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The Influence of Rural and Urban Substance Abuse Treatment Counselor Characteristics on Client Outcomes

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Abstract

Focus group data was collected from 28 substance abuse treatment counselors employed in rural and urban areas to examine their perceptions of factors influencing treatment outcomes. The influence of the counselor characteristics (i.e., education, experience, and recovery status) on client outcomes and geographic differences are explored. Focus group data was analyzed by three raters using line-by-line coding, focused coding, and memoing. This analytic approach revealed geographic differences in the counselors' perceptions of the effect of counselor education, experience, and recovery status on client outcomes. Recommendations for treatment planning and future research are provided.

Keywords

substance abuse treatment counselors; treatment outcomes; rural

Much of the existing knowledge surrounding substance abuse treatment outcomes is derived from three national, multi-site longitudinal treatment evaluation studies sponsored by the National Institute on Drug Abuse since the late 1960s (Fletcher, Tims, & Brown, 1997). However, limitations of these studies include the lack of information gathered at the counselor contextual-level, excluding non-metropolitan areas, and the sole focus on quantitative survey data collection. In fact, the counselor context may be one of the most important factors in effective substance abuse treatment. Therefore, the purpose of this qualitative study is to examine both rural and urban substance abuse treatment counselors' perceptions of factors influencing treatment outcomes. Specifically, the influences of the counselor characteristics (i.e., education, experience in the field, and recovery status) on client outcomes are explored and geographic differences are examined.

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Counselor Characteristics

Some research has suggested that the therapist and the therapeutic relationship are two of the most significant factors related to positive substance abuse treatment outcomes (Luborsky et al., 1986; Luborsky, McLellan, Diguier, Woody, & Seligman, 1997). In fact, when determining predictors for early drop-out from treatment, Kleinmen and colleagues (1990) discovered therapist assignment was found to be the strongest predictor of early drop-out from treatment, while no patient characteristics were determined to be significant. One study revealed that clients with positive perceptions of their counselors had more favorable treatment outcomes (e.g., improved psychological functioning and a longer length of stay in outpatient treatment) as compared to clients with negative perceptions of their counselors (see Kasarabada, Hser, Boles, & Huang, 2002). In addition, Rohrer, Thomas, and Yasenchak (1992) examined client perceptions of the ideal characteristics of a substance abuse counselor. The top five positive counselor traits included being understanding of the client, concerned, caring, experienced, and honest, while negative traits included being an “asshole,” dishonest, treating clients like children, and uneducated (Rohrer et al., 1992).

One counselor characteristic that has been shown to be an important factor related to positive client treatment outcomes is a counselor's level of educational attainment. The educational requirements to be a substance abuse counselor vary by state, which differentiates substance abuse counseling from other types of mental health counseling (e.g., 45% of states do not require a college degree to be a substance abuse counselor while 98% of states require a masters degree for mental health counseling; Kerwin, Walker-Smith, & Kirby, 2006). In return, substance abuse counselors are typically required to complete more supervised hours than other mental health counselors, which enforces the idea that substance abuse counselors participate in an apprentice style training model, where much of the skills are developed on the job under the direction of a mentor, while other types of mental health counselors participate in a professional style training where classroom instruction is emphasized (Kerwin et al., 2006). And although there has been a movement to professionalize the field, there are still a number of “para-professionals” practicing substance abuse counseling (Mulvey, Hubbard, & Hayashi, 2003). Previous research in substance abuse counseling has found that education level and cognitive functioning among counselors are positively correlated (Sias, Lambie, & Foster, 2006). Counselors with higher levels of education have also been found to purposively have a more limited range of treatment goals as based on the Addiction Research Foundation's Goal Inventory -- an inventory which includes dealing with family problems, obtaining residential care for the client, helping clients obtain employment, assisting clients in social adjustment, helping clients to stop using illegal drugs and/or alcohol, and enhancing the client's ability to cope with problems of living (Stoffelmayr, Mavis, Sherry & Chiu, 1999). Furthermore, Stoffelmayr and colleagues (1999) found that residential program counselors with less education utilized a broader repertoire of treatment techniques. In addition, Sias and colleagues (2006) also found that counselors with higher education levels had higher levels of moral reasoning.

