

Counselors' Attitudes Towards Working With Clients With Substance Use Disorders Ψ

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Attitudes des Conseillers et Conseillères Envers les Clients Souffrant de Troubles de Toxicomanie

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Abstract

Substance use disorders (SUDs) are a significant and growing problem in all walks of life in Canada and the United States. Counselors are increasingly likely to have clients with SUDs regardless of their area of expertise. There is limited research on counselors' attitudes towards working with such clients, or the factors that contribute to these attitudes. In an online survey of 263 Canadian counselors, we found attitudes were mostly positive, although statistically significantly less positive than toward working with clients with major depression. Numerous variables showed significant bivariate relationships with attitudes towards working with clients with SUDs, but only more frequent contact with such clients, fewer workplace situational constraints, and less frequent feelings of anger towards such clients remained as significant predictors of more positive attitudes in a regression analysis. Our research highlights the importance of providing more support for counselors to ensure better service to clients with SUDs.

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Résumé

Les troubles de toxicomanie présentent un problème sérieux et grandissant au Canada et aux États-Unis, indépendamment du niveau socio-économique. Les conseillers et conseillères, peu importe leur domaine d'expertise, risquent alors de traiter des clients ayant des troubles de toxicomanie. Très peu est connu sur l'attitude ou les facteurs qui contribuent à cette attitude de la part des conseillers et conseillères face à leurs interventions avec ce type de clients. Un sondage en ligne auprès de 263 conseillers/conseillères canadiens a révélé que la majorité des attitudes étaient positives, mais que les attitudes sont statistiquement moins positives qu'envers les clients souffrant de dépression majeure. Plusieurs variables ont démontré des relations bi-variées significatives dans les attitudes envers les clients souffrant de troubles de toxicomanie. Cependant, une augmentation dans les contacts avec les clients, une réduction dans les contraintes situationnelles en milieu de travail et une diminution de sentiments de colère étaient les seuls indicateurs significatifs d'attitudes plus positives dans l'analyse de régression. Cette recherche arrive à point et souligne l'importance d'apporter plus d'appui aux conseillers/conseillères afin d'assurer que ces clients reçoivent de meilleurs services.

Keywords

anger, attitudes, counselors, major depression, substance use disorder

Mots Clés

attitudes, colère, conseillers/conseillères, dépression majeure, troubles de toxicomanie

Significance of the Scholarship to the Public

Counselors' attitudes towards working with clients with substance use disorders (SUDs) are mostly positive. More positive counselor attitudes are associated with greater frequency of work with clients with SUDs, workplace environments that are more supportive of this type of work, and less frequent feelings of anger toward these clients. This study informs us about important variables affecting counselor attitudes and the importance of providing supports to counselors to help ensure better service to clients for whom substance use is a factor.

Substance use disorders (SUDs) are a significant social, economic, and humanitarian problem across the globe. In Canada, 1.5 million people, or

4.4% of the population, in 2012 met the criteria for a SUD within the previous year (Statistics Canada, 2013), and in the United States, 9.7 million people (3.6%) over age 12 were reported to have a SUD in 2016 (Center for Behavioral Health Statistics and Quality, 2017). Unfortunately, many of these individuals do not seek treatment; in fact, one 2008 study found that only 14.7% of Americans living with a SUD had sought treatment within the previous year (Grella et al., 2009) and a nationwide Canadian survey reported 82.5% of 855 adult respondents recovering from addiction experienced one or more barriers to initiating recovery (McQuaid et al., 2017). Research has shown that one major barrier to seeking treatment for a mental health issue is anticipated stigmatization and fear of negative responses from healthcare professionals such as general practitioners, psychiatrists, psychologists, and counselors (Barney et al., 2006; McQuaid et al., 2017; Schomerus & Angermeyer, 2008). This fear is not unfounded; attitudes amongst healthcare professionals have been found to be more negative towards patients with SUDs than towards patients with other mental illnesses, physical disabilities (e.g., Christison et al., 2002), or intellectual disabilities (e.g., Boyle et al., 2010). These negative attitudes hinder the development of the therapeutic relationship (Palmer et al., 2009), increase rates of treatment dropout and relapse (Brener et al., 2010; van Boekel et al., 2013), and decrease rates of treatment success (Luoma et al., 2007; van Boekel et al., 2013).

Despite the importance of counselor attitudes, there are relatively few studies published about counselors' attitudes, especially their attitudes towards clients with SUDs. In fact, over the past five decades, only 25 studies have been conducted that examined counselors' attitudes towards clients with SUDs and most of these are over a decade old. Counselors' attitudes were found to be generally positive (Ball et al., 2002; Carroll, 1993; Dunston-McLee, 2001; Kahle & White, 1991; Rodgers-Bonaccorsy, 2010) as well as more positive than those of other social and healthcare professionals (Carroll, 1993). Nonetheless, a minority of counselors in some of these studies did report having stigmatizing and stereotypical views towards clients with SUDs (Kahle & White, 1991; West & Miller, 1999). Given changes within the last decade in the social and political landscape of substance use, such as the legalization of cannabis, the mounting opioid crisis, and a more open public discussion about mental health and addiction, it is likely that counselors' attitudes may have shifted, particularly within the last five years. Given that more than half of the studies on counselors' attitudes were conducted before 2000 and only one was conducted within the last five years (Balich et al., 2015), it is possible that much of the extant research is out of date, which supports the need for the present study.

