treatment centres were personally e-mailed a brief message with a Link to the Online Survey, which was a secure link that allowed participants to complete the survey online at SurveyMonkey.com (Appendix E). On September 15, 2008 addiction counsellors at the five treatment centres were e-mailed, as a group, the Thank-you and Final Reminder Message (Appendix F). On September 15, 2008 addiction counsellors at the sixth treatment centre were mailed survey packets. On September 24, 2008 these

counsellors were sent the Link for Online Survey, and on October 15, 2008 they received an e-mail with the Thank-You and Final Reminder Message.

In total, 153 survey packets were mailed out. Twelve of these paper surveys were sent back due to various leaves and absences (e.g., maternity, health, and leave of absence). A total of 110 surveys were completed and returned (63 paper surveys and 37 electronic surveys). Removing ineligible counsellors (whose survey packages were sent back), this represents a 78% response rate.

Data Analyses

Study 1 data analyses were conducted using the Statistical Package for the Social Sciences (SPSS 13.0). The analyses were designed to explore and explain the relationship of addiction counsellor self-efficacy (as measured by the ACSES composite score and five ACSES subscale scores), job satisfaction (as measured by the MSQ-Short Form composite score and two subscale scores), and burnout (as measured by CBI composite score and five subscale scores). Statistical analyses included bivariate correlations and multiple regressions with mediation.

Study 2

Method

Participants from Study 1 were invited to participate in individual interviews to further explain and explore the lived experience of counsellor self-efficacy, job satisfaction, job motivation, and burnout at a deeper and more descriptive level. The timing of the Study 2 interviews took place in the middle of Study 1 data collection. The interviews began in October 2009, when about 50 completed surveys (from Study 1) had been returned. The interviews were finished in November, which was one month before the last completed Study 1surveys was returned. In total, 10 addiction counsellors from Study 1 participated in Study 2.

Participants

Addiction counsellors were informed of the qualitative component of this study by their treatment site managers, the Information/Consent letter mailed in their survey packet, the Brief Message with the Link to the Online Survey, and the Thank-You and Final Reminder e-mail message. In all information sources, addiction counsellors who completed the survey were asked to contact the researcher if they were interested in participating in an individual interview. After contacting the researcher (by telephone or e-mail) the researcher arranged a date and time for the telephone interview to take place. After confirming the date, time, and telephone number where the interviewee could be reached, each Study 2 participant received an Information/Consent Letter for Interviewees (Appendix H), which was sent by mail to their work address or as an e-mail attachment to their work e-mail. In total, 15 addiction counsellors (representing all treatment centres) contacted the researcher with interest in completing an interview. Thirteen interviews were scheduled and in total, 10 interviews were completed (i.e.,

three interviewees are not available to complete the interview on the date and time initially agreed upon).

The 10 participants in Study 2 represent a stratified and representative sample of Study 1 participants. Study 2 participants were mostly (80%) female and had predominantly undergraduate degrees (60%), with 40% indicating enrolment or completion of graduate and post graduate studies. Less than half of the counsellors in Study 2 reported belonging to a professional association (40%). Of those who were registered, half (50%) were Registered Social Workers. The length of time counsellors had been employed in the addiction treatment field ranged from just over a year to nearly 20 years, with a mean of 7.1 years. Similarly, the length of time counsellors had been employed as addiction counsellors ranged from just over a year to more than 18 years, with a mean of 5.7 years. All counsellors (100%) report receiving clinical supervision. As well, most addiction counsellors (80%) reported working for other addiction treatment organizations, prior to their current place of employment. Table 2 provides a summary of the demographic information of Study 2 participants (with comparisons from Study 1 in brackets).

Table 2

Demographic Characteristics of Study 2 Participants (*n* = 10) with Study 1 Participants in Brackets

Variables	Study 2 [Study 1]
Gender (% Female)	80.0 [77.1]
Level of Education (%)	
Bachelor's Degree	60.0 [65.1]
Master's Degree	20.0 [13.8]
Other	20.0 [0.9]
Certification/Licensure Status (%)	
Not Certified or Licensed	60.0 [62.5]
Licensed Social Worker	20.0 [31.2]
Licensed Provisional Psychologist	20.0 [1.8]
Years of Paid Experience in the Addiction Field	
Range	1 to 20 [0.17 to 32]
Mean (Standard Deviation)	7.1 (5.9) [7.1 (7.1)]
Years Working as an Addiction Counsellor	
Range	1 to 18 [0.17 to 32.8)]
Mean(Standard Deviation)	5.7 (5.4) [6.3 (6.7)]
Presence of Supervision	100 [61.5]
Experience at Addiction Treatment Sites (Other than Current Place of Employment) (%)	80.0 [42.7]

Procedure

The quantitative results from Study 1 provided general findings regarding the relationship among addiction counsellor self-efficacy, job satisfaction and burnout. For Study 2, 10 addiction counsellors were individually interviewed to further extend and explore the relationship among addiction counsellor self-efficacy beliefs, job satisfaction, job motivation, and burnout.

A semi-structured interview protocol was used for all interviews. The interview protocol was developed to take the research participants through their experiences of self-efficacy, job satisfaction, motivation, and burnout and explain and explore how these are

related and to add meaning to some of the preliminary quantitative survey results (Auerbach & Silverstein, 2003). After the interview protocol was initially developed; it was pilot tested with one counsellor working at a government-funded addiction treatment agency. Based on this counsellor's feedback minimal changes were required (e.g., instead of asking directly about 'insider' or personal experiences with burnout, counsellors were asked to comment on burnout from an 'outsider' perspective).

The researcher interviewed all participants and opened each interview with a brief description of informed consent and then posed general questions about addiction counselling in order to establish rapport (e.g., "How did you become an addiction counsellor?"). The interview then moved to questions about addiction counsellor self-efficacy beliefs, phrased as perception of self-confidence (e.g., "How do you think your perception of your confidence has changed since you first began addiction counselling?"). The interview protocol included questions regarding *self-efficacy* (e.g., What influences your confidence in your counselling ability?), *job satisfaction* (e.g., Can you tell me about a time when you were satisfied with your job as an addiction counsellor?), *job dissatisfaction* (e.g., Can you tell me about a time when you were less satisfied or dissatisfied with your job as an addiction counsellor?), *job motivation* (e.g., Can you tell me about a time when your job really energized you or motivated you?), *job amotivation* (e.g., Can you tell me about a time when you lacked the usual energy and motivation you have for addiction counselling?), and *burnout* (e.g., What are some aspects of the job that may contribute to burnout?). As well, participants were asked to comment on the preliminary survey results (refer to Appendix G). To ensure participants were provided the opportunity to bring up unanticipated topics and ideas there was flexibility in the presence of additional questions to further pursue such areas.

The 10 individual interviews were completed over the telephone and recorded to cassette tapes. Counsellors were telephoned at their home or place of work, depending on their preference and availability. Interviews ranged from 25 to 95 minutes in length, with the average interview lasting 39 minutes.

Coding and Data Analyses

Interviews were transcribed verbatim. To promote the integration of quantitative and qualitative data phases, several a priori (theoretical) codes based on the central research concepts (i.e., self-efficacy, job satisfaction, job motivation, and burnout) were developed prior to coding. Then, using a content analysis approach, interviews were analyzed individually and coded through repeated readings. This approach incorporated both deductive and inductive coding procedures. Pattern coding, which groups coded segments of individual interviews into a smaller set of themes and constructs that reoccurred within and across interviews, were also used to develop codes (Miles & Huberman, 1994). Two researchers independently coded segments of one interview transcript (relevant interview segments were determined prior to coding through a collaborative effort). Coding disagreements were resolved through discussion. After reaching an acceptable level of inter-rater agreement (i.e., above 90%), one researcher independently coded the remainder of the data. A total of 78 codes were initially created through this coding process. With repeated readings, a total of 28 codes remained. These codes were further distilled into themes using procedures described by Miles and Huberman (1994) in which the coded data were manipulated and then graphically displayed in order to identify relationships, patterns, and themes. To organize the data displays the researcher also used Creswell and Plano Clark's (2007) suggestion of providing a count (i.e., 1 or 0) to the presence or absence of a particular idea for each coded transcript. By

providing a single count to each transcript, rather than a count for the number of times a code was mentioned within a transcript, this reduced the likely over inflation of certain ideas by highly verbal participants and participants who frequently repeated themselves. This means the maximum frequency count an idea could receive is 10, as there were 10 participants who completed the Study 2 interview.

The current study reports three major themes and highlights: (a) the importance of clients, (b) information sources and learning opportunities, and (c) organizational factors on addiction counsellor job-related beliefs. Quotes were used to highlight key statements, provide concrete evidence to support themes, and provide a voice for the participants (Creswell & Plano Clark, 2007). To ensure anonymity, pseudonyms were used, for example, "Sierra" refers to a female addiction counsellor.

CHAPTER 4

Results

The following chapter presents results from the quantitative Study 1 and qualitative Study 2. Analyses of Study 1 were designed to explore the relationships among the quantitative survey study variables (i.e., self-efficacy, job satisfaction, and burnout). After presenting the descriptive statistics and bivariate correlations of the study variables, the predictors of burnout are examined though hierarchical multiple regression, followed by a mediation analysis. Results from Study 2 add context, specific examples, and depth to the quantitative findings.

Study 1

Data Inspection and Screening

Prior to data analysis, data from measures of addiction counsellor self-efficacy, job satisfaction and burnout were screened for normality. Recall that counsellor self-efficacy was measured by the Addiction Counselor Self-Efficacy Scale (ACSES), job satisfaction was measured using the Minnesota Satisfaction Questionnaire – Short Form (MSQ-Short Form), and burnout was measured with the Counselor Burnout Inventory (CBI).

Survey data from 110 addiction counsellors were examined. Upon initial inspection, 11 values were missing from four participants on the ACSES, three values were missing from six participants on the MSQ-Short Form, and two values were missing from four participants on the CBI. A non-random pattern of missing data was observed among two participants who did not complete ACSES Group Counselling Skills subscale items and among five participants who did not complete one item on the MSQ-Short Form (e.g., "The freedom to

use my own judgement"). Randomly missing data were replaced by the mean substitution method, whereas the non-random missing data remained uncoded.

Descriptive Statistics

Reliability coefficients for all study variables were above .75 (range .75 - .95). The means, standard deviations, dispersion statistics, and alpha coefficients for ACSES, MSQ-Short Form, and CBI composite and subscale scores are presented in Table 3. Participants reported greater confidence in their Basic Counselling Skills, Addiction Treatment Skills, and Assessment, Treatment, and Referral Skills, compared to their Skills for Working with Co-occurring Mental Health Disorders and Group Counselling Skills. Respondents endorsed significantly higher satisfaction with Intrinsic MSQ-Short Form items, compared to Extrinsic items. Participants were more likely to endorse CBI items relating to Devaluing Clients, Feeling Incompetent, and Deterioration of Personal Life as 'Rarely true' and were more likely to endorse 'Sometimes-to-rarely true' on items measuring Exhaustion and Negative Work Environment.

Table 3

Means, Standard Deviations, Ranges, and Alpha Coefficients for ACSES, MSQ-Short Form, and CBI Composite, and Subscale Scores (N = 110)

Composite and Subscale Variables	# of Items	Mean	SD	Range	α
ACSES Composite	31	152.96	16.13	111 – 186	.95
Addiction Treatment Skills	8	40.89	4.61	28 – 48	.87
Assessment, Treatment Planning, Referral Skills	5	24.77	3.23	14 – 30	.82
Skills for Working with Co-occurring Mental Health Disorders	6	26.50	4.71	13 – 36	.89
Group Counselling Skills	6	28.04	4.72	6 – 36	.90
Basic Counselling Micro Skills	6	32.55	2.89	24 – 36	.85
MSQ-Short Form Composite	20	78.64	12.01	39 – 99	.81
Intrinsic	12	49.10	6.37	24 – 59	.89
Extrinsic	6	21.61	5.14	7 – 30	.85
CBI Composite	20	37.66	10.00	21 – 61	.88
Negative Work Environment	4	9.40	3.17	4 – 16	.77
Devaluing Client	4	5.12	1.49	4 – 9	.77
Deterioration of Personal Life	4	7.16	2.86	4 – 13	.77
Exhaustion	4	9.14	3.92	4 – 20	.75
Incompetence	4	6.85	2.51	4 – 16	.83

Correlations

Bivariate correlation coefficients for self-efficacy, job satisfaction, burnout, and demographic characteristics are presented in Table 4. The ACSES composite was significantly and positively related to the MSQ-Short Form composite and Intrinsic subscale, and significantly negatively related to the CBI composite and CBI subscales of Devaluing Clients, Deterioration of Personal Life, Exhaustion, and Incompetence. The MSQ-Short Form composite was significantly and positively related to the ACSES composite and subscales of Addiction Treatment, Assessment and Treatment Planning, and Skills for Working with Co-

occurring Mental Health, but not the Group Counselling or Basic Counselling skills subscales. The MSQ-Short Form composite and Intrinsic subscales were significantly negatively related to the CBI composite and subscales, whereas the MSQ-Short Form Extrinsic subscale was significantly negatively related the CBI composite and four of the five subscales (the exception of being the CBI Incompetence subscale). The MSQ-Short Form Intrinsic subscale was positively and significantly related to the ACSES composite and subscale variables, however, the MSQ-Short Form Extrinsic subscale was not related to either the ACSES composite or subscales. The CBI composite and CBI subscale of Devaluation of Clients were significantly negatively related to all ACSES and MSQ-Short Form composite and subscale scores. The CBI Negative Work Environment was significantly negatively related to the MSQ-Short Form composite and subscales, but not the ACSES composite or subscales. The CBI Incompetence subscale was significantly and negatively related to the ACSES composite and subscales and the MSQ-Short Form composite and Intrinsic subscale, but not the Extrinsic subscale. The CBI Deterioration of Personal Life subscale was significantly negatively related to the ACSES composite and ACSES subscales of Addiction Treatment, Assessment and Treatment Planning, and Skills for Working with Co-occurring Mental Health (but not Group Counselling or Basic Counselling). The CBI Exhaustion subscale was significantly negatively related to the ACSES composite and ACSES subscales of Assessment and Treatment Planning and Group Counselling. The strongest relationships were among the MSQ-Short Form study variables and the CBI composite and the CBI Negative Work Environment subscale, which were both negatively related.

Bivariate correlations of the study variables with gender, experience in the addiction field, and supervision are also presented in Table 4 (variables 16 – 18). Results indicate that

gender was significantly related to the CBI Incompetence subscale. Specifically, male counsellors rated themselves as significantly more competent than female counsellors. Experience was significantly positively related to ACSES composite and its subscales (with the exception of the Basic Counselling Skills subscale) and significantly negatively related to the CBI Devaluating Clients and Incompetence subscales. Specifically, more experience in the addictions field was associated with higher ratings of self-efficacy, with the exception of basic counselling skills, and more experience in the addiction field was related to lower ratings of devaluating clients and feelings of incompetence. Lastly, the presence of supervision was significantly related to MSQ-Short Form composite, MSQ-Short Form subscales, and the CBI Deterioration of Personal Life subscale meaning the presence of supervision was related to higher ratings of job satisfaction and lower ratings of deterioration of personal life.