Many of the “para-professionals” practicing in the field are counselors that are in recovery from alcohol and drug dependence. These counselors are thought to have an “edge” over counselors not in recovery when it comes to rapport building with clients due to their shared experiences (Martino, Ball, Nich, Frankforter, & Carroll, 2009). When a counselor is able to convey to their clients a genuine understanding of the difficulties in obtaining sobriety and avoiding relapse because they too have “walked in their shoes,” a bond is created that is difficult to match for those counselors that are not in recovery. In fact, “shared experiences” are the basis of the recovery process in self-help programs such as Alcoholics Anonymous (AA) and Narcotics Anonymous (NA) (Martino et al., 2009). However, no significant

differences have been found in client outcomes based on the counselors' recovery status (Culbreth, 2000). While some differences have been found between counselors that are in recovery and those that are not, the differences are in the counseling methods utilized and in the way substance addiction is viewed (Culbreth, 2000), but not in actual client treatment outcomes. For example, counselors in recovery have been found to be less flexible in their treatment approach and less likely to allow for client input into their treatment goals (Moyers & Miller, 1993). However, Stoffelmayr and colleagues (1998) determined that recovering counselors actually utilize a greater range of treatment practices.

Rural versus Urban Substance Abuse Treatment and Counselors

Several recent studies, the National Epidemiological Survey on Alcohol and Related Conditions (Dawson, Grant, Stinson, Chou, Huang, & Ruan, 2005), the National Survey on Drug Use and Health (Wright, Sathe, & Spagnola, 2007), and the National Survey of Substance Abuse Treatment Services (N-SSATS; Lenardson & Gale, 2008), have reported that rural residents seeking substance abuse treatment must still deal with limited availability and utilization. In fact, while more than a quarter of the U.S. population resides in a rural area, less than ten percent of available treatment facilities are located in rural areas (Lenardson & Gale, 2008). This forces rural dwellers seeking substance abuse treatment to travel greater distances, which has been shown to have a negative impact on both length of stay and treatment completion (Beardsley, Wish, Fitzelle, O'Grady, & Arria, 2003; Fortney, Booth, Blow, Bunn, & Cook, 1995). When this is combined with the lack of public transportation in rural areas, the result is an additional barrier that rural substance abuse counselors must assist their clients in overcoming while attempting to engage them in treatment.

There are also cultural differences substance abuse counselors in rural areas face that counselors in urban areas do not, such as the high value placed on self-reliance in rural areas, and a distrust of mental health services which makes treatment utilization more difficult for rural clients (Sullivan, Hasler, & Otis, 1993). Furthermore, rural clients entering treatment must do so without the benefit of anonymity that most urban clients have, due to the fact they may be recognized while attending a 12-Step meeting or group counseling session. These are all obstacles counselors must overcome when trying to treat rural substance abusers.

The literature is limited in examining substance abuse treatment counselor differences in education, experience, and recovery status by geographic region. The few existing studies that are available suggest that there minimal demographic differences between rural and urban substance abuse counselors. In fact, a study by Eliason and Hughes (2004) determined that while the urban substance abuse counselor workforce is more culturally diverse, rural counselors had slightly higher levels of educational attainment. However, urban substance abuse counselors are more likely to be specifically trained in substance abuse treatment (17.8% compared to 6.6%; CASA, 2000). While this may be a disadvantage in some respects, it may also benefit the rural counselor since they typically take on the role of a generalist due to the lack of mental health treatment options available to their clients. Another study of rural versus urban substance abuse treatment found no demographic variations among urban and rural counselors other than urban counselors had slightly more experience than their rural counterparts (Bouffard & Smith, 2005). There are no known studies examining the role of recovering counselors in rural versus urban areas.