In addition to understanding counselors' current attitudes towards working with clients with SUDs, it is also important to identify predictors of these attitudes. The contact hypothesis (Williams, 1947) states that the negative attitudes and stereotypes held by the in-group are a result of ignorance, and that first-hand experience with the out-group will disconfirm these stereotypes, thus improving attitudes. Contact between in-groups and out-groups goes beyond face-to-face interactions to include forms of indirect contact such as conversations with friends and family, media coverage, and observation of the out-group in public (Lee et al., 2004). Allport (1954) proposed four conditions that he argued were necessary in order for contact to reduce prejudice: equal status between the groups, common goals, intergroup cooperation, and the support of authorities, law, or custom. Meta-analyses by Pettigrew and Tropp (2006) and Pettigrew et al. (2011) found that, although Allport's four conditions facilitate the positive effect of contact, they do not need to be present for contact to reduce prejudice. These meta-analyses also found that intergroup contact reduces prejudice, irrespective of the type or demographic makeup of the group, and that the effect of contact is likely mediated by affective factors such as reduced anxiety and increased empathy. A meta-analysis by Paluck et al. (2019) found that contact between in-groups and out-groups is particularly effective as a strategy to reduce prejudice towards people with mental or physical disabilities.

The contact hypothesis is supported by past research on attitudes of counselors, counseling trainees, and other health professionals that suggest several factors are directly and positively correlated with positive attitudes. These include: SUD education and training (Balich et al., 2015; Caplehorn et al., 1997; Davis et al., 2010; Dunston-McLee, 2001; Forman et al., 2001; West & Miller, 1999), experience working with clients with SUDs (Caplehorn et al., 1997; Forman et al., 2001), frequent contact with clients with SUDs (Dunston-McLee, 2001; van Boekel et al., 2014), working in a specialized SUD clinic (Gilchrist et al., 2011; van Boekel et al., 2014), having confidence in clinical skills and treatment effectiveness (van Boekel et al., 2014; Van Kampen, 2010), having had an SUD oneself (Caplehorn et al., 1997; Davis et al., 2010), and having had an experience with a close person with an SUD (Davis et al., 2010; Koch et al., 2006). In addition, Rodgers-Bonnacorsy (2010) found a positive effect of role support (i.e., perceived support from work colleagues; Cartwright, 1980) on counselors' attitudes.

Still other variables have been found to have negative relationships with attitudes. For example, negative emotions, such as fear and anger, were found to be associated with more negative attitudes towards clients with SUDs (van Boekel et al., 2014). Albery et al. (2003) found that, amongst a sample

of nonspecialist substance use workers (including volunteer counselors), the development of positive attitudes toward individuals with SUDs was hindered when situational constraints were above a certain level. Situational constraints were defined as work-related factors such as patient load, stress, time pressure, organizational issues, and problems with morale in the workplace. Attribution beliefs have also been studied in relation to attitudes towards clients with SUDs; attributing responsibility to the client for their addiction was found to be associated with more negative attitudes amongst psychologists, whereas perceiving the client as in control of their disorder did not have a significant effect (van Boekel et al., 2014). Finally, the effect of age on counselors' attitudes has also been studied; one study found a negative correlation (Carroll, 1996), whereas another found no significant relationship between age and counselor attitudes (Muldoon, 1998).

Finally, the personal substance use habits of mental health professionals have also been investigated as possible predictors of attitudes towards individuals with SUDs. Results from these studies were mixed; one study that included psychologists found that heavy drinkers reported being more permissive towards drug use but also that participants who did not use illicit drugs had more positive attitudes towards SUD treatment outcomes (Richmond & Foster, 2003). Another study that included psychologists found no relationship between alcohol consumption habits and attitudes toward clients with SUDs (van Boekel et al., 2014).

Despite the growing problem of SUDs and the importance of practitioners' attitudes for working with such a stigmatized group, there has yet to be a study that focuses specifically on the attitudes of counselors towards clients with SUDs. The current study was designed to address this specific gap in the research. Our study had two purposes. First, we examined counselors' attitudes towards working with clients with SUDs and compared them to their attitudes towards working with clients with another commonly encountered disorder, major depressive disorder (MDD), as this provides us with a basis for comparison. We expected to find generally positive attitudes towards working with both groups of clients, but also hypothesized that we would find counselors' attitudes towards working with clients with SUDs to be significantly less positive. Second, based on the empirical literature and the contact hypothesis, we examined (a) educational and experience variables (i.e., hours of SUD training, educational interventions, and previous experience with SUD clients), (b) work-related factors (i.e., frequency of working with SUD clients, SUD clinic setting or not, role adequacy, role support, situational constraints, and time worked in an SUD clinic), and (c) personal or demographic variables (i.e., personal substance use, personal experience with

SUDs, emotional reactions, attribution beliefs, age, and gender) to explore which of these variables are significantly related to counselors' attitudes towards clients. We also examined which of these significant variables at the bivariate level explained counselors' attitudes in the presence of the other variables. Although different potential predictors of healthcare professionals' attitudes have been investigated across a number of studies, most of these studies did not focus solely on counselors and did not examine the contributions of these variables in the presence of others. We expected most variables to show significant bivariate relationships (continuous variables) or differences (categorical variables) with attitudes but it was unclear which variables would remain statistically significant in the presence of the other variables.

Methods

Participants

The sample consisted of 263 participants, ranging in age from 24 to 75 years, with a mean age of 45.9 years ($SD = 12.4$ years). The majority of participants identified as female ($n = 200$; 76.0%); other gender identities reported were male ($n = 57$; 21.7%), genderqueer ($n = 4$; 1.5%), and questioning ($n = 1$; 0.4%), with $n = 1$ missing. A large majority of the sample reported having European heritage ($n = 209$; 79.5%). The next most commonly reported ethnicity was mixed heritage ($n = 16$; 6.1%), followed by Middle Eastern ($n = 6$; 2.3%), South Asian ($n = 6$; 2.3%), Jewish/Semitic ($n = 5$; 1