Multiple Regressions with Mediation

As discussed in Chapter 2, literature supports the predictive relationship between low self-efficacy and low job satisfaction as precursors to burnout. Table 5 presents the results from two hierarchical multiple regressions exploring the predictors of burnout. To control for the significant bivariate correlations of experience and gender on burnout, these variables were entered at step 1, followed by counsellor job satisfaction at step 2, and self-efficacy at step 3. As a group, the variables significantly predicted burnout, $F(4, 101) = 23.05$, $p < .001$, $R^2 = .49$. Experience and gender entered at step 1 were not significant predictors of burnout by themselves, but the entry of job satisfaction at step 2 and self-efficacy at step 3 significantly increased the explained variance. At the final step, job satisfaction emerged as the variable that explained the most variance ($\beta = -.62$, $p < .001$), followed by self-efficacy ($\beta = -.18$, $p < .05$).

Table 4

Bivariate Correlations of ACSES, MSQ-Short Form, CBI Composite and Subscale Scores, and Demographic Variables (N = 110)

Variable	1.	2.	3.	4.	5.	6.	7.	8.	9.	10.	11.	12.	13.	14.	15.	16.	17.	18.
1. *ACSES Composite*	1.00	.87**	.85**	.78**	.73**	.77**	.23*	.33**	.08	-.35**	-.02	-.41**	-.25**	-.23*	-.50**	.09	.34**	-.06
2. AdixRx		1.00	.76**	.60**	.51**	.61**	.20*	.29**	.06	-.32**	-.04	-.35**	-.26**	-.18	-.44**	-.01	.34**	-.05
3. Asplanref			1.00	.64**	.48**	.62**	.26**	.34**	.13	-.34**	-.05	-.29**	-.28**	-.24*	-.45**	.06	.31**	-.02
4. COD				1.00	.36**	.45**	.23*	.24*	.17	-.31**	-.05	-.32**	-.23*	-.17	-.44**	.04	.23**	-.05
5. Group					1.00	.55**	.13	.22*	.00	-.23*	.02	-.32**	-.11	-.20*	-.33**	.19	.32**	-.06
6. Micro						1.00	.12	.23*	-.03	-.22*	.06	-.44**	-.16	-.11	-.34**	-.01	.14	0.00
7. *MSQ- Short Form Composite*							1.00	.93**	.93**	-.65**	-.72**	-.34**	-.46**	-.45**	-.28**	-.09	0.00	.28**
8. Intrinsic								1.00	.74**	-.59**	-.55**	-.36**	-.43**	-.39**	-.35**	-.12	.04	.24*
9. Extrinsic									1.00	-.61**	-.78**	-.25**	-.44**	-.42**	-.16	-.06	-.02	.27**
10. *CBI Composite*										1.00	.74**	.46**	.77**	.84**	.59**	-.11	-.17	-.14
11. NegWorkEnv											1.00	.22*	.47**	.52**	.21*	.04	.02	-.14
12. DevalClient												1.00	.21*	.28**	.30**	.07	-.20*	-.04
13. DetPerLife													1.00	.54**	.35**	-.01	-.09	-.22*
14. Exhaustion														1.00	.34**	-.17	-.11	-.09
15. Incompetence															1.00	-.23*	-.31**	.02
16. Gender																1.00	.20*	-.20*
17. Experience																	1.00	-.24*
18. Supervision																		1.00

Note. AdixRx = Addiction Treatment Skills; Asplanref = Assessment and Treatment Planning Skills; COC = Skills for Working with Co-occurring Mental Health;

Group = Group Counselling Skills; Micro = Basic Counselling Micro Skills; NegWorkEnv = Negative Work Environment; DevalClient = Devaluation of Clients;

DetPerLife = Deterioration of Personal Life.

*$p < .05$, **$p < .01$.

Since the correlations between the CBI Incompetence subscale and the study variables were actually stronger than with the CBI Composite, hierarchical regression was also carried out with Incompetence as the dependent variable. Similar to the previous regression, experience and gender were entered in step 1, followed by job satisfaction at step 2, and self-efficacy at step 3. The variables as a group significantly predicted Incompetence, $F(4, 101) = 14.36$, $p < .001$, $R^2 = .37$. Experience, entered at step 1, was significant predictor of Incompetence ($\beta = -.29$, $p < .01$), whereas gender was not. At the final step, self-efficacy emerged as the variable that explained the most variance ($\beta = -.43$, $p < .001$), with job satisfaction explaining a reduced amount of variance ($\beta = -.20$, $p < .05$).

Table 5

Summary of Hierarchical Regression Predicting Addiction Counsellor Burnout and Incompetence

	Predicting Burnout				Predicting Incompetence			
Variable	β	R^2	ΔR^2	ΔF	β	R^2	ΔR^2	ΔF
Step 1		-.02	.02	1.24		.13***	.13	7.45***
Experience	-.12				-.29**			
Gender	-.08				-.17			
Step 2		.46***	.44	79.25***		.22***	.09	11.20***
Experience	-.12				-.29**			
Gender	-.13				-.19*			
Job Satisfaction	-.66***				-.30***			
Step 3		.49*	.03	5.05*		.37***	.15	23.45***
Experience	-.06				-.14			
Gender	-.13				-.18*			
Job Satisfaction	-.62***				-.20*			
Self-Efficacy	-.18*				-.43***			

Note. * $p < .05$. ** $p < .01$. *** $p < .001$.

After determining job satisfaction and self-efficacy as significant predictors of burnout and incompetence, the mediating effect of self-efficacy was explored. Self-efficacy did not significantly mediate the effect of addiction counsellor job satisfaction on burnout (Sobel's $z = -1.68$, $p = .095$). However, it did significantly mediate the relationship of job satisfaction on incompetence (Sobel's $z =$

-2.23, p = .026). Figure 1 presents the mediation analysis in which self-efficacy has a partial mediating effect on the relationship between job satisfaction and incompetence.

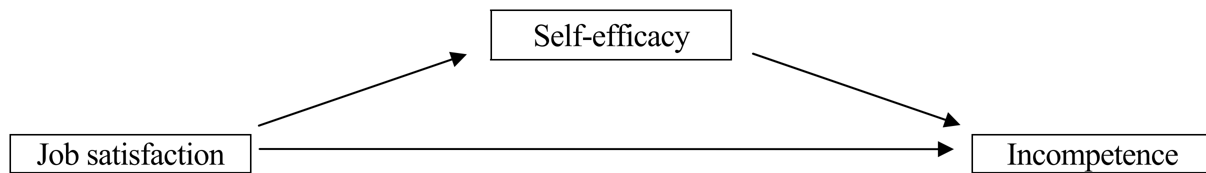

Figure 1. Partial mediating effect of self-efficacy on job satisfaction and incompetence.

Study 2

Brief Overview

Findings from the qualitative interviews provide support for self-efficacy as a mediator in the relationship between job satisfaction and burnout and illuminate three main themes namely, the role of clients, learning opportunities, and organizational factors as influencing the job-related beliefs of addiction counsellors. Appendix I presents counsellors comments with corresponding figures that explain the relationship of self-efficacy and job satisfaction with motivation and burnout. Table 6 presents a detailed chart depicting a content analysis of the qualitative data from Study 2. In Table 6 the job-related variables (i.e., Master Codes) of self-efficacy, job satisfaction, motivation, and burnout are presented along the leftmost horizontal axis, while the Emerging Themes (i.e., role of clients, importance of learning opportunities, and organizational factors) are presented along the vertical axis. For clarity, the Master Codes are further distilled into positive or negative response types. For objectivity, the frequencies of responses are provided next to each content area.

Support for Reduced Job Satisfaction and/or Reduced Self-Efficacy Leading to Burnout

Throughout the interviews, counsellors were asked how they thought confidence, job satisfaction, motivation, and burnout are related (refer to Appendix I for verbatim results). Several counsellors (n = 5) commented that these job-related variables are closely related: “They are first cousins. Any one out of balance will cause consequent negative impacts on the other ones and improvements, often minute; in one of them will lead to improvements in the others” (Jon).

Counsellors agreed that high confidence (n = 4) and high job satisfaction (n = 2) are precursors to high motivation, whereas, low motivation results from low confidence (n = 5) and low job satisfaction (n = 2). Counsellors frequently reflected on the relationship between job satisfaction, self-efficacy and motivation (n = 10) [i.e., “You will be more motivated to learn and grow and

perform if you feel confident in your counselling skills, but also if you are supported in your environment and you have a higher degree of job satisfaction" (Katherine)] .

Of those who reflected on burnout ($n = 5$), three counsellors noted how burnout could result from low confidence or job satisfaction: "[My education gave me] a full bag of magic tricks. If I did not have my education I could not do my job. I think education has a lot to do with it because if you do not have the skills what are you going to do? You are going to get burnt out" (Jodi), and "Dissatisfaction with the job is a big symptom of burnout, that is where it kind of starts, right. Like something is bugging you and you think gee-whiz I am not as happy as when I first started here" (Lydia).

Table 6

Summary of Addiction Counsellor Comments as they Relate to the Themes of Clients, Learning Opportunities, and Organizational Factors (n = 10)

		Emerging Themes with Frequency of Respondents					
Master Code	Clarifier	Clients	*n*	Learning opportunities	*n*	Organizational factors	*n*
Addiction counsellor self-efficacy or 'Confidence'	*Improves*	+ changes (i.e., small - clients willing to change and work)	10	mastery experience (increases confidence and reduce anxiety as a student and at present job)	10	hire counsellors with a passion, natural talent, or personal interest in addiction	4
		client/counsellor relationship established	9	clinical supervision (verbal persuasions)	9	supportive leadership (e.g., environment encourages growth and learning with positive feedback)	4
		with experience, let client live consequence of own behaviour	5	ability to grow from mistakes	7	offer training programs	3
		return for sessions	2	seek out opportunities to improve	7	framework of addictions that encourages counsellors to let clients live the consequences of their behaviour	2
				mastery experience and life experience, more than age, give more accurate perceptions of skills	7	framework of addictions that does not place client abstinence as only goal	1
				Mentorship/use of senior members	7	use of best-practice for addiction	1
				grow from experience as a student not book learning	7		
				book/research learning	6		
				new counsellors are overconfident, but increase accuracy in self-perceptions with experience	6		
				education, but not ability			table
				high comfort level	2		continued

Master Code	Clarifier	Clients	*n*	Learning opportunities	*n*	Organizational factors	*n*
Addiction counsellor self-efficacy or 'Confidence'	*Reduces*	present many problems/overwhelming	6	high level of anxiety/discomfort (especially when new to the field)	5	caseload – when booking so far into the future, counsellors question how effective they can be	2
		reaction to counsellors (younger counsellors may be perceived by clients as less skilled)	3				
Confidence for working with COC client populations	*Improves*	daily contact/successful experiences	2	training in COC (unique population)	10 (9)	training opportunities	9
				clinical supervision	9		
				collaboration with psychologist/psychologist	7		
				successful experience working with COC	7		
				university practicum	2	acknowledge COC are a unique subtype of client to work with	9
				Genuine interest in COC	2	daily experience/exposure to COC in treatment centres	6
				experience working with mental health clients	2	collaboration with psychologist/psychiatrist at treatment centre	3
	Reduces	relapse rates	2	fear of harming COC	5	previous healthcare system that considered mental health and addictions as separate entities requiring segmented services (Note: counsellors commented how this is changing and currently improving their confidence)	3
				higher level of anxiety	2		
		slower process, more re-entries, gains are slower and not as big	2	avoidance of COC client type in caseload	1		table continued

Master Code	Clarifier	Clients	*n*	Learning opportunities	*n*	Organizational factors	
Confidence for providing group counsel	*Improves*			successful experience	10	provide opportunity to for successful experiences	10
				co-facilitation (learn and grow from strengths and weaknesses of other counsellors)	8	provide training opportunities/supervision	9
				observe sessions (modeling)	8	require co-facilitation	3
				supervision	7		
	Reduces	more intimidating/dynamic group of people to work with, compared to individual counselling	3	lack of experience	10	complexity of services provided, not all counsellors are required to run group or are exposed to group therapy	5
		immature/unwilling to participate	2	lack of training (education)	4		
				high level of anxiety	3		
Job satisfaction	*Positive contributors*	+ changes	5	let go of where counsellors want clients to be	3	support from management, supervisors, coworkers	6
		returning post-treatment to express gratitude	3	be a new learner, not incompetent, but new (year 6 – 7 on job)	3	policies that protect counsellors (i.e., policies around safety)	5
		ability to help others	2	look for small changes	2	fluid transitions for clients	2
		empowering clients	2	teaching co-workers	2	praise and affirmation	2
		teaching clients	2	opportunities to work on programs that will support counsellors	1	encouraging staff to point out policies/practices that do not make sense ‘stupid hunting’	1
						feeling heard by management	1
		connecting with clients	1	knowing that you can do the job	1	communication – kept up to date with the amalgamation	1
	Negative contributors	relapsing clients	5	not able to take courses because they come at the expense of client services	2	structured environment or canned program prevents creativity/individuality	6
		overwhelming caseload	3			need more flexible work environment (e.g., compressed work week, flex time)	5
		clients who cannot commit	1			top-down communication	5
		struggling clients	1			poor compensation (expect improvement with amalgamation)	5

table continues

Master Code	Clarifier	Clients	*n*	Learning opportunities	*n*	Organizational factors	*n*
Job satisfaction continued	*Negative contributors*					hierarchy prevents professional growth	4
						need more positive feedback/ recognition	4
						unsupported by management	4
						micromanagement	3
Motivation	*Contributors*	form client-counsellor relationship	4	personal/professional development, despite relapse rates	4	positive feedback from supervisors	2
		moments of closure	4	allow clients to live the consequences of their behaviour	4	ceremonies that share client success	2
		motivated clients	3	meaning that comes from the job	2	opportunities to contribute to program development	1
		days clients graduate from the program	2	reminder of how resilient people are	1	comes from management (top-down)	1
				saying 'yes' to addiction counselling each day	1		
	Reducers	stuck clients	2	unsuccessful experiences	3	dissolving a world class organization	1
Burnout	*Contributors*	taking on stress from clients (vicarious trauma or compassion fatigue)	5	not intermalizing it is the clients who make changes, not counsellors	6	caseload	3
		client type	3	lack of counsellor skills (need skills to do this job)	3	overwhelming paperwork	2
		not seeing results	3				
		hard to rate success on client abstinence and changes	2			poor communication within a treatment centre	2
						lack of coordinated goal between the organization and treatment centre	1
						hiring counsellors who are a poor match	1

table continues

Master Code	Clarifier	Clients	*n*	Learning opportunities	*n*	Organizational factors	*n*
Burnout continued	*Prevention*	focus on client-counsellor relationship, not client relapse	7	insight into one's own well being/setting clear boundaries	5	supportive work environment (co-workers look out for one another, management/supervisors respectful to counsellors who need to refuel, daily meetings, reflection teams, resources provided to improve self-care)	10
				educational background, theoretical framework of addictions	4		
				counsellor self-care	4		
				learn to let clients live consequence of own behaviour	1		
				resist temptation to overwork	1		

Theme 1: Role of Clients

Counsellors from Study 2 highlighted the importance of clients making positive changes, the nature of the client-counsellor relationship, relapsing clients, and client-type as affecting individual job-related confidence, satisfaction, motivation, and burnout (refer to the 'Clients' column in Table 6). All counsellors (n = 10) highlighted, "the importance of clients making small positive changes" (Cody) for improving confidence. However, they (n = 9) further explained that rather than basing their own success on client changes it is more important and less "frustrating" (Niki) and "difficult" (Kari) to base their success on the client-counsellor relationship: "I look at whether or not I am successful in my relationships with my clients – if they can share things openly and honestly and contact me, whether they are struggling or not" (Kari), and "I measure my success largely on the relationship that I am able to build with my clients, the feedback I am getting from my clients, and the responses of my clients" (Katherine). Some counsellors suggested (n = 5), that with experience counsellors are better able to "allow clients to live the consequences of their behaviour" (Jon) and when working with clients who "cannot make a commitment [to] just let go of them and detach. I just let them be. What am I supposed to do? Save them? I just cannot do it" (Jodi).