This study makes a contribution to the literature by collecting qualitative data on counselor perceptions of the counselor characteristics that affect client substance abuse treatment outcomes. Specifically, the research questions examined are three-fold. First, does a counselor's education affect counselor's perceptions of client's substance abuse treatment

outcomes differentially in rural versus urban areas? Second, how do geographic differences in counselor's experience (e.g., the number of years working in the field) affect counselor's perceptions of client's treatment outcomes? Third, does a counselor's recovery status affect counselor's perceptions of client's substance abuse treatment outcomes and does this vary by rural versus urban locales? There are no known studies which have examined the counselor characteristics of education, experience in the field, and recovery status among both rural and urban counselors. It is expected that the counselor characteristics of education, experience in the field, and recovery status will differentially affect client substance abuse treatment outcomes in rural versus urban areas; however the directionality of these relationships is not expressed a priori since this qualitative study is exploratory in nature.

Method

Participants

Data were collected from 28 substance abuse treatment counselors that participated in four focus groups. Focus group counselor participants were recruited from an annual regional conference which provides continuing education for drug prevention and treatment professionals. IRB and Public Relations approved recruitment flyers requesting participation in a one to two hour focus group were distributed in continuing education sessions and displayed at an information booth.

Counselors employed in a Kentucky state-funded substance abuse treatment program were eligible to participate in one of two focus groups for rural counselors or one of two focus groups for urban counselors. During the screening process, counselors were also asked to provide the county in which they were employed. Rural-urban continuum codes were used for classification purposes in the present study because they distinguish metropolitan counties by the population size of their metro area, and non-metropolitan counties by degree of urbanization and adjacency to a metro area(s). Specifically, there are nine rural-urban continuum codes, which have been subdivided into three metro and six non-metro groupings. Counselors employed in metro counties (i.e., counties coded as a 1, 2, and 3) were categorized as urban and counselors in the remainder of the counties were classified as being employed in a rural county.

Procedures

For the focus group participants, informed consent was obtained by the focus group facilitator, who is the lead author. IRB approved study personnel, the first and second authors, met with potential focus group participants, described the study and the informed consent procedures, assured the prospective participants that deciding not to participate would have no adverse effects, and answered any questions. All counselors agreed to participate in the focus group and signed the informed consent document.

In the four focus groups, 10 participants were employed in rural counties and 18 were employed in urban counties. Three focus group participants were African American (11%) and the remaining 25 participants were white (89%), which is similar to Kentucky's racial distribution (U.S. Census Bureau, 2008). Ten participants were male (36%). Each focus group lasted approximately 60 to 90 minutes and was conducted on-site at the Kentucky School of Alcohol and Other Drug Studies in a private room. After obtaining permission from all the focus group participants, each focus group was audio recorded. In addition, the first author moderated the focus group using a scripted protocol that introduced the study purpose, outlined the agenda, re-emphasized confidentiality, outlined the procedures for incentives, and provided the ground rules. The second author took detailed notes. Since participants may feel uncomfortable disclosing their personal experiences, participants were

also encouraged to provide more general responses that were common to the “typical counselor.” Focus groups were conducted in July 2008. Each counselor received \$50 for participating in a focus group and food was provided.

Focus Group Questions

The focus group protocol included the focus group questions which were developed to gather in-depth, qualitative data on the factors impacting client behavioral treatment outcomes from a provider perspective on a variety of topics. Specifically, the purpose of this paper was to examine how a substance abuse treatment counselors' education, experience in the field, and recovery status could affect client outcomes. In addition, differences in themes between counselors employed in rural versus urban areas were identified. Feedback on the focus group questions were obtained from two experts in the substance abuse treatment field and revisions were made to the focus group protocol. The focus group questions for this paper included:

- How do you think a counselor's education affects client's substance abuse treatment outcomes?
- How do you think a counselor's experience (e.g., the number of years working in the field) affects client's substance abuse treatment outcomes?
- Do you think a counselor's recovery status (e.g., whether or not the counselor has a personal history of substance abuse problems) affects client's substance abuse treatment outcomes?