When recalling moments of high job satisfaction most counsellors described instances when clients made positive changes (n = 5), followed by occasions when clients returned to the treatment centre to share their stories of post-treatment sobriety (n = 3), and the opportunity their job provides to help (n = 2), empower (n = 2), and teach clients (n = 2).

> I get a huge sense of reward [at my job] because I watch people step outside themselves, try different behaviours and ways of communicating, and try to express themselves and identify their emotions better. As well, I have [had] several clients who have come back after six

months of sobriety or a year and that is immensely rewarding knowing that I had a small piece in that (Kari).

As Jodi recounted, when clients return to express gratitude this reinforces the program's effectiveness and emphasizes the importance of the counsellor-client relationship:

> It's like just seeing me doing outreach, even though I do not talk to [my former clients], I know it is working. Sometimes I wonder about this program, but we are starting to see results because people have come to know us.

Job motivation was said to occur as a result of client-counsellor relationships (*n* = 4), moments of closure (*n* = 4), working with motivated clients (*n* = 3), and client graduation day (*n* = 2). Jon commented:

> I am energized and motivated at times where there is closure. It feels like the client has changed by Prochaska and DiClemente's Transtheoretical Model (Prochaska, Norcross, & DiClemente, 1994). They have moved from preparation to maintenance or maybe even contemplation or pre-contemplation. The metaphor I use is sowing water by the river. We are really privileged to be able to travel with people when they are doing that sort of stuff.

Similarly, Kari noted:

> I get really energized when people are motivated and actively working on changes. I equate it to watching someone get healthier in their physical habits. It is inspiring to watch people do something like that and it is kind of the same feeling you get when you watch people make changes in their mental health or lifestyle.

Reduction in job satisfaction was associated with relapsing clients (*n* = 5) [i.e., "I wound up with a good connection with a client and he wound up relapsing. I did not like that part of it" (Sierra).], overwhelming caseloads (*n* = 3) [i.e., "I am sure compassion fatigue affects me to some

degree, but not to the degree that having too many things on the go at work does" (Anna).], and un-committed (*n* = 1) or struggling clients (*n* = 1):

> Watching people struggle is probably the hardest part. I would like for them to be healthier and making better choices and changes, but I think I have found a way to deal with that so it is not as unsatisfying. I have learned to let go of where I would like them to be and that everybody is where they are in their journey and as much as I would like them to be in a different place that is where they need to be and I need to be [there] with them (Kari).

Counsellors reported taking on the stress from clients (i.e., compassion fatigue and vicarious trauma) (*n* = 5), challenging client-type (*n* = 3), and not seeing results (*n* = 3) as major contributors to burnout. In discussions of burnout counsellors repeatedly referred to the importance of having clear boundaries and self-care: "Our clients come in and a lot of the time they are under stress. It is not a pretty picture and sometime just dealing with that stuff is draining" (Lydia) and:

> I see counsellors take on the client issues and allowing negative discussions about events that have taken place in the client's life effect their day. Counsellors sometimes lose sight of their boundaries and what they need to do for their own self-care (Cody).

Counsellors (*n* = 2) with more than a decade of experience commented on the change in client type over the past 10 years. As Jon articulated, clients entering treatment today are generally younger and struggling with stimulant addiction and have a much higher prevalence of co-occurring disorders, which require ongoing learning and training to reduce the "jacked up anxiety."

Summary of theme 1: Role of clients. When the addiction counsellor Study 2 research participants were thinking about confidence, job satisfaction, job motivation, and burnout they all recognized that clients have a large effect on their job-related beliefs. When clients make positive changes this increases counsellor confidence, job satisfaction, and job motivation, however,

counsellors base more of their success on the relationships they are able to build with their clients. For most counsellors, basing success on client changes is both difficult and frustrating. With experience, counsellors recognized that they are able to detach from clients and recognize that clients make the changes, not the counsellors. Furthermore, counsellors recognized that clear client-counsellor boundaries and self-care are necessary to prevent job burnout.

Theme 2: Importance of Learning Opportunities

Counsellors from Study 2, regardless of age, gender, or experience in the field, highlighted the importance of learning and professional development opportunities as contributing to confidence, satisfaction, and motivation, while lack of skills was described as contributing to burnout (refer to the 'Learning opportunities" column in Table 6).

In discussions of confidence for addiction counselling, working with clients with co-occurring disorders, and group counselling counsellors mentioned the four conventional sources of self-efficacy (i.e., enactive mastery experiences, verbal persuasions, vicarious learning, and somatic complaints) and added the importance of research or book learning. Specifically, counsellors recognized successful past experiences (i.e., enactive mastery experiences) as the most important source of confidence [for addiction counselling (n = 10), working with co-occurring disorder clients (n = 7), and group counselling (n = 10)]. As Sierra commented:

> The more experience you have, you run into so many different types of clients, with different capabilities, different levels of where they are at, and even cognitive abilities. Until you have met up with a variety of clients or developed confidence working with different subsets you just do not have the experience to say 'Yes, I can tackle any issue.'

For most counsellors, (n = 9), verbal persuasions from supportive clinical supervisors also increased confidence for addiction counselling:

> [When I did not really know what I was doing] I looked to my supervisor who was an absolute wizard and he made it ok to learn and grow [on the job] and [reassured me] that I was still helping even though I was not the expert or seasoned veteran (Katherine).

Counsellors (*n* = 8) also highlighted that modeling (i.e., vicarious experience) was especially helpful when developing confidence for facilitating groups as most counsellors joining the workforce "have less training and experience in that skill set" (Sierra). Many counsellors (*n* = 5) also recalled being anxious when they first started working as addiction counsellors: "From when I first started counselling to now, I am much less anxious than I used to be. [When I first started] I was scared to death" (Jon) and "As my understanding of people, their behaviour and mental health has gotten stronger my comfort level in working with addictions has gotten stronger as well" (Kari). Several counsellors (*n* = 6) interviewed also described referring to the internet, books, or research materials, in addition to other sources, to improve their confidence in a particular area: "[To improve my confidence] I would read four books, talk to six people, talk to my mentor and consciously look for opportunities to get better" (Jon).

When discussing job satisfaction and motivation many counsellors (*n* = 3 and *n* = 4, respectively) commented on how their personal approach to addiction counselling has evolved and the importance of continual professional development opportunities. As Sierra commented "I have improved so much as a counsellor throughout the training, working with clients, and great supervision. I now know that my counselling skills are a lot better than when I first started." Lydia noted that being in a position where she can improve her skills on a daily basis "from experience, encouragement, and positive feedback" contribute to her motivation as it is from these sources that she finds meaning in her job:

> I am learning a lot everyday that I am here and that is a really big thing for me. It is really motivating because I feel like my skills are growing everyday and everyday there are new challenges, new people, new situations, and new ideas. I would have been gone from here a long time ago [if it was otherwise] because it is really important for me to feel like I am growing everyday in the position that I am in (Lydia).

As students, counsellors (*n* = 7) agreed their confidence was increased by exposure to practical experience, more so than through their program coursework or book learning: "What sets me apart is my practicum and experience. Having your peers and ongoing supervision when you are doing your practicum is huge because that is when the big learning comes into play" (Kari). Similarly, Sierra pointed out that when she completed a one year counselling certificate she "was a pretty darn good counsellor", but it was not until she graduated with a bachelor's degree that she was actually able to become a counsellor: "It is not education per se that improves our skills, but the practicum and actual counselling experience."

A few (*n* = 4) counsellors indicated that level of education may affect counsellor confidence, but not necessarily ability, as counsellors with graduate degrees are treated differently and "presented more opportunities for advancement and receive increased compensation" (Katharine).

In addition to improving confidence, a few counsellors (*n* = 4) indicated their educational background provides a theoretical framework that prepared them for the stress and strain associated with addiction counselling. As noted earlier, a counsellor with a social work background explained that education contributes to confidence and reduces burnout because it provides "a full bag of magic tricks. If I did not have my education I could not do my job. I think education has a lot to do with it because if you do not have the skills what are you going to do? You are going to get burnt out" (Jodi). Counsellors (*n* = 4) with backgrounds in addiction and/or psychology noted the importance of

'self-care' and 'insight into one's own well-being' for improving confidence and competence, and reducing burnout and turnover.

Counsellors mostly agreed ($n = 6$) that counsellors "fresh out of university" (Kari) are over confident in their skills and believe they "are way more helpful than they actually are" (Jon). As Jodi noted "When we leave school we are going to be really confident, but after time we realize that we do not know everything, but by then experience has kind of caught up to us and if there is anything that we need to know, we have the skills to find the answer." As Jon suggested, confidence in relation to ability is more accurate around year "five to seven."

Co-occurring disorders. Counsellors were asked why as a workforce they may be less confident in treating clients with co-occurring addiction and mental health related problems compared to other counselling skills. Most counsellors ($n = 9$) suggested that clients with concurrent disorders present unique challenges that require additional knowledge and mastery experiences to reduce anxiety. Although a couple counsellors ($n = 2$) were able to translate their confidence for working with mental health patients to clients with concurrent disorders Cody noted:

> I was probably more confident in my abilities than I should have been coming into this treatment centre to deal with co-occurring [disorders]. Co-occurring disorders present a new set of dynamics that are much different than working with clients who have either mental health or strictly addictions.

In addition, counsellors ($n = 5$) mentioned not wanting to cause harm to their clients or doing anything remotely close to that and working with concurrent disorder clients increases the "fear of harming them" (Lydia) and "jacks up anxiety dramatically" (Jon). To improve confidence for working with clients with concurrent disorders counsellors suggested the use of training ($n = 10$),

clinical supervision (*n* = 9), successful experiences (*n* = 7), and collaboration with psychologist and psychiatrists (*n* = 7) to reduce anxiety.

Counsellors (*n* = 2) with higher ratings of confidence for treating concurrent disorders described having a specific interest in co-morbidity that sparked their desire to acquire further knowledge and skills for working with this population. These counsellors describe actively seeking out learning opportunities. As Melissa commented:

> I am always reading and educating myself. I have finished reading the casebook of DSM so I am more confident in it. I work with many clients, many of whom are diagnosed and not diagnosed and I am really just very interested in it.

Further, highlighting an avoidance type of behaviour one counsellor recalled that in the past she would not even pick up a client with a known co-occurring disorder. She further acknowledged that clients with co-occurring disorders are not her favourite type of client because "they return more often and it's a slower process" (Niki).

Groups. Counsellors were asked why they might have less confidence in their group counselling skills as compared to other counselling skills. Respondents (*n* = 10) suggested the main reasons were having limited mastery experiences in group counselling, limited training in group facilitation, and the unique dynamics that each group presents. Furthermore, Jon commented:

> With the increasing complexity of addiction services, the numbers of tasks have increased and people are doing less and less group [work]. Group [counselling] can be pretty stressful if you do not do it, but if people do group for a while with clinical supervision they would be fine.

As well, Katherine described that "in school you do not learn quite as much about group [counselling] and may not get a whole lot of exposure to it if your practicum site or internship does

not offer it. And groups can be intimidating if you do not have experience or lack confidence in it." To improve confidence for group facilitation, counsellors suggested the use of mastery experiences ($n = 10$), training opportunities [co-facilitating and formal learning ($n = 8$)], modeling [vicarious experiences ($n = 8$)] and clinical supervision ($n = 7$).

Summary of theme 2: Leaning opportunities. Counsellors highlighted the four major sources of confidence (i.e., enactive mastery experiences, vicarious learning, verbal persuasions, and modeling) in their interviews and added that confidence can be improved by book or research learning. However, counsellors agreed that experience is the greatest source of confidence, even more so than post-secondary courses. Counsellors recognize that clients with co-occurring disorders are a unique type of client and generally believe that counsellors need more training, clinical supervision, and successful experiences to reduce their anxiety. Counsellors suggest that not every addiction counsellor is required to facilitate group therapy, but of those that are confidence can be improved by successful experiences, training opportunities (co-facilitating and formal learning), modeling, and clinical supervision.

Theme 3: Importance of Organizational Support

Counsellors from Study 2 highlighted several aspects of their organization (such as continual opportunities for training and a supportive work environment) as contributing to confidence, job satisfaction, motivation, and the prevention of burnout (refer to the 'Organizational' column in Table 6). In discussions of confidence counsellors most often commented on their organizational framework of addictions ($n = 5$), the importance of their organization hiring counsellors with a genuine interest in addictions ($n = 4$), and support across the organization that encourages counsellors to continually grow and learn ($n = 4$). Working under a framework of addictions that "meets the client where they are at and views the client as fully responsible and capable for their own decisions"

(Sierra) compared to a pure abstinence approach was associated with increased confidence for several counsellors (*n* = 5).

Some counsellors (*n* = 3) expressed concern about heavy caseloads although one counsellor noted “the increasing volume of intake is very much out of our control [and] is the nature of civil service, which is a conundrum shared by public health agenc[ies] across North America” (Jon). Two counsellors indicated heavy caseloads limits the number of clients they can see in a day, which leads to questioning their effectiveness:

> You start questioning how effective you are as a counsellor if you can only see this person once or twice a month and they are higher needs. It is caseload versus available time to get all the administrative stuff done like furthering your own learning through training (Anna).

Counsellors noted that their organization’s approach to clients with co-occurring disorders has made some positive changes, which are improving the counsellor confidence for working with these clients. Specifically, counsellors (*n* = 9) mentioned receiving training opportunities: “Our site is doing some good stuff with clients with co-occurring disorders. We have a psychiatrist that comes in on a weekly basis. We can refer our clients to them so there is quick access and consultation” (Katharine), “We do a lot on best practices for addiction and have a senior member who is teaching [the counsellors] cognitive behavioural therapy” (Jon), “There are courses that we can take on concurrent disorders from [our organization]” (Lydia); and daily exposure to clients with both diagnosed and undiagnosed mental health related problems (*n* = 6).

Counsellors commented on their organization as contributing to their confidence for facilitating group sessions by providing counsellors with opportunities for successful experiences (*n* = 10), training and supervision (*n* = 9), and requiring co-facilitation (*n* = 3). However, many

counsellors acknowledged that not all counsellors working at their organization are required to facilitate groups (*n* = 5).

When discussing job satisfaction counsellors highlighted several features of their organization that contribute their individual job satisfaction. Counsellors most often mentioned the support from management, supervisors, and co-workers as contributing to their job satisfaction (*n* = 6): “I use clinical supervision, mentorship, and I have a wonderful boss. I really love this place” (Jon), “We are pretty lucky in that we [addiction counsellors and staff] tend to watch out for one another” (Sierra), and “Our manager is specifically very good. He is considerate with staff, very supportive, very fair, and very understanding of personal circumstances” (Katherine). Counsellors (*n* = 5) also commented on the organizational policies surrounding safety as contributing to their satisfaction.

Counsellors commented on several features of their organization that reduce their job satisfaction. Over half the counsellors interviewed commented on the structured environment as reducing their job satisfaction (*n* = 6):

> When there was a lot of control stuff going on and rigidity [it] really bothered me because when [you] have come to a point in [your] life when [you] are accepting of [yourself] and wanting to make the most of [yourself] and a part of that is in the work that you do, where you cannot be yourself and have to fit into this role that the institution or particular location wants you to be. It is very, very, difficult and frustrating” (Lydia).

Lack of flexibility (*n* = 5) [i.e., “I see how there is a very structured, rigid approach to how we are managed and supervised here and I can see how that contributes to peoples unhappiness because there is not a lot of flexibility or opportunity to have individuality” (Kari).], top-down style of communication (*n* = 5) [i.e., “When decisions are put into place without any consultation with the

counsellors in a very top-down style, then counsellors generally feel discounted, unimportant, and not valued" (Katherine).], and compensation ($n = 5$) [i.e., "It is ridiculous that it is so low paying, but maybe accreditation will help with that" (Jodi) and "I would like to see better service awards, more recognition financially, more recognition in terms of vacation time" (Katherine)] were also mentioned as reducing job satisfaction.

Although only discussed in a single interview, the concept of generational perception was mentioned as a possible contributor to reduced job satisfaction. This particular counsellor wondered if younger generations of front line workers may have higher expectations and less experience working in awful places. Given this counsellor's previous experience working in 60 to 70 hour work weeks, in a non-unionized environment, "where you look over your shoulder and if at the end of the shift and you are alive, it is a good day" (unanimous), it is understandable that this counsellor considers [him/herself] fortunate to be working with the present organization.

When discussing job motivation a couple of counsellors ($n = 2$) noted moments when they received positive feedback from their supervisors:

> [I was really energized and motivated] in a situation where I received really good feedback from my supervisor and was commended on the work that I had been doing and that it had not gone unnoticed. [This] just reaffirms the things that you hope you are learning and that they see it and that you know you are on the right track (Anna).

Other counsellors ($n = 2$) mentioned the importance of ceremonies to celebrate client success: "At [my treatment centre] there is a ceremony each Friday and that is where the client graduates the program…that is just the best" (Sierra).

All counsellors ($n = 10$) indicated a supportive work environment as the best prevention of burnout. Specifically, counsellors mentioned "having so much support here. I know I will be at this

job for a long time" (Anna), "we are pretty lucky in that we tend to watch out for one another" (Sierra), "I guess my job is extra enjoyable when I get a colleague who wants to observe me and wants to learn. We get to review and debrief and share 'Oh my goodness, did you see how that worked?'" (Melissa), "if there was anything [i.e., policy] that counsellors thought was stupid, they were asked to report it. How many managers would do that?" (Jodi) and "we try to promote the concepts [of self-care] and we have a committee to encourage staff to look at where they are. Are they feeling healthy? And what kind of things they can do to distress" (Cody). Jon noted that at his treatment centre, counsellors are supported "on a daily basis by receiving 'thanks' and in instances where we have handled clients well then we receive specific details in terms of specific affirmation and then unit affirmation."

Summary of theme 3: Organizational factors. Counsellors from Study 2 highlighted the importance of support from colleagues, management, and leadership as contributing to their confidence, job satisfaction, motivation, and prevention of burnout. Counsellors also mentioned the training opportunities their organization provides to them as contributing to their confidence. Lowered job satisfaction was considered by counsellors to result from a structured and rigid management approach in which they are managed which does not allow for counsellors to be creative or show individuality.

CHAPTER 5

Discussion

The purpose of this research was to discover and describe the relationships of self-efficacy, job satisfaction, motivation, and burnout among addiction counsellors. Although previous studies have supported the influence of counsellor motivational beliefs, such as self-efficacy, on client outcomes this study adds to the current research literature by using a mixed methods approach. In this final chapter, an integrated summary and discussion of the quantitative Study 1 and qualitative Study 2 findings are presented along with a description of the study's limitations and implications for future research and application.

Summary and Discussion of Findings

General Findings

Consistent with the generally accepted theoretical perspective of SCT, it was expected that self-efficacy would positively correlate with job satisfaction, experience, and supervision and negatively correlate with burnout. Furthermore, it was expected that the qualitative results from Study 2 would add contextual details by eliciting elusive and experiential information, which indeed occurred as interviewees highlighted the crucial role of clientele, learning opportunities, and organizational factors on their job-related beliefs that would have otherwise remained latent. This combination of quantitative survey research with qualitative 'insider' or emic perspective provides support for and emphasizes the rich and complementary information that may be gathered from using a mixed methods approach.

Specific Findings

Self-efficacy. Results from Study 1 indicate that counsellors are less confident in their skills for treating clients with concurrent disorders and their skills for group counselling, compared to their

skills for basic counselling, addiction treatment, and case management. Results from Study 2 enrich these findings by adding that counsellors tend to experience greater levels of anxiety when they have less experience (i.e., are newer to the profession or are not experienced at the task), are working with clients with co-morbidity, and/or are providing group counsel when they perceive this task above their skill set. Counsellors referred to Bandura's (1977) proposed sources of self-efficacy: interpretation of successful past experiences, vicarious experience, verbal persuasions, and somatic experiences. The counsellors' inclusion of book and research materials perhaps highlights that changes in technology over the past three decades and present day ease of access to quality (i.e., best practice resources) information—through the internet and various media sources. Bandura would likely concur that such research materials increase efficacy expectations which do not require self-knowledge of one's ability to successfully perform a task.

Similar to Bandura's SCT (1997) and Adams and Gallon (1997), counsellors agreed that successful experience is the most essential source for the development of positive self-appraisals of one's own skills and for the development of accurate self-efficacy. Given that "successful performance depends on realistic evaluations" (Klassen & Lynch, 2007, p. 502) of one's strengths and weaknesses this implies that supervisors or counsellor educators working with counsellors new to the profession should provide accurate appraisals of counselling skills by providing honest feedback, coaching and counselling in areas that need improvement, and recognizing areas where performance is at least satisfactory to enhance self-efficacy (Larson & Daniels, 2001).

Study 2 reinforces Bandura's concept of reciprocal determinism which suggests that human behaviour is both influenced by and influences a person's cognition and social environment, as counsellors mentioned the continuous interaction among their individual cognitive and affective processes, and collective social and organizational culture. For example, counsellors with confidence

to treat clients with co-occurring disorders indicated they purposely seek information sources (i.e., courses, mentors, senior members) and opportunities to improve their skills (i.e., clinical supervision, vicarious learning, and successful experiences), suggesting this opportunity-seeking behaviour results from a high level of confidence. Furthermore, counsellors highlighted the positive effect of their organization's framework of addictions (i.e., meeting clients where they are) which encourages counsellors to let clients live the consequences of their behaviour, rather than taking a pure abstinence approach whereby sobriety is considered the only indicator of a successful outcome and counsellors are encouraged to be accountable for their clients' choices. Counsellors commented that once their organizational framework of addictions is internalized, confidence and job satisfaction improve as the individual and collective goal is perceived as attainable compared to a goal of pure abstinence, which is not always achievable—let alone sustainable—given the high relapse rates of addictive behaviours.

Moreover, counsellors noted that with the advent of the unified health care system whereby addictions and mental health are treated under the same umbrella and addiction and mental health treatment providers work collaboratively, counsellors are becoming more confident in their skills and rather than 'avoiding' or referring co-morbid clients to other care providers, these counsellors are actively working with psychologists and psychiatrists and seeking out opportunities to improve their skill set in the area (Caprara, Barbaranelli, Borgogni, & Steca, 2003; Grau et al., 2001). This suggests that organizations which develop and reinforce employee confidence for certain skills may increase motivation for professional development and opportunities for professional development may also increase employee confidence, which may in turn translate into improved client outcomes (Stoffelmayr et al., 1999; Siqueland et al., 2000; Grau et al., 2001; Judge & Bono, 2001).

Most counsellors recognize that, as front line staff, they frequently work with clients with concurrent disorders (both diagnosed and undiagnosed), but depending on their treatment centre, may or may not be required to provide group counsel. Therefore, counsellors agreed that professional development should be available to all counsellors for co-occurring disorders and correspond to job requirements when group counsel is expected.

Job satisfaction. Similar to previously-reported literature, counsellors in this study are more satisfied with the intrinsic aspects of their work (i.e., their work itself), compared to the extrinsic aspects (i.e., conditions of their work) (Evans & Hohenshil, 1997; Gallon et al., 2003). This is consistent with Oberman's (2006) findings that counsellor educators were most satisfied with the work itself, interpersonal relationships, and achievement and least satisfied with policy, administration, supervision and salary. Themes from Study 2 emphasized the role of motivated and appreciative clients (e.g., clients learning to make healthy choices, positive lifestyle changes, achieving sobriety, or expressing gratitude), and a supportive and healthy work environment (e.g., the presence of continual learning and professional development opportunities; opportunities to use skill set; affirmative and collaborative communication among co-workers, management, and leadership; and adherence to policies that promote the well-being of staff) as contributing to job satisfaction. In contrast, reduced job satisfaction was associated with clients failing to making positive changes or relapsing (especially among less experienced counsellors), heavy caseloads (impeding counsellors ability to complete training opportunities and reduce counsellor perception of their ability to effectively counsel), top-down decision-making processes, and compensation.

According to Herzberg's Two Factor Theory (1959), job satisfaction and dissatisfaction act independently of one another meaning that certain features in the workplace may cause job satisfaction (i.e., intrinsic motivators: opportunities for achievement, recognition, work itself,

responsibility, personal growth, and promotion), whereas, other features may cause job dissatisfaction (i.e., hygiene factors: organizational policy, quality of supervision, relations with management, work conditions, salary, and relations with others). Therefore, rather than occurring on a single continuum, Herzberg suggests that job satisfaction and dissatisfaction are bi-directional constructs that act independently of one another. In addition, Herzberg theorized that external or 'hygiene factors' only cause the presence or absence of job dissatisfaction (rather than contributing to job satisfaction) and only result in short-term motivation, whereas, the presence of intrinsic motivators result in long-term job motivation.

Given that financial compensation was mentioned by several counsellors in Study 2 as contributing to reduced job satisfaction and has been associated with reduced organizational commitment in the literature, further research is necessary to determine if non-tangible rewards (i.e., praise and recognition), as suggested by Knudson et al. (2003) would indeed be interpreted by employees as comparable in value to monetary recognition.

Motivation. Results from Study 2 highlight the energizing effect of working with motivated clients who make positive changes, successful counselling experiences, effective programs, nourishing work environments that promote continual opportunities to learn and grow, and the intrinsic rewards of addiction counselling. Counsellors did not consistently or explicitly associate episodes of high motivation with achieving predetermined personal goals in their recollections of moments of high motivation as Csikszentmihalyi (1997), Emerson, (1998) and Halbeslem and Bowler (2007) conceptualize motivation. Counsellors did, however, highlight a heightened personal engagement or 'flow' in their occupation as a result of such experiences.

Burnout. Results from Study 1 suggest that most counsellors are not experiencing high levels of burnout since as a workforce they occasionally (i.e., sometimes-to-rarely) experience a negative

work environment and exhaustion and rarely experience devaluation of clients, feelings of incompetence, and deterioration of personal life. According to Study 2, contributors of counsellor burnout include the draining effect of working with clients who frequently relapse and/or who have more severe addictions, heavy caseloads, vicarious trauma, and compassion fatigue. Similar to Schaufeli and Peeters' (2000) conceptualization of burnout, counsellors noted that burnout is a process that develops over time and occurs along a spectrum. Perhaps offering further support to the notion that counsellors in this study are not experiencing high levels of burnout is their frequent description of overwhelming caseloads which according to Shaufeli and Peeters (2000) refers to the first stage of burnout whereby an imbalance of resources and demands leads to job stress. The next two stages of burnout, according to these authors, include the depletion of emotional resources and development of negative attitudes and behaviours leading to a detached and mechanical manner of interacting with clients in an attempt to reduce emotional exhaustion. This ineffective method of coping, however, impedes the counsellor-client relationship which in turn negatively affects feelings of personal goal accomplishments resulting in self- doubt and feelings of incompetence. The final stage of burnout is classified by a reduction of personal accomplishment (Schaufeli & Peeters, 2000).

Relationships among self-efficacy, job satisfaction, motivation and burnout. Results from Study 1 suggest that higher self-efficacy is bi-directionally related to higher job satisfaction and both of these constructs are bi-directionally related to lower levels of burnout, which is supported by previous literature and the qualitative findings from Study 2 (Jex & Bliese, 1999; Grau et al., 2001; Schwarzer & Hallum, 2008; Caprara et al., 2003; Yousef, 2002). Findings from Study 1 indicate self-efficacy demonstrates a positive bi-directional relationship with intrinsic job satisfaction, and negative bi-directional relationships with several components of burnout: incompetence, devaluing clients, deterioration of personal life, and exhaustion. Interestingly, results from Study 1 suggest self-

efficacy is not bi-directionally related to extrinsic job satisfaction (i.e., the conditions of one's work). Overall job satisfaction, however, is bi-directionally related to self-efficacy for addiction treatment, assessment and treatment planning, and skills for working with clients with co-occurring addiction and mental health, but not bi-directionally associated with group counselling or basic counselling skills. As expected, the strongest bi-directional relationship suggests that higher extrinsic job satisfaction is associated with a lower negative work environment. Further, male counsellors tend to rate themselves as less incompetent than do females and work experience is bi-directionally associated with higher ratings of self-efficacy (with the exception of basic counselling skills) and lower ratings of incompetence. Finally, the presence of supervision is bi-directionally related to higher job satisfaction and lower deterioration of personal life.