Content Analysis

Immediately following the focus groups, audio recordings of the four focus groups were transcribed by the second author. Individual research participants were not identified on the transcripts. A content analysis approach was used to develop themes from the qualitative focus group data (e.g., Hall, Baldwin, & Prendergast, 2001). Three raters independently used a line-by-line coding scheme of each focus group transcript. Specifically initial coding, also known as open coding, was first used to condense and categorize the data (Strauss & Corbin, 1990). Next, focused coding took place to build upon the initial coding (Lofland, Snow, Anderson, & Lofland, 2006). Throughout the process of both initial and focused coding, memoing occurred. Memoing has been defined as the step between coding and the first draft of the data analysis (Charmaz, 2001). This strategy allowed for theoretical extension and refinement of the existing literature on substance abuse treatment outcomes from a counselor's perspective. From this analytic approach, 3 education themes, 3 experience themes, and 4 recovery status themes emerged (see Table 1 for overview of thematic findings). Geographic differences between themes were also discovered during the content analysis approach. Illustrative quotes were selected from the focus group transcripts to support each theme.

Results

Education

Three themes regarding education emerged from the focus group data including that education is beneficial, experience matters more than education, and counseling is an innate ability. First, substance abuse treatment counselors felt that formal education (e.g., a Bachelor's or advanced graduate degree) was beneficial and could improve clients' behavioral outcomes. Both urban and rural counselors believe that education results in enhancing and learning new clinical skills (e.g., new treatment methods). However, rural counselors also cited other benefits. Rural counselors thought education made them more

marketable and allowed them to claim more billable hours. In addition, one rural counselor said "...I think higher education helps us to do our paperwork better, which we have plenty of." Managed care and accountability standards have led to ever-growing amounts of paperwork and counselors felt as though paperwork distracted from the clinical aspect of their jobs.

Second, both urban and rural counselors believed that while education was important, experience mattered more. Examples of on the job training, such as learning from and listening to clients as well as other counselors, were thought to be critical in producing positive client outcomes. An urban focus group participant said "Categorically no. It {education} doesn't automatically translate. I have seen people very well credentialed that I would not let counsel my dog. And I don't own one, but if I had one, they wouldn't touch him." The notion of some counselors not being qualified enough to treat a non-human being such as a dog, was also related to another theme. Specifically, the third theme that emerged from only the urban counselors was the perception that counseling was an innate ability, regardless of education level. One urban focus group participant said: "I am a true believer that counselors are born, not made. I've known some very, very good counselors who were just recovering people and I've known some who have Ph.D.'s that I wouldn't send my dog to." The notion that being an effective counselor is an inherent ability was discussed in both urban focus groups.

Experience in the Counseling Occupation

In addition to education, focus group participants were also asked how they think tenure in the counseling field affects clients' substance abuse treatment outcomes. Three themes emerged from the focus group; however, only one theme was specific to being employed in an urban treatment program. In regards to the first theme, both rural and urban focus group participants thought that experience could produce better client outcomes but it could also be detrimental to clients' outcomes – depending on the individual counselor. For example, one urban counselor said:

If you have somebody who is in recovery and has a lot of experience, has no education...I heard a good comment the other day, they can "crack the egg." They crack that egg just right out front, and everything just falls forward from that point. Whereas someone with high degrees of, you know, Ph.D.'s ..., they can talk to them for months on end and nothing ever happens. On the other side, it could just be reversed.

A rural counselor also discussed that the effect of a counselor's experience on client outcomes depends on the individual counselor. Specifically, this participant used the double-edged sword analogy by stating:

I think it can go either way It {experience} can be a two-edged sword in that it can be real easy to start putting someone in a box. And all of a sudden "you remind me of soand-so" so I am going to do the exact same treatment with you that I did with them, and maybe that is not proper. So, I don't...if it does anything, it probably on the whole helps out, but again it can be a two-edged sword.