Results from the regression analysis with mediation are twofold. Findings from the entry of experience, gender, job satisfaction and self-efficacy, suggest job satisfaction is a stronger predictor of burnout than self-efficacy, with the combined variables explaining 49% of the variance of burnout. In contrast, entering the same variables of experience, gender, job satisfaction and self-efficacy, to predict incompetence suggests that self-efficacy, rather than job satisfaction, is the stronger predictor of incompetence, with the combined variables explaining 37% of the variance.

Quantitative findings from Study 1 support self-efficacy as partially mediating the relationship between job satisfaction and incompetence. These findings are further supported by the qualitative Study 2 findings that indicate counsellors who believe they are not skilled to do the job (i.e., low in self-efficacy) and are not supported by their treatment centre and do not receive continual training opportunities (i.e., low in job satisfaction) are more likely to experience burnout in the form of incompetence. To prevent or reduce incompetence counsellors would likely receive benefit from improving their confidence, which can be done by increasing exposure to successful mastery

experiences, verbal persuasions, and vicarious learning opportunities, and reducing somatic complaints.

Results from Study 2 highlight the interconnectedness of the study variables and present a more complex picture than portrayed in Study 1. In the interviews, counsellors spoke of their clients, ongoing learning opportunities, and organizational features as influencing their confidence, job satisfaction, motivation and burnout. Overall, results from Study 2 suggest that self-efficacy may play a particularly important role in reducing feelings of incompetence and work in collaboration with job satisfaction to prevent burnout. It is hoped that results from this study will inform administrators and policy makers who wish to improve confidence and job satisfaction, and reduce burnout among addiction counsellors.

Provided that counselling efficacy is greatly affected by counsellor's organizational framework of addictions as this framework sets the stage for collective and individual goals affecting their personal measures of success. This supports an ecological perspective whereby human behaviour (i.e., setting and obtaining goals in one's career) may be predicted by individual and collective motivational beliefs.

Practical Implications

The practical implications of this study may be applied at an individual counsellor or organizational level. Since the presence of job satisfaction and confidence are considered to reduce burnout and incompetence and increase motivation, attempts should be made to increase both job satisfaction and self-efficacy. Specifically, findings from this study indicate counsellors will more likely be satisfied if they find intrinsic meaning in their jobs, perceive small positive changes in their clients as indicators of successful intervention, have clear boundaries and do not take on client issues, feel supported by management and leadership (i.e., receive praise and affirmation), are able to

express individuality and creativity, and have opportunities to grow professionally. Similarly, management can support counsellors by hiring a workforce that acknowledges the vital and valuable services that addiction workers provide, taking preventative steps to ensure counsellors do not suffer from compassion fatigue, providing opportunities for counsellors to take on greater responsibly and increasing autonomy, and continuing to provide direct and indirect opportunities for professional development.

From an organizational perspective, several of the stressors and strains listed by addiction counsellors may be difficult for the organization to influence (i.e., client relapse rates, increasing client complexity, etc.). Therefore, improvement of professional self-efficacy may be paramount for maintaining a healthy and effective workforce. To improve self-efficacy counsellors should receive accurate verbal persuasions, be provided opportunities to observe 'successful' counselling sessions, be coached on methods to reduce anxiety, and receive opportunities to acquire successful experiences (Bandura, 1977). Findings from Study 2 also indicate that the provision of specific training opportunities should continue, along with clinical supervision, mentorship, and delivery of best-practice services. Developing and implementing programs and policies aimed at identifying and supporting counsellor self-efficacy would be a worthwhile endeavour and a promising avenue for future research.

This study provides useful information on the synergistic dynamics of job-related risks of burnout. Given the relationship of high job satisfaction and self-efficacy with lowered burnout and feelings of incompetence, organizational efforts should aim to maintain a healthy workforce that is satisfied with both the intrinsic and extrinsic aspects of their jobs and have strong motivational beliefs in their competence and performance as counsellors.

Information should be provided to assist counsellors in obtaining support and the development of programs to promote employee well-being. Employers should address employee mental health needs with a view of overall psychological health and job performance.

Limitations of the Study

Limitations Related to Sampling Methodology

This study relied on samples taken from one geographical region and only included counsellors working at government funded addiction treatment agencies. There was minimal diversity in terms of ethnic group identity and gender. Although these demographic data reflect the characteristics of the addiction treatment workforce in this government funded organization, future research will need to explore if similar findings can be generalized across more diverse samples including addiction counsellors working at non-profit treatment centres.

The voluntary recruitment of participants and organizational climate are two other factors which may have introduced error not accounted for in the current study and limit reliability or transferability of study results. The recruitment of participants may have resulted in selection bias. The managers that elected for their staff to participate may provide an organizational climate that is highly supportive of research and professional development. Such work environments may foster a greater sense of efficacy in their employees in comparison to work environments that do not foster continuous learning.

At the time of data collection, government funded treatment centres (where participants were recruited from) were undergoing major organizational changes in preparation for the amalgamation into the Alberta Health Board. During this time counsellors were experiencing greater change and uncertainty which most likely influenced their survey and interview responses.

Addiction counsellors also had the option of participating in the individual interview and/or completing the survey. As a research participant volunteer, those individuals who completed the interview and/or survey may have responded differently than individuals who chose not to participate.

Limitations Related to Measurement Methodology

The survey instruments and individual interviews in this study were based on self-report methodology. Value-laden constructs such as counselling self-efficacy, job satisfaction, job motivation, and burnout may elicit the tendency to rate one's self favourably and provide socially desirable responses (i.e., confident, skilful, satisfied, and motivated) (Wendler, 2007). Future research should include some type of impression or social desirability management to determine if responses correlate with social desirability. A measure of social desirability could then be included as a co-variate or additional predictor variable when conducting analyses involving the ACSES, MSQ-Short Form, and/or CBI.

Limitations Related to Research Design

The data collected was completed in a one phase, cross-sectional, study design. This limits the ability to draw causal inferences. Future research may consider using longitudinal designs that are better able to determine the causal relationship between counsellor self-efficacy, job satisfaction, motivation, and job burnout.

Implications

Future Research

The ACSES and CBI are relatively new scales, therefore, it is suggested that additional psychometric research be conducted to further strengthen each scale's validity. Given the homogeneity of participants in this study it is recommended that a broader cross-section of

counsellors be included to capture the diversity and representation of addiction counsellors as a whole. Although both the ACSES and CBI provide counsellors with a better understanding of self-efficacy and burnout as it relates to counselling, larger quantitative studies are needed to establish normative data for assisting researchers and decision-makers in drawing more accurate conclusions from the ACSES and CBI data. The provision of normative data would allow researchers and trainers to determine the relative standing of counsellors and trainees at both an individual and collective level.

Future research could also examine how diverse training, educational attainment, and professional development opportunities are associated with addiction counselling self-efficacy beliefs and work-related variables. As well, a replication study would help determine if and to what extent the organization's transitional period (i.e., undergoing an organizational change and amalgamating into the Alberta Health Board) affected survey results.

One goal for future ACSES scale development includes the ability to ultimately determine a relationship between addiction counsellor motivational beliefs and clinical outcomes. Recognizing the demonstrated relationship between individual's motivational beliefs, their task interest and task performance, future research should expand on the relative contribution of addiction counselling self-efficacy beliefs to actual counsellor performance. This type of research would provide predictive validity evidence of the ACSES and represents a critical next step in providing support for research-based practices.

Results from Study 2 highlighted the contextual influences of interpersonal factors (i.e., the meaning one gives to one's job), interpersonal factors (i.e., being able to teach clients and co-workers), and organizational factors (i.e., decision-making processes, management style) that contribute to motivational beliefs and job stress and strain. Not only have these contextual influences

been understudied in motivation research, but they are frequently overlooked by traditional quantitative researchers who rely on psychometric instruments, which are ill equipped for examining counsellor's beliefs about counselling (Blustein et al., 2001). Bronfenbrenner's ecological approach (1979) provides a useful model for understanding contextual features in addiction counselling and its environment. Influences on counsellors and addiction counselling involve more than the microsystems (e.g., factors in the counselling session), but also include influences from the broader layers of the mesosystem (e.g., factors in the treatment centre), the exosystem (e.g., organizational and community factors), and the macrosystem (e.g., culture of the addictions field). The latter three layers have been largely ignored in motivation research among helping professionals to date.

Bandura (1997) suggests that organizational collective efficacy can be measured by aggregating each member's appraisal of his or her own individual ability to execute a specific function in the group or by aggregating all members' appraisals of the group ability as a whole. The latter may be more suitable when organizational achievements depend on the synergistic dynamics of members working together (Bandura, 2001; Caprara et al., 2003). Therefore, it may be worthwhile to investigate how collective efficacy relates to job stress, strain and turnover, with results likely to shed light on organizational commitment.

Appendix A

Demographic Form

Directions: Please answer the following questions as they relate to you.

1. What is your ethnic background?

___Aboriginal
___African
___Asian
___Caucasian
___Latin
___Other (specify) ________________

2. What is your gender?

___Male
___Female

3. What is your age?

___________________ Years

4. What is your highest level of education completed?

___High School – diploma or equivalent
___Some College, no degree
___Associate's degree in _______________
___Bachelor's degree in ________________
___Master's degree in _________________
___Doctoral degree in _________________
___Other (specify) ____________________

5. How many years (in total) have you worked in the addiction treatment field?

___________________ Years

6. Total number of years/months working at XXX [your current treatment agency]:

____ Years ____ Months

7. Total years/months working as an addiction counsellor:

____ Years ____ Months

8. Certification/Licensure Status (Check all that apply)

___Not certified or licensed
___Registered Social Worker
___Registered Psychologist
___Registered Nurse
___Registered Provisional Psychologist ___Previously certified or licensed, not now
___Certified Addiction Counsellor (CSAC, CASAC, etc.)
___Other (specify) ______________

9. What percentage of your time do you spend in a typical week on the following?

NOTE: Percentage should add up to 100%

Task	***%***
Screening and assessments	________
Individual counselling	________
Group counselling	________
Family counselling	________
Case management	________
Providing clinical supervision	________
Documentation	________
Administrative activities	________

10. Do you receive regular (e.g., weekly) clinical supervision? If **yes**, how often?

_____ Yes, ____ times per __________
_____ No

Appendix B

University of Alberta Ethics Form

FACULTIES OF EDUCATION, EXTENSION AND AUGUSTANA
RESEARCH ETHICS BOARD
(EEA REB)

I. Application for Ethics Review of Proposed Research
(Revised November 26, 2007)

Principal Investigator -
Sara Elliott-Erickson

Department/Faculty -
Education Psychology/Educational Studies

Complete mailing address -
#504, 11933 Jasper Avenue, Edmonton AB, T5K 0P1

Email – sbelliot@gmail.com
Supervisor's email (if applicable) - rk2@ualberta.ca

Co-applicant(s) -
Co-applicants *not* under the jurisdiction of the EEA REB are required to consult with their own REB.
Project title - Addiction Counselling Self-Efficacy Scale (ACSES), job satisfaction, and burnout: A mixed method study
ANTICIPATED Data Collection Timelines
Start Date (2008/06/15)
End Date (end of data collection) (2008/08/31)

Status (if student) -
( ) Master's Project (X) Master's Thesis ( ) Doctoral Dissertation ( ) other (specify)

Funding Source (if applicable) N/A

► Do you plan to gather data in University of Alberta units other than Education, Extension or Augustana? **No**
If yes, name the unit(s). It is the Applicant's responsibility to ensure that proper permission is sought. Please elaborate in Sections III and IV of this application.

► Is another post-secondary educational institution involved in this project? **No**
If yes, name the institution(s) and the nature of the involvement.
It is the Applicant's responsibility to consult with the REB of all involved institutions to obtain ethical approval. See Section IV of this application.

► I, the applicant, agree to notify the EEA REB in writing of any changes in research design, procedures, sample, etc. that arise after the EEA REB approval has been granted. A *Request for Change in Methodology* form must receive approval from EEA REB before the modified research can proceed.

► I also agree to notify the EEA REB *immediately* if any untoward or adverse event occurs during my research, and/or if data analysis or other review reveals undesirable outcomes for the participants.

► I have read the University of Alberta Standards for the Protection of Human Research Participants [GFC Policy Manual, Section 66 http://www.uofaweb.ualberta.ca/gfcpolicymanual/policymanualsection66.cfm] and agree to comply with these Standards in conducting my research.

S. Elliott-Erickson — Signature of Applicant
May 13 2008 — Date

► As the supervisor/instructor, I have read and approve submission of this application to the EEA REB, and ensure that the proposed project is compliant with the University of Alberta Standards for the Protection of Human Research Participants [GFC Policy Manual, Section 66 [http://www.uofaweb.ualberta.ca/gfcpolicymanual/policymanualsection66.cfm].

Robert Klassen — Printed name of Supervisor/Instructor
Signature of Supervisor/Instructor
May 13, 2008 — Date

ETHICS REVIEW STATUS

☑ Application approved by EEA REB member ☐ Application approved by EEA REB ☐ Application not approved

Signature of EEA REB Member or Chair

ETHICS APPROVAL HAS BEEN GRANTED FOR ONE YEAR FROM THIS DATE:

May 16, 2008

Date of Approval Distribution of approval page: Original to EEA REB file; Copies to Applicant, Supervisor/Instructor (if applicable), Unit student file (if applicable)

Appendix C

Information Letter for Managers

FACULTY OF EDUCATION
Department of Educational Psychology
AUGUST, 2008

Dear ________________,

Thank you for reading this email as I know your time is valuable and limited. I am conducting a study that investigates addiction counsellors' self-efficacy to treat clients and the relationship among self-efficacy to treat clients, job satisfaction and motivation. For my study, I will be contacting approximately 150 adult treatment addiction counsellors at their place of employment and asking them to complete a 10 minute survey. The survey will be available in both paper and electronic form. In addition, I will be conducting 10-12 interviews with addiction counsellors, lasting approximately 30 to 60 minutes in length. These interviews will provide rich detail to the survey data and provide an opportunity to gain more insight into self-efficacy beliefs, job satisfaction and motivation. The title of my proposed master's thesis is *Addiction Counselling Self-Efficacy Scale (ACSES), job satisfaction, and motivation: A mixed methods study*. Questions in the from the ACSES scale were developed from counselling self-efficacy research and theory (Wendler, 2007; Bandura, 2001) and from the Centre for Substance Abuse Treatment's (CSAT) national competencies that are described as essential for the effective practice of addiction counselling (Centre for Substance Abuse Treatment, 1998).Given these established competencies and lack of assessment instruments for self-evaluation of addiction counselling skills, we believe that the validation of an addiction counselling self-efficacy scale could greatly advance the field of addiction counselling. Furthermore, results from this study will provide insight into the maintenance of a satisfied and motivated workforce, within large treatment organizations such as XXX. This project has been approved by my institution's research ethical review board and approved by XXX.

I respectfully request your assistance to for this project. Specifically, I am looking for addiction counsellors at your treatment site to participate. I would greatly appreciate it if you would be willing to assist me in my research by letting addiction counsellors working at XXX know (in person, at staff meeting, or through email):

1) the study consists of a 10 minute survey and an interview, which will take less than an hour to complete,

2) the University of Alberta, XXX, and you all support employee participation in this Master's thesis study and you will allow participants to complete the paper or electronic version of the survey during working hours,

3) this is an potential opportunity for addiction counsellors to help make a difference in the field of addiction counselling,

4) all information collected will not be associated with anyone's name or identifying information,

5) and that I am more than willing to present the results of this study to addiction counsellors and interested staff working at XXX, after defending my thesis.

Next week I will sign a contract to conduct third part research in XXX. Once documents are signed, I will call you and then begin mailing out survey packages (information/consent letters, a paper copy of the survey, and a self addressed stamped envelope), about one week later, I will send an email to addiction counsellors with a secure link to the same survey online. I expect to complete my survey data collection by October, 2008. As a result, I will need the surveys completed by then. I greatly appreciate your cooperation. If you have any questions, please feel free to contact me by phone or email. You may also contact my faculty supervisor.

Respectfully,

Sara Elliott-Erickson

Principal Investigator
Sara Elliott-Erickson**,** M.Ed (in progress)
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Appendix D

Information/Consent Letter for Addiction Counsellors

FACULTY OF EDUCATION
Department of Educational Psychology

Addiction Counselling Self-Efficacy Scale (ACSES), Job Satisfaction, and Motivation: A Mixed Methods Study

Principal investigator: Sara Elliott-Erickson (Master's Student)
Supervisor: Robert Klassen

Greetings _First Name Last Name,

This Addiction Counsellor information/consent letter is only part of the process of informed consent. It should give you the basic idea of what the research project is about and what your participation will involve. If you would like more details about something mentioned here, or information included here, please feel free to ask. Please take the time to read this carefully and to understand any accompanying information.

IMPORTANT: PLEASE READ THIS INFORMATION FORM BEFORE COMPLETING THE SURVEY!

My name is Sara Elliott-Erickson, and I am a graduate student at the University of Alberta in the department of Educational Psychology. As part of the requirements for completing my Master's degree, I am conducting a study with my supervisor, Dr. Robert Klassen, on addiction counsellors' self-efficacy to treat clients, job satisfaction and motivation. The purpose of this research project titled *Addiction Counselling Self-Efficacy Scale (ACSES), job satisfaction, and motivation: A mixed method study* is to examine how addiction counsellors view their abilities in a number of addiction counselling skills and how this is relates to job satisfaction and motivation. If you choose to participate, you will complete a set of questions that will ask you to rate your confidence in handling a variety of counselling tasks as well as your personal opinion about a number of related counselling and occupational issues. This survey should take approximately 10 minutes to complete.

All your responses to the survey questions will be kept COMPLETELY CONFIDENTIAL. Only group data will be reported, meaning no data will ever be reported in connection to you individually. A summary of the main findings will also be available to you on your employers' internal website, once this study is completed. There are no known risks or discomforts associated with participating in this study. Benefits of participation include learning more about addiction counsellors' self-efficacy beliefs, job satisfaction and motivation, and more about your approach to a variety of addiction counselling tasks. Participation in this study is voluntary and you are free to withdraw at any time. You indicate your voluntary agreement to participate by completing the survey. Attached is a paper copy of the survey along with a self-addressed, stamped envelope. If you chose to participate

please complete this survey and mail it back to me at your earliest convenience. In the next few days I will also send you an email, at your work account, with a link to the same survey online. Please keep this information sheet for your records. Feel free to contact me if you would like to receive further information regarding the research findings.

Also, if you choose to complete the survey and would like to further contribute to this study by completing a 30 to 60 minute interview about your experience of self-efficacy beliefs, job satisfaction and motivation please contact me by phone or email me.

The plan for this study has been reviewed for its adherence to ethical guidelines and approved by the Faculties of Education, Extension and Augustana Research Ethics Board (EEA REB) at the University of Alberta. For questions regarding participant rights and ethical conduct of research, contact the Chair of the EEA REB at (780) 492-3751.

Thank you very much for your time,

Sincerely,

Principal Investigator
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Master's Candidate—Department of Educational Psychology
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Edmonton, AB T6G 2G5
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Associate Professor –Department of Educational Psychology
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Edmonton, AB T6G 2G5
PH: (780)492-9170
robertklassen@ualberta.ca

Appendix E

Email Message to Addiction Counsellors with Link to Online Survey

Good afternoon ____,

Thank you for reading this message. As part of the requirements for completing my Master's degree, I am conducting a study with my supervisor, Dr. Robert Klassen, on addiction counsellor's self-efficacy to treat clients, job satisfaction and motivation.

Earlier this month I sent you a paper copy of the survey with stamped envelope. If you have already completed the survey and mailed it back to me, I am thankful for your help and support! I look forward to sharing the findings with your treatment centre.

If you have not had the opportunity to complete the survey yet, but would like to contribute to this study, I have now made the survey available online (using a secure website). The survey, which takes less than 10 minutes to complete, may now be accessed electronically by clicking the following link: https://www.surveymonkey.com/XXX

Or, you can mail back the paper copy of the survey, whichever you prefer.
Also, if you are interested in participating in an individual interview please contact me at my phone number or email provided.

Thank you for your time!
Regards,
Sara Elliott-Erickson
Master's Candidate—Department of Educational Psychology
University of Alberta
Edmonton, AB T6G 2G5
Phone: (780) 719-9941
Email: sarae@ualberta.ca

If you are experiencing problems related to the work you do as an addiction counsellor, please click on the link below to obtain information regarding XXX's Employee Assistance Program:
http://XXX/human_resources/116.htm

Appendix F

Thank-you and Final Reminder Email Message to Addiction Counsellors

Good day ________,

Thank-you addiction counselors at XXX treatment site for your help and support in my Master's thesis project examining self-efficacy, job satisfaction and motivation!

This is the final reminder…

If you have not had the opportunity to complete the paper or electronic copy of the survey, but would like to contribute to this study…The survey (which takes less than 10 minutes to complete and may be filled out during work hours) may be accessed electronically by clicking: https://www.surveymonkey.comXXX

Or, the paper copy of the survey may be sent in the mail, whichever you prefer.

The electronic copy of the survey will be available online until October 31, 2008. Please submit all surveys by then.

Thank you for your time!

Sara Elliott-Erickson

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If you are experiencing problems related to the work you do as an addiction counsellor, please click on the link below to obtain information regarding XXX's Employee Assistance Program: http://XXX/human_resources/116.htm

Appendix G

Interview Guide

"Before we start I would like to let you know that all your responses will be kept anonymous meaning you name will never be associated with what we talk about today. Also, if you mention your treatment site in the interview I will not be associating any responses with specific treatment sites. It is important for the relevance of this research that you be as candid as possible. For accuracy I would like to record this conversation. May I have your permission to do so?"

To begin, can you tell me how long you have been an addiction counsellor?
Have you worked at any other treatment agencies, besides the one you currently work at?

Next, can you tell me about how you came to be an addiction counsellor?
(Was it something you were good at? Did you set goals along the way? Were there any obstacles you faced along the way? How did you overcome these obstacles? Did you always know you were going to be an addiction counsellor?)

How do you evaluate how successful or capable you are as an addiction counsellor?
Since you first began working as an addiction counsellor, how has your perception of your abilities to treat addiction clients changed? What has influenced this change? (i.e., what affects self-efficacy beliefs?) What affects your confidence as an addiction counsellor?

Tell me about a time when your job as an addiction counsellor was especially satisfying.
(What was going on, how long had you been counselling, how were you feeling, what helped you get to that place? What did you learn from that experience? How did you feel about your counselling skills – were you confident?)
Was there ever a time when you were unsure of your counselling skills in a particular area, but worked toward improving that skill? What did you do to improve your skills? How did you feel when you persevered despite an obstacle?

Tell me about a time when your job as an addiction counsellor was especially satisfying/unsatisfying? What was going on, how long had you been counselling, what were you feeling, what events led you to that place? What did you learn from that experience?

Can you think of a time when your job motivated or energized you? Tell me about this experience and how it made you feel about your own counselling skills.

Can you tell me about a time when you felt unmotivated or lacked energy in your work as an addiction counsellor?* (Why did you feel unmotivated? How did you perceive yourself as a counsellor when you were experiencing lack of motivation? Were you satisfied with your job?)
*If they have not experienced amotivation… Can you think of a time when another addiction counsellor or colleague was experiencing amotivation or burnout? How do you know they were experiencing amotivation? What was going on with them at work? Do you think they were confident in their counselling skills?

From my understanding, addiction counselling is an inherently stressful and demanding job, and it is my understanding that job turnover is relatively high among addiction counsellors. Can you explain some of the aspects of the job that negatively impact counsellors?

Do you feel capable of treating clients with co-occurring disorders? How have your capabilities changed from the time you first began counselling to present with respect to co-occurring disorders? (i.e., job satisfaction and amotivation)

The next few questions are related to survey results and you responses are intended to explain some of the outcomes.

1. Compared to other counselling skills, many addiction counsellors reported less confidence in their group counselling skills and skills to treat clients with co-occurring disorders. Why do you think counsellors tend to rate themselves this way?

2. Counsellors also tended to rate themselves as less confident in their ability to assess a clients financial concerns… do you think assessing financial concerns is an important activity for addiction counsellors, within XXX to do? Do you think there should be more training opportunities for addiction counsellors to improve this skill?

3. With regard to satisfaction, addiction counsellors tended to rate their satisfaction with the way their boss handles his/her workers somewhat lower – why do you think this is?

4. Do you think the way company policies are put into practice affects addiction counsellors? How so?

5. Do you think there is adequate opportunity for advancement on the job? What could be done differently?

6. Do you think you and other addiction counsellors at your treatment facility are praised enough for doing a good job? What improvements would you like to see?

7. A lot of addiction counsellors indicated they were frustrated with the systems in their workplace. What systems, in your workplace do you find difficult to work within? What could be done to improve these systems?

8. Why do you think some counsellors would feel like they do not have time to engage in personal interests outside of work?

9. What are some symptoms that addiction counsellors might feel if they were experiencing burnout? Are these symptoms recognized in your workplace? What would happen is someone was experiencing burnout?

10. Do you have any ideas as to how self-efficacy, job satisfaction and motivation/burnout are related? [Explain what is meant by self-efficacy]

11. Do you think (age, gender, experience, education) effects addiction counsellors perception of their confidence in their counselling skills. How so?

That is all the questions I have today. Do you have any questions for me before we go? Well thank you very much _______________.

Pleasantries

Appendix H

Information/Consent Letter for Interviewees

FACULTY OF EDUCATION
Department of Educational Psychology

Addiction Counselling Self-Efficacy Scale (ACSES), job satisfaction, and motivation: A mixed method study

Principal investigator: Sara Elliott-Erickson (Master's Student)
Supervisor: Robert Klassen

Greetings _First name Last name,

This Addiction Counsellor Information Form for Interviewees is only part of the process of informed consent. It should give you the basic idea of what this research project is about and what your participation will involve. If you would like more details about something mentioned here, or information included here, please feel free to ask. Please take the time to read this carefully and to understand any accompanying information prior to your ***interview on _____from ___________ to ________ am/pm***

IMPORTANT: PLEASE READ THIS INFORMATION FORM BEFORE COMPLETING THE INTERVIEW!

My name is Sara Elliott-Erickson, and I am a graduate student at the University of Alberta in Educational Psychology. As part of the requirements for completing my Master's degree, I am conducting a study with my supervisor, Dr. Robert Klassen, on addiction workers self-efficacy to treat clients, and that relationship to job satisfaction and motivation. The purpose of this research project entitled *Addiction Counselling Self-Efficacy Scale (ACSES), job satisfaction, and motivation: A mixed methods study* is to examine how addiction workers view their abilities regarding a number of addiction counselling skills and how addiction counsellor self-efficacy to treat clients relates to job satisfaction and motivation. If you choose to participate in the interview, you will have already contacted me indicating your interest in assisting me in this study and we would have arranged a time and location (telephone number where you can be reached at) for your interview. The interview should take approximately 30 to 60 minutes to complete and will add a richness to the survey findings that can be obtained by no other method.

Although I do have your contact information is it important that you understand that all your responses during the interview will be kept COMPLETELY CONFIDENTIAL. None of your responses will ever be connected to you individually and only group data will be reported. A summary of the main findings will also be available to you on your treatment agencies internal website, once the study is completed. There are no known risks or discomfort associated with

participating in this study. Benefits in participation include learning more about addiction counsellors' self-efficacy beliefs, job satisfaction and motivation, and more about your approach to a variety of addiction counselling tasks. Participation in this study is voluntary and you are free to withdraw at any time. Once the interview has taken place, you will have 24 hours to change your mind and opt out of the study, in which case all information obtained during the interview will be safely destroyed. You indicate your voluntary agreement to participate by participating at the specified time and location for the interview. Please keep this information sheet for your records. Feel free to contact me if you would like to receive further information regarding the research findings.

The plan for this study has been reviewed for its adherence to ethical guidelines and approved by the Faculties of Education, Extension and Augustana Research Ethics Board (EEA REB) at the University of Alberta. For questions regarding participant rights and ethical conduct of research, contact the Chair of the EEA REB at (780) 492-3751.