Both rural and urban counselors cited the benefits of experience including a large clinical skill set. Counselors that have honed and developed an extensive set of clinical skills are able to tailor their therapeutic approach to meet the client's needs. A rural counselor stated "Ahhh, they still get over on you after years of experience ... I think experience helps in that again, it gives you more exposure to different ways, different activities you can do with clients." Interestingly, being sensitive to different cultures was an example of a clinical skill that was only mentioned in the urban focus groups. Counselors that have been employed in

the substance abuse treatment field for numerous years may be more adept at identifying and addressing the culturally specific needs of their clients. As one urban counselor said:

I think if the older counselors, as long as they keep their education, their knowledge base, you know, maintain, in my opinion, I would think that they would make a better counselor just based on their experience and exposure to different kinds of personalities, cultural factors, you know, the whole gambit, than the new person who is eager and has all the book knowledge, ready to take off running.

The notion that client outcomes depend primarily on the client was a theme that emerged from only the urban focus groups. Regardless of the number of years that the counselor has been employed in the field, urban counselors expressed that individualized client treatment planning is needed. One urban counselor stated:

The stuff that I have read, and the stuff that I have experienced is based on, it's more of an individual response from the client, irrespective of education and experience, either one. And under the umbrella of client focused treatment plan or client focused program, where you take the client from where they are, I think it all comes into play. And the education by itself, or experience by itself will not yield a better outcome, unless it is applied to the client in the client's interest, based on what the client needs.

Another urban counselor reaffirmed this sentiment in stating “And that's how...you know, if it's experience or the education, it depends on where that client is as to what piece they might need...But then someone who is from the street and needs “in the face” or direct is not going to get it when you are trying to do theory. {It's a} very important piece, the individuality.” It is interesting to note that despite the purpose of the focus groups (which was to illicit responses on counselor characteristics that affect clients' treatment outcomes), the urban participants repeatedly brought the discussion back to the individual client.

Recovery Status

Counselors were asked how recovery status plays into their clients' treatment success. Four recovery status themes emerged from the focus group data including that it helps as a rapport building tool, it can serve as an excuse for a lack of client engagement, it is more central to clients earlier in the recovery process, and all people are in some form of recovery. Overall, both rural and urban counselors stated that having a counselor who is in recovery could be helpful in their client's recovery process, but it still depends on the individual client. Focus group participants felt that it would be easier for counselors in recovery to establish rapport with clients and not “look down” on them. One urban counselor discussed the need for recovering counselors to also have education by stating:

And when I talk about clinical competence, there is clinical competence and then there's experiential competence – I have gone through recovery, I'm in recovery, so I have that piece, and I think that we just need to learn how to blend that, so it's not one's better than the other, I think it's just one's different than the other, and together we make a pretty good team, and good package.

An additional theme that emerged, regardless of the geographic region of the counselor, was that a counselor's recovery status could be an excuse for the client's lack of engagement in the recovery process. Clients that may not be fully committed to the recovery process -- for example those mandated to treatment -- could be looking for any reason to justify their lack of treatment success. One reason clients could use to neutralize their lack of treatment success could be that their counselor is not in recovery and has not “walked a mile in their shoes.” A rural counselor stated “I think clients who want to make that (a counselor's recovery status) a treatment issue are looking for an issue. A lot of times I protect my

anonymity being in recovery, and I'll hear that and then they'll later find out that I am in recovery and so then it will switch to – 'you're Caucasian,' or 'you're not from Kentucky'...it will be something. So I don't give that a lot of credence.” In a related fashion, one urban focus group participant discussed how recovery status became so central in their organization, that the management directed staff not to discuss their status. Specifically, this urban counselor said:

I worked at an inpatient treatment center in the past, and when I started working there we had staff who were in recovery and staff that were not in recovery and that was talked about a lot. Well it got to the point where the management decided that we were no longer allowed to disclose our recovery status because they felt it was almost becoming a distraction, and that it was hurting the client's recovery because they didn't maybe respect the knowledge of the people who weren't in recovery, and the people who were in recovery couldn't work with everybody. And it is a good mix to have, people who are in recovery and have that perspective, but also people who know how to live without substances and have that knowledge base from education from experience, not of using, but of their education and working with folks. So they ended up just not even allowing staff to share anymore whether or not they were in recovery.

Disclosing one's recovery status to a client seemed to be an individual decision among the focus group participants, with the exception of the aforementioned participant who said management mandated that staff not discuss their recovery status. Some experienced counselors had developed strategies to negate the question about their recovery status, while some focus group participants knew counselors that were new to the field who made up addictions in order to establish rapport with clients.

Another theme that emerged from both the rural and urban focus group participants was that recovery status was more central to clients in the earlier stages of change. The Stages of Change model, also known as the transtheoretical perspective, is a public health model of behavior which examines an individual's progression through four distinct stages of readiness to change their perceptions and behaviors regarding substance use (Prochaska & DiClemente, 1983). These four stages include pre-contemplation, contemplation, action, and maintenance. An urban counselor stated:

I just want to say that I get asked that question {if I'm in recovery} almost all of the time. And I have talked to other colleagues about what their responses have been, and just based on what I can see, it seems to be more important to the clients that are earlier in the stages of change. Those that are progressed a little bit further into the change process, it doesn't seem to make as much of a difference to them.

This may be related to the excuse theme discussed above, because clients earlier in the recovery process may not have made a conscious decision (e.g., they are either in the pre-contemplation or contemplation stage) to change their substance use behaviors.

The final theme that emerged from the focus group transcripts was the notion that we are all in recovery. This theme was specific to the urban focus groups. The urban counselors expressed that to some degree it did not matter whether a counselor was in recovery, because he or she was trying to improve his or her behavior in some way. Counselors could be struggling with other health behaviors such as smoking or overeating. One urban counselor stated:

I'm not in recovery, but when I first got into the business I told a friend of mine that I never learned anything about alcohol in school, we really didn't have any classes about that. And I wanted to learn about alcoholism and he said “Fine, come with

me” and he took me to an AA Meeting. And I went to AA for 6 years. We all have something to recover from, and once we understand the process in recovery and we understand 12 Steps and we understand that community we become part of that community, it's easier to be with clients and clients have more respect even though I'm not an alcoholic. Because, and most of the professionals that I've known throughout the years all assume I'm in recovery because...so when I was in an AA Meeting I would always say “Hi, my name is, and I am a recovering human being,” and that was accepted, and so, I think if you're not recovering and you want to work with this clientele, you better learn about recovery and learning about it personally by going to AA once a week for 6 years really does a lot for understanding the process.

This counselor used Alcoholics Anonymous (AA) as a self-help forum to address his specific behavior issues which were not alcohol-related as well as to learn about the specific struggles related to alcohol and drug dependence.

Discussion

The results of this study indicate that substance abuse counselors in both rural and urban venues share many of the same opinions regarding the activities involved in the occupation of counseling, the benefits of counselor education and experience, and the meaning of counselor recovery status. Both urban and rural counselors agree that counselor experience can have benefits, including a more diverse treatment repertoire. Though this may seem an obvious conclusion, it is important to note that past findings indicate that the quality of such experience is important (Sias et al., 2006). That is, having worked in a variety of treatment settings, both urban and rural, experimenting with a variety of treatment techniques, and being exposed to different types of clients creates a greater wealth of experience than working in a less varied environment.

Though the substance abuse counselors participating in this research indicate that experience was useful, rural and urban counselors agree that it may or may not produce better outcomes. While counselors from both settings highlight that prolonged work in the substance abuse treatment field can result in burnout and negative attitudes about the likelihood of sustained recovery among clients, only the urban counselors espouse the belief that client outcomes often depend more on the particular client than the counselor. There is extant literature that reflects on the occupational burnout that is prevalent among those working in the substance abuse treatment field, discussing both the causes and effects of this burnout (Lacoursiere, 2001; Garner, Knight, & Simpson, 2007; Shoptaw, Stein, & Rawson, 2000; Knudsen, Ducharme, & Roman, 2006; Burke & Greenglass, 2001; Elman & Dowd, 1997). Though substance abuse counselor burnout and pessimistic attitudes about client outcomes contribute to negative client experience and lower recovery rates, it is clear from this research that it is a substantial concern for substance abuse counselors. The sentiment expressed by participants in the urban focus groups that the client's recovery status was more dependent on the client than the counselor may reflect an attempt to manage negative client outcomes in a way that relieves urban counselors from experiencing some of the difficult emotions that can become involved when the substance abuse counseling process does not result in client abstinence.

Although experience in the field for substance abuse counselors can have both positive and negative aspects, rural and urban counselors agreed that additional education and training can only improve counselor functioning in the treatment setting. Despite the belief among focus group participants that experience is a more significant factor, this study found that substance abuse counselors in urban and rural communities have overwhelmingly positive attitudes about the value of education. Even urban counselors – who also suggested that

counseling was an innate ability – agreed that formal education and staying current on new treatment strategies can improve counselor efficacy. Past research supports these conclusions, with findings that indicate counselor education and counselor cognitive functioning are positively correlated (Sias et al., 2006; Rest & Narvaez, 1994; Thoma, 1986). Specifically, more educated counselors have been found to possess characteristics like the ability to “read” clients and assess their individual needs, which may improve client outcomes (Sias et al., 2006).

In this research, rural counselors cited additional benefits of education that urban substance abuse counselors did not, such as having a competitive edge when on the job market and being able to claim more billable hours. These are likely greater concerns for those working in the rural setting since their counseling job opportunities are more limited than those in urban venues and they may have fewer opportunities to use their counseling skill set to supplement their income (e.g., working part time at another treatment facility or hospital).

With regard to recovery status among substance abuse counselors, both the urban and rural focus groups asserted the belief that substance abuse counselors in recovery often have an easier time establishing rapport with clients. While both groups perceived recovery status as a potential rapport building tool, past research indicates that it may have few enduring positive effects on the client-counselor relationship and on client recovery (Culbreth, 2000). Recovering counselors are typically less educated than their non-recovering colleagues and may feel less motivated to pursue additional training than counselors that are not in recovery (Culbreth, 2000; Sias et al., 2006; Stoffelmayr et al., 1998). Additionally, substance abuse counselors that are in recovery may have a more rigid treatment style and lower levels of autonomy, perhaps due to their lower levels of education (Culbreth, 2000); however, recovering counselors' more firm treatment styles may be acceptable by clients if they know their counselor is successful in their own recovery process. Other research has yielded different results, suggesting that substance abuse counselors in recovery tend to use a more eclectic approach to treatment (Humphreys, Noke, & Moos, 1996; Stoffelmayr et al., 1998). Regardless of whether or not recovering counselors have better client outcomes, results of both the current and past research indicate that being a counselor in recovery seems to ease the initial tension between these substance abuse treatment professionals and their clients, though it is unclear if this initial rapport established through shared experience has a continuing impact on the counselor-client relationship or client outcomes.

Though counselors from urban and rural treatment facilities shared many of the same thoughts regarding topics discussed, some different themes did emerge during the focus group sessions. It appears that substance abuse counselors from urban areas expressed more varied attitudes regarding the effects of counselors' level of experience and recovery status than did their rural counterparts. Urban counselors, for example, identified such skills as being able to recognize the culturally specific needs of their clients as useful and potentially predictive of client success. Given past literature that has found a significant positive correlation between counselor-client gender and ethnicity matching and treatment success, it is clear that identifying client's culturally specific needs and incorporating them into the treatment process can be an important part of the therapeutic process (Kasarabada et al., 2002). Further, it is not surprising that substance abuse counselors in rural Kentucky did not identify this as an important skill since the racial and ethnic make-up of these rural communities is relatively homogenous, with counselors and clients matched racially and culturally more often than in urban communities.

Though the findings of this research are certainly important, there are some limitations that must also be considered. First, generalizability may be limited as these findings are based on four focus groups. Second, these analyses did not consider how different themes were

patterned by counselor gender – rather the focus was mainly on rural-urban counselor differences. Past research has found that counselor gender can be a significant factor when considering such diverse themes as treatment strategies, rate of burnout, and, in certain circumstances, even client outcomes (Jones & Zoppel, 1982; Vredenburg, Carlozzi, & Stein, 1999; Sterling, Gottheil, Winstein, & Serota 1998; Green, Polen, Dickinson, Lynch, & Bennett, 2002; Price & Spence, 1994). Another factor not considered by these analyses, counselor caseload, has also been found to be significantly correlated with counselor burnout and with negative client outcomes in some instances (Luborsky et al., 1997; Garner et al., 2007). Specifically, as substance abuse counselors become overworked, they are less able to effectively serve their clients on an individual basis. In addition to these limitations it is important to note that states differ in their requirements for substance abuse counselors, so the attitudes expressed by participants in the urban and rural focus groups, especially their perceptions of the value of education, may not be generalizable to counselors in all states (Kerwin et al., 2006).

Conclusions

Regardless of the limitations of this study, these findings are an important contribution to the literature on substance abuse treatment and can guide future research. While there is a great wealth of past research that quantitatively investigates counselor characteristics and their correlation to client recovery, burnout, and other themes, this research provides insight into the perceptions of the substance abuse counselors themselves. Understanding their observations about the value of counselor experience, education, and recovery status can provide administrators and others working with these professionals a better sense of the use-value of these various counselor characteristics in the field. This can assist those preparing to work in the substance abuse treatment field or those overseeing substance abuse counselors with preparing themselves or others for the kinds of challenges they will experience in this occupation. Specifically, results of this research suggest that counselors would benefit from increased training opportunities that would help them remain current regarding treatment options and alternative therapies. Further, the results of this research suggest that being a counselor in recovery does not exempt one from the gains of these educational opportunities, as additional counselor education can provide practitioners with knowledge that will have sustained benefits for clients and counselors alike. Given the proliferation of paraprofessionals working as substance abuse counselors, increased access to educational opportunities is also advisable (Mulvey et al., 2003).

In addition to creating more opportunities for substance abuse counselors to further their education, the findings of this study indicate that providing clients with supplementary services (e.g., medical services, transportation assistance, and family/social services) would also create benefits for their counselors (Ducharme, Mello, Roman, Knudsen, & Johnson, 2007). While education, experience, and recovery status are individual counselor characteristics that can impact the success of the treatment process, providing more comprehensive services to clients would improve client retention and outcomes (Ducharme et al., 2007). Though the responsibility for providing these core and support services has to come from sources other than the counselors, many of whom are often already overburdened, their availability in the treatment setting would create an environment that is better for both clients and their counselors.

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Table 1

Education, Experience in the Counseling Occupation, and Recovery Status Focus Group Themes

Topic Area	Theme
<i>Education</i>	Education is beneficial
	Experience matters more than education
	Counseling is an innate ability*
<i>Experience in the Counseling Occupation</i>	Depends on the individual counselor
	Provides a large clinical skill set
	Outcomes depend primarily on client*
<i>Recovery Status</i>	Recovery status is a rapport building tool
	Recovery status can serve as an excuse for a lack of client engagement
	Knowledge of counselor's recovery status is more central to clients earlier in the recovery process
	All people are in some form of recovery*

Note.

* denotes themes specific to urban counselors only