Thank you very much for your time,

Sincerely,

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Appendix I

Qualitative Data from Study 2 Participants

General Explanation of Relationship among Self-Efficacy, Job Satisfaction, Motivation, and Burnout

"They are closely related. I think they are all tied together." (Anna)
"They all play into each other." (Kari)
"They are highly related." (Lydia)
"They are first cousins. Any one out of balance will cause consequent negative impacts on the other ones and improvements, often minute; in one of them will lead to improvements in the others." (Jon)
"Probably close." (Jodi)

Relationships between Job Satisfaction, Self-efficacy, and Motivation

Figure I1. High job satisfaction and high self-efficacy produces high motivation

"You will be more motivated to learn and grow and perform if you feel confident in your counselling skills, but also if you are supported in your environment and you have a higher degree of job satisfaction." (Katherine)

"[I] have the sense that [my] job skills can be of some use, which is motivating." (Melissa)

Figure I2. High self-efficacy produces high job satisfaction, which produces high motivation

"Of course you would be more motivated to do your job when you feel more satisfied in you job and you will feel more satisfied in your job when you are more efficient at it." (Sierra)

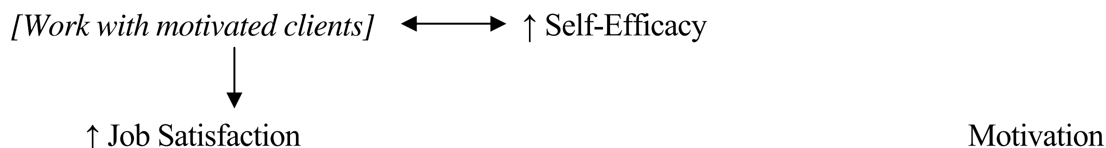

Figure I3. Motivated clients produce high job satisfaction and high self-efficacy

"When you have the opportunity to work with motivated clients your job satisfaction goes right up and you have more of a sense that your job skills can be of some use." (Melissa)

“When I perceive I am very skilled, have the opportunity to use those skills on the job, and have the opportunity to work with motivated clients my job satisfaction goes right up.” (Melissa)

“[A moment that was especially satisfying as an addiction counsellor] was when I saw one of my clients and she says ‘I am doing really good…it really helps to see you on a regular basis because it keeps me accountable.’ Just seeing me, even though I do not [always meet with her] I know it is working. [At times like these] I feel very confident in my counselling skills.” (Jodi)

Figure I4. High self-efficacy produces high job satisfaction and motivation

“The more confident you are in your counselling skills, the more satisfied you are and the more motivated you are to do what you are doing, which also contributes to how confident you are.” (Anna)

“Skills can always be improved so I think confidence is the biggest factor in the perception of skills and adaptability. And, those things come from experience, encouragement, and positive feedback. The job satisfaction comes from doing a good job and knowing it, and the motivation comes from both of those and personal factors like, why am I in this field? What is it that I enjoy about this job? What is the meaning behind it for me?” (Lydia)

Figure I5. High self-efficacy produces high job satisfaction

“When I feel confident in what I am doing, then I feel more satisfied and I feel just a sense of competency.” (Kari)

“The perception in [another province] is very much an abstinence attitude. I actually find myself much better at my job [in Alberta] because the attitude [at my treatment centre] is to meet the client where they are at. I don’t even view it as a harm reduction approach. I view it as the client is wholly responsible and capable of making their own decisions. Whereas in [the other province] the whole attitude is we tell them what to do ‘you have to quit using all substances’ that’s the way it is – there is not other way. I have actually found that my job enjoyment and satisfaction has risen dramatically because now I do not have to tell people what to do anymore.” (Sierra)

Figure I6. Low job satisfaction and low self-efficacy produce low motivation

"If you do not feel confident or competent and you are not happy with your job – are not feeling supported, not feel like you are being given opportunities and things like that – you become very unmotivated to learn and try new things and you get really, really stuck." (Katherine)

"If I do not feel confident and I do not feel satisfied, my motivation is going to decrease for what I am doing." (Cody)

Figure I7. Low self-efficacy produces low satisfaction, which produces low motivation.

"If you don't feel confident you could not feel satisfied and therefore, would feel less motivation." (Sierra)

Figure I8. Low self-efficacy produces low satisfaction and low motivation

"If I do not feel as confident or competent I could see how I would feel less satisfied and less motivated." (Kari)

"I think that in some ways people are less motivated if they do not have the skills to do the job. If you do not think you are doing anything or you are capable at your job, your job satisfaction is going to be right down there too." (Niki)

Figure I9. Low self-efficacy produces low motivation

"The less you perceive your skills as being capable, the less motivated you are to do what you are doing." (Anna)

"I think people are less motivated if they do not have the skills to do the job." (Natalie)

Relationship between Job Satisfaction, Self-Efficacy, and Burnout

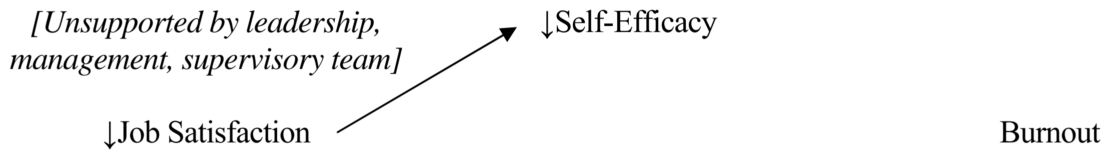

Figure I10. Low job satisfaction produces low self-efficacy

"When I am feeling unsupported by leadership, management, and my supervisory team [I have reduced job satisfaction] I fell like I am not as effective and cannot be as effective." (Katherine)

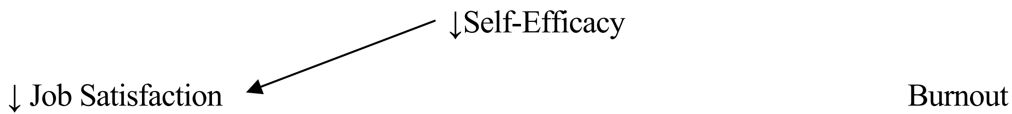

Figure I11. Low self-efficacy produces low job satisfaction

"If you do not think you are doing anything as a counsellor, or you are capable at your job, then your job satisfaction is going to be down." (Natalie)

Figure I12. Low job satisfaction produces high burnout

"Dissatisfaction with the job is a big symptom of burnout, that is where it kind of starts, right. Like something is bugging you and you think gee-whiz I am not as happy as when I first started here." (Lydia)

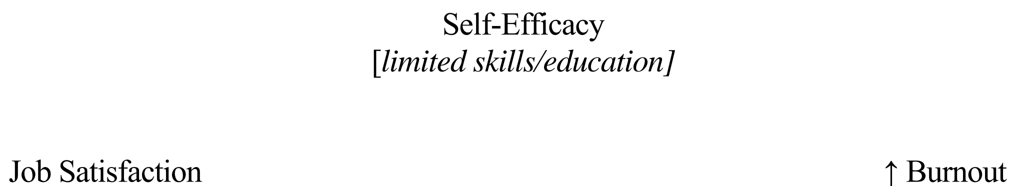

Figure I13. Low self-efficacy produces burnout

"[My education gave me] a full bag of magic tricks. If I did not have my education I could not do my job. I think education has a lot to do with it because if you do not have the skills what are you going to do? You are going to get burnt out." (Jodi)

Figure I14. Low job satisfaction and high self-efficacy produce burnout

"When your skills are developed enough and you are not using them enough, then you could develop job dissatisfaction or perhaps if someone does not have enough variety or something like that the resulting dissatisfaction will result in burnout. If you are not able to try out new things or be creative when that is part of your skill set, then you will just think 'I cannot do this and I cannot do this and what can I do here?' and you get frustrated." (Lydia)

REFERENCES

Adams, R. J., & Gallon, S. L. (1997). *Entry-level addiction counselor competency survey: National results.* Portland, Oregon: Northwest Regional Educational Laboratory.

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

Alberta Alcohol and Drug Abuse Commission. (2006). *The costs of substance abuse in Canada 2002: Alberta fact sheet*. Edmonton, Alberta: Author.

Alberta Alcohol and Drug Abuse Commission. (2007). *Developing an Alberta Alcohol Strategy: Background information.* Edmonton, Alberta: Author. Retrieved September 19, 2008 from http://www.aadac.com/documents/ab_alcohol_strategy_background.pdf.

Alberta Health Services – Alberta Alcohol and Drug Abuse Commission. (2008). *Review of addiction services in Alberta*. Edmonton, Alberta: Author.

Amadeo M., & Fassler, I. (2001). Social workers and substance-abusing clients: Caseload composition and competency self-ratings. *American Journal of Drug and Alcohol Abuse 26*(4), 629-640.

American Psychiatric Association. (2000). *Diagnostic and Statistical Manual of Mental Disorders Fourth Edition Text Revision*. United States: Author.

Anderson, C. E. (2000). Supervision of substance abuse counsellors using the integrated developmental model. *The Clinical Supervisor, 19*(2), 185-195.

Angerer, J.M. (2003). Job burnout. *Journal of Employment Counselling, 40*, 98-107.

Auerbach, C. F., & Silverstein, L. B. (2003). *An introduction to coding and analysis: Qualitative data.* New York University Press: United States of America.

Bandura, A. (1977). Self-efficacy: Toward a unified theory of behavioural change. *Psychological Review, 84,* 122-147.

Bandura, A. (1986). *Social foundations of thought and action: A social cognitive theory*. Englewood Cliffs, New Jersey: Prentice Hall.

Bandura, A. (1994). Self-efficacy. In V. S. Ramachaudran (Ed.), *Encyclopaedia of human behaviour* (Volume 4, pp. 71-81). New York: Academic Press.

Bandura, A. (1995). Guide for constructing self-efficacy scales. *Unpublished manuscript.*

Bandura, A. (1997). *Self-Efficacy: The exercise of control.* New York: W.H. Freeman and Company.

Bandura, A. (2001). Social Cognitive Theory: An agentic perspective. *Annual Reviews of Psychology*, *52,* 1-26.

Barak, M., Nissly, J. & Levin, A. (2001). Antecedents to retention and turnover among child welfare, social work and other human service employees: What can we learn from past research? A review and meta-analysis. *Social Service Review, 75,* 625-661.

Barbee, P. W., Scherer, D., & Combs, D. C. (2003). Pre-practicum service learning: Examining the relationship with counsellor self-efficacy and anxiety. *Counsellor Education and Supervision, 43*, 108-119.

Barnes, K. L. (2004). Applying self-efficacy theory to counsellor training and supervision: A comparison of two approaches. *Counsellor education and Supervision, 44*, 56-69.

Blustein, D. L., Fama L. D., White S. F., Ketterson T. U., Schaefer B. M., Schwam M. F. et al. (2002). A qualitative analysis of counseling case material: Listening to our clients. *The Counseling Psychologist, 29*(2), 242-260.

Bronfenbrenner, U. (1979). *The ecology of human development: Experiments by nature and design*. Cambridge, Massachusetts: Harvard University Press.

Brown, B. L. (1999). Self-efficacy beliefs and career development. *ERIC Digest, 205,* 1-2.

Bryman, A. (2004). *Social Research Methods* (2nd ed.).New York, United States: Oxford University Press.

Canadian Centre on Substance Abuse. (2005a). *Addiction treatment indicators in Canada: An environmental scan.* Ottawa, Ontario: Author. Retrieved June 15, 2008 from http://www.ccsa.ca/pdf/ccsa-011132-2005.pdf.

Canadian Centre on Substance Abuse (2005b). *Designing a tool to measure the impact of client length of stay on treatment outcome: Overview*. Ottawa, Canada: Author.

Canadian Centre on Substance Abuse. (2006). *The costs of substance abuse in Canada 2002: Highlights*. Ottawa, Ontario, Canada: Canadian Centre for Substance Abuse.

Canadian Centre on Substance Abuse. (June, 2008). NTS proposes tiered treatment model. *Action News, 18*(2), 3-4.

Caprara, G.V., Barbaranelli, C., Borgogni, L., & Steca, P. (2003). Efficacy beliefs as determinates of teachers' job satisfaction. *Journal of Educational Psychology, 95*(4), 821-832.

Carroll, K.M. (2001). Constrained, confounded and confused: why we really know so little about therapists in treatment outcome research. *Addiction, 96,* 203-206.

Cashwell, T. H., & Dooley, K. (2001). The impact of supervision on counsellor self-efficacy. *The Clinical Supervisor, 20*, 39-47.

Centre for Substance Abuse Treatment. (2006a). *Addiction counseling competencies: The knowledge, skills, and attitudes of professional practice*. Technical Assistance Publication (TAP) Series 21. DHHS Publication No. (SMA). 06-4171. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2006. Retrieved September 19, 2007 from http://www.nattc.org/respubs/tap21/tap21.pdf.

Centre for Substance Abuse Treatment. (2006b). *Services integration. Co-Occurring centre for excellence overview paper 6*. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2006.

Creswell, J. W. (2007). *Qualitative inquiry and research designs: Choosing among five approaches* (2nd ed.). London, United Kingdom: Sage Publications.

Creswell, J. W. & Plano Clark, V. L. (2007). *Designing and conducting mixed methods research.* United States of America: Sage Publications.

Csikszentmihalyi, M. (1997). *Finding flow: The psychology of engagement with everyday life.* New York: Basic Books

Dickie, V. A. (2003b). Data analysis in qualitative research: A plea for sharing the magic and the effort. *American Journal of Occupational Therapy, 57*(1), 49-56

Dombeck, M., & Wells-Moran, J. (2006). Methods for changing your identity and your motivations. *Psychological self-tools: Online self-help book.* Retrieved May 26, 2008 from: http://www.mentalhelp.net/poc/view_doc.php?type=doc&id=9783&cn=353.

Ellet, A. J. S. (2001). Human caring, self-efficacy beliefs and professional organizational cultural correlates of employee retention in child welfare. *Dissertation Abstract International, 61* (8 A); 3350.

Elman, B. D., & Dawd, E. T. (1997). Correlates of burnout in inpatient substance abuse therapists. *Journal of Addictions and Offender Counseling, 17*(2), 56-65.

Emerson, H. (1998). Flow and occupation: A review of the literature. *Canadian Journal of Occupational Therapy, 65*(1), 37-44.

Ericson, N. (May 2001). *OJJDP fact sheet: Substance abuse the Nations number one health problem.* New Jersey, United States: Office of Juvenile Justice and Delinquency Prevention.

Evans, W. N., & Hohenshil, T. H. (1997). Job satisfaction of substance abuse counsellors. *Alcoholism Treatment Quarterly, 15*(2), 1-31.

Evers, W., Tomic, W., & Brouwers, A. (2001). Effects of aggressive behaviour and perceived self efficacy on burnout among staff of homes for the elderly. *Issues in Mental Health Nursing, 22*, 439-454.

Fillion, L., Tremblay, I., Truchon, M., Cote, D., Struthers, C. W., & Dupis, R. (2007). Job satisfaction and emotional distress among nurses providing palliative care: Empirical evidence for an integrative occupational stress-model. *International Journal of Stress Management, 14*(1), 1-25.

Friedlander, M. L., & Snyder, J. (1983). Trainees' expectation for the supervision process: Testing a developmental model. *Counsellor Education and Supervision, 22*(4), 342-348.

Gallon, S. L., Gabriel, R. M., & Knudsen, J. R. W. (2003). The toughest job you'll ever love: A Pacific Northwest treatment workforce survey. *Journal of Substance Abuse Treatment, 24,* 183-196.

Gottlieb, N. H., Mullen, P. D., & McAlister, A. L. (1987). Patients' substance abuse and the primary care physician: Patters of practice. *Addictive Behaviours, 12*, 23-32.

Graham, S. F. (2002). Dance: A transformative occupation. *Journal of Occupational Science, 9*(3), 128-134.

Grau, R., Salanova, M., & Peiro, J. M. (2001). Moderator effects of self-efficacy on occupational stress. *Psychology in Spain, 5*(1), 63-74.

Griffeth, R. W., Hom, P. W., & Gaertner, S. (2000). A meta-analysis of antecedents and correlates of employee turnover: Update, moderator tests, and research implications for the next millennium. *Journal of Management, 26*(3), 463-488.

Gossop, M., Stewart, D., & Marsden, J. (2006). Effectiveness of drug and alcohol counselling during methadone treatment: content, frequency, and duration of counselling and association with substance use outcomes. *Addiction, 101*(1), 404-412.

Grella, C. E., Greenwell, L., Prendergast, M., Farabee, D., Hall, E., Cartier, A., et al. (2007). Organizational Characteristics of Drug Abuse Treatment Programs for Offenders. *Journal of Substance Abuse Treatment, 32*(3), 291-300.

Halbesleben, J. R. B. & Bowler, W. M. (2007). Emotional exhaustion and job performance: The mediating role of motivation. *Journal of Applied Psychology, 92*(1), 93-106.

Health Canada. (2001). *Best Practices: Treatment and rehabilitation for youth with substance use problems.* Ottawa, Ontario: Author. Retrieved June 13, 2008 from http://www.hcsc.gc.ca/hl-vs/alt_formats/hecs-sesc/pdf/pubs/adp-apd/youth-jeunes/youth-jeuneseng.pdf.

Heppner, M. J., O'Brien, K. M., Hinkleman, J. M., & Flores, L. Y. (1996). Training counselling psychologists in career development: Are we our own worst enemies? *The Counselling Psychologist, 24*, 105-125.

Herie, M., Godden, T., Shenfeld, J., & Kelly, C. (2007). *Addiction: A guide for people with addiction and their families.* Canada: Centre for Addiction and Mental Health.

Herzberg, F., Mausner, B., & Snyderman, B. (1959). *The motivation to work.* New York: John Wiley.

Herzberg, F., Mausner, B., & Snyderman, B. B. (1993). *The motivation to work.* United States: Transaction Publishers.

Hirschifeld, R. R. (2000). Does revising the intrinsic and extrinsic subscales of the Minnesota Satisfaction Questionnaire Short Form make a difference? *Educational and Psychological Measurement, 60*(2), 255-270.

Holden, G. (1991). The relationship of self-efficacy appraisals to subsequent health-related outcomes: A meta analysis. *Social Work and Health Care, 16*, 53-93.

Huppert, J. D., Bufka, L. F., Barlow, D. H., Gorman, J. M., Shear, M. K., & Woods, S. W. (2001). Therapist, therapist variables, and cognitive behavioural therapy outcome in a multicenter trial for panic disorder. *Journal of Consulting and Clinical Psychology, 65*(9), 747-755 http://www.umanitoba.ca/unevoc/2002conference/text/papers/jacobs.pdf.

Jammison, N. L., Terry, D. J., & Callan, V. J. (2004). A longitudinal study of employee adaptation to organizational change: The role of change-related information and change related self efficacy. *Journal of Occupational Health Psychology, 9*(1), 11-27.

Jex, S. M., & Bliese, P. D. (1999). Efficacy beliefs as a moderator of the impact of work related stressors: A multi-level study. *Journal of Applied Psychology, 84*, 349-361.

Johnson, R. B., & Onwuegbuzie, A. J. (2004). Mixed methods research: A research paradigm whose time has come. *Educational Researcher, 33*(7), 14-26.

Judge, T. A., & Bono, J. E. (2001). Relationship of core self-evaluations traits – self esteem, generalized self-efficacy, locus of control, and emotional stability – with job satisfaction and performance: A meta analysis. *Journal of Applied Psychology, 86*(1), 80-92.

Kear, M. (2000). Concept analysis of self-efficacy. *Graduate Research in Nursing*. Retrieved May 13, 2008 from http://graduateresearch.com/Kear.html.

Kesler, K. (1990). Burnout: A multimodal approach to assessment and resolution. *Elementary School Guidance and Counselling, 24*, 303-311.

Khaled, J. H., Quick, J. C., Conaway, M., Sime, W. E., Martin, W., Hurwitz, et al. (2007). The prevalence and severity of burnout among academic orthopaedic departmental leaders. *The Journal of Bone and Joint Surgery (American), 89,* 896-903.

Klassen, R. M., & Lynch, S. L. (2007). Self-efficacy from the perspective of adolescents with LD and their specialist teachers. *Journal of Learning Disabilities, 40*, 494-507.

Knudsen, H. K., Ducharme, L. J., & Roman, P. M. (2006). Counselor emotional exhaustion and turnover intention in therapeutic communities. *Journal of Substance Abuse Treatment, 31*, 170-180.

Knudsen, H. K., Johnson, J. A., & Roman, P. M. (2003). Retaining counseling staff at substance abuse treatment centers: Effects of management practices. *Journal of Substance Abuse Treatment, 24*, 129-135.

Krannich, R. S., & Humphrey, C. R. (1986). Using key informant data in comparative community research: An empirical assessment. *Sociological Methods & Research, 14*(4), 473-493.

Kranz, K. M. (2003) Development of the Alcohol and Other Drug Self-Efficacy Scale. *Research on Social Work Practice, 13*(6), 724-741.

Larson, L. M., Clark, M. P., Wesley, L. H., Koraleski, S. F., Daniels, J. A., & Smith, P. L. (1999). Video versus role plays to increase counselling self-efficacy in pre-practica trainees. *Counsellor Education and Supervision, 38*, 237-248.

Larson, L. M., & Daniels, J. A. (1998). Review of the counselling self-efficacy literature. *The Counseling Psychologist, 26,* 179–218.

Larson, L. M., Suzuki, L. A., Gillespie, K. N., Potenza, M. T., Bechtel, M. A., & Toulouse, A. L. (1992). Development and validation of the Counselling Self-Estimate Inventory, *Journal of Counselling Psychology, 39*, 105-120.

Leach, M. M., Stoltenberg, C. D., McNeill, B. W., & Eichenfield, G. A. (1997). Self-efficacy and counsellor development: Testing the integrated developmental model. *Counsellor Education and Supervision, 37*, 115-124.

Lee, M. S., Baker, C. R., Cho, S. H., Heckathorn, D. E., Holland, M. W., Newgent, R. A. et al. (2007). Development and initial psychometrics of the Counsellor Burnout Inventory. *Measurement and Evaluation in Counselling and Development, 40*, 142-154.

Lent, R. W., & Hackett, G. (1987). Career self-efficacy: Empirical studies and future direction. *Journal of Vocational Behaviour, 30*, 347-382.

Lent, R. W., Hoffman, M. A., Hill, C. E., Treistman, D., Mount, M., & Singley, D. (2006). Client specific counselor self-efficacy in novice counsellors: Relation to perceptions of session quality. *Journal of Counseling Psychology, 53*(4), 453-463.

Lent, R. W., Loopez, F. G., & Bieschke, K. J. (1991). Mathematics self-efficacy: Sources and relation to science based career choice. *Journal of Counseling Psychology, 38*(4), 424- 430.

Levin, J. D., Culkin, J., & Perrotto R. S. (2002). *Introduction to chemical dependency counseling*. United States of America: Rowman & Littlefield Publishers.

Lubbers, R.W. (2004). Self-efficacy and affective well being among young workers: Examining job quality as an antecedent of employee health and performance outcomes. *Dissertation Abstract International: Section B: The Sciences and Engineering, 64(10-B), 5261.*

Mauer, T. J., & Andrews, K. D. (2000). Traditional, Likert, and simplified measures of self efficacy. *Educational and Psychological Measurement, 60*(6), 965-973.

Maslach, C., & Jackson, S. E. (1981). MBI research edition manual. Palo Alto,California, United States: Consulting Psychologist Press.

Maslach, C., & Jackson, S. E. (1996). *Maslach Burnout Inventory manual* (3rd ed.). Palo, California: Consulting Psychologist's Press.

Melchert, T. P., Hays, V. L., Wiljanen, L. M., & Kolocek, A. K. (1996). Testing models of counsellor development with a measure of counselling self-efficacy. *Journal of Counselling and Development, 74*, 640-655.

Miles, M. B., & Huberman, A. M. (1994). *Qualitative data analysis: An expanded sourcebook* (2nd ed.). Thousand Oaks, California: Sage Publications.

Murdock, T. B., Wendler, A. M., & Nilsson, S. C. (2005). Addiction Counselling Self-Efficacy Scale (ACSES): Development and initial validation. *Journal of Substance Abuse Treatment, 29*(1), 55-64.

National Institute of Drug Abuse. (June 2008). *NIDA info facts: Treatment approaches for drug treatment*. United States: Author.

Oberman, A. H. (2006). The job satisfaction of counsellor education faculty members in institutions with doctoral level programs accredited by the CACREP using Herzberg's Theory of Motivation. *Dissertation Abstracts International, 66* (7-A), 2521.

O'Cathain, A., Murphy, E., & Nicholl, J. (2007). Why and how, mixed methods research is undertaken in health services research in England: A mixed methods study. *BioMed Central Health Services Research,* 85(7), 1-11.

O'Cathain, A., Murphy, E., & Nicholl, J. (2008). The quality of mixed methods studies in health services research. *Journal of Health Services Research and Policy, 13*(2), 92-98.

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

Oyefeso, A., Clancy, C., & Farmer, R. (2008). Prevalence and associated factors in burnout and psychological morbidity among substance misuse professionals. *BioMed Central Health Services Research, 39*(8). Retrieved May 21, 2008 from http://www.biomedcentral.com/1472-6963/8/39.

Pajares, F. (2002). *Overview of social cognitive theory and self-efficacy*. Retrieved November 9, 2007, from http://www.des.emory.edu/mfp/eff.html.

Perdue, S. V., Readon, R. C., & Petrson, G. W. (2007). Person-environment congruence, self-efficacy, and environmental identity in relation to job satisfaction: A career decision theory perspective. *Journal of Employment Counselling, 44*(1), 29-39.

Pinquart, M., Juang, L. P., & Silbereisen, R. K. (2003). Self-efficacy and successful school to work transitions: A longitudinal study. *Journal of Vocational Behaviour, 63*(3), 329-346.

Prochaska, J. O., Norcross, J. C., & DiClemente, C. C. (1994). Changing for good: the revolutionary program that explains the six stages of change and teaches you how to free yourself from bad habits. New York: W. Morrow.

Salanova, M., Grau, R. M., & Martinez, I. M. (2006). Job demands and coping behaviour: The moderating role of professional self-efficacy. *Psychology in Spain, 10,* 1-7.

Schaufeli, W. B., & Peeters, M. C. W. (2000). Job stress and burnout among correctional officers: A review of the literature. *International Journal of Stress Management, 7*, 19-48.

Scheerer, C. Cahill, L. Kirby, K., & Lane, J. (2004). Cake decorating as occupation: Meaning and motivation. *Journal of Occupational Science, 11*(2), 68-74.

Schneider Institute for Health Policy (February, 2001). *Substance abuse, the nation's number one health problem.* Brandeis University: Robert Wood Johnson Foundation.

Schwarzer, R. & Hallum, S. (2008). Perceived teacher self-efficacy as a predictor of job strain and burnout: Mediation analyses. *Applied Psychology: An International Review, 57*, 152-171.

Sheu H. B. & Lent, R. W. (2007). Development and initial validation of the Multicultural Counselling Self-efficacy Scale – Racial Diversity Form. *Psychotherapy: Theory, Research, Practice, Training, 44*(1), 30-45

Shoptaw, S., Stein, J. A., & Rawson, R. A. (2000). Burnout in substance abuse counsellors: Impact of environment, attitudes, and clients with HIV. *Journal of Substance Abuse Treatment, 19*, 117 126.

Sipps, G. J., Sugden, G. J., & Faiver, C. M. (1998). Counsellor training level and verbal response type: Their relationship to efficacy and outcome expectations. *Journal of Counselling Psychology, 35*, 397-401.

Siqueland, L., Crits-Christoph, P., Barber, J. P., Butler, S. L., Thase, M., Najavits, I., et al. (2000). The role of therapist characteristics in training effects in cognitive, supportive-expressive, and drug counselling therapies for cocaine dependence. *The Journal of Psychotherapy Practice and Research, 9*(3), 123-130.

Skinner, W., O'Grady, C., Bartha, C., & Parker, C. (2004). *Concurrent substance use and mental health disorders*. Toronto: Centre for Addiction and Mental Health.

Smith, G.J., & Wynne, H. J. (February 2002). *Measuring gambling and problem gambling in Alberta: Using the Canadian Problem Gambling Index (CPGI).* Canada: Alberta Gaming Research Institute.

Spector, P.E. (1997). *Job satisfaction: Application, assessment, causes, and consequences.* Thousand Oaks, California, United States: Sage Publishing.

Stajkovic, A. D., & Luthans, F. (1998). Self-efficacy and work related performance: A meta analysis. *Psychological Bulletin, 124*, 240-261.

Steward, R. J. (1998). Connecting counsellor self-efficacy and supervisor self-efficacy: The continuing search for counselling competence. *The Counselling Psychologist, 26*(2), 285-294.

Stoffelmayr, B. E., Mavis, B. E., Sherry L. A., & Chiu C. W. (1999). The influence of recovery status and education on addiction counsellors' approach to treatment. *Journal of Psychoactive Drugs, 31*(2), 121-127.

Substance Abuse and Mental Health Services Administration, Office of Applied Studies. (2004). *Treatment Episode Data Set (TEDS). Highlights – 2002. National admission to substance abuse treatment services.* DASIS Series: S-22, DHHS Publication No. SMA 04-3946. Rockville, MD: Author.

Topp, J., Sawka, E., Room, R., Poulin, C., Single, E., & Thompson, H. (1998). *Policy discussion paper on problem gambling*. Ottawa, Canada: Canadian Centre on Substance Abuse.

Tsigilis, N., Zachopoulou, E., & Grammatikopoulos, V. (2006). Job satisfaction and burnout among Greek early educators: A comparison between public and private sector employees. *Educational Research and Review, 1*(8), 256-261.

US Department of Health and Human Services & Office of Disability, Aging, and Long Term Care Policy. (April 2005). *Measuring long-term care work: A guide to selected instruments to examine direct care worker experience and outcomes*. United States: Authors.

Weiss, D. J., Dawis, R. V., England, G. W., & Lofquist, L. H. (1967). *Manual for the Minnesota Satisfaction Questionnaire*. United States: Work Industrial Project Industrial Relations Center University of Minnesota.

Wendler, A., & Murdock, T. (2005, August). *Addiction counsellor self-efficacy and job satisfaction.* A poster presentation at the annual meeting of the American Psychological Association, Washington D.C.

Wendler, A. M. (2007). Validation of the Addiction Counseling Self-Efficacy Scale (ACSES) (Doctoral Dissertation, University of Missouri-Kansas City, January 2007). *Dissertation Abstracts International, 68*, 189.

Whittaker, S. M. (2007). A multi-vocational synthesis of supervisees' anxiety and self-efficacy during clinical supervision: Meta analysis and interviews. *Dissertation Abstracts International Section A: Humanities and Social Sciences, 67*, (11-A). (UMI No. 99009-030)

Whittinghill, D., Whittinghill, L. R., & Loesch, L. C. (2000). The benefits of a self-efficacy approach to substance abuse counselling in the era of managed care. *Journal of Addictions & Offender Counselling, 20*(2), 64-75.

Yang, H. L., Kao, Y. H., Huang, Y. C. (2007). The job self-efficacy and job involvement of clinical nursing teachers. *Journal of Nursing Research, 14*(3), 237-249.

Yousef, D. A. (2002). Job satisfaction as a mediator of the relationship between role stressors and organizational commitment: A study from an Arabic cultural perspective. *Journal of Managerial Psychology, 17*(4), 250-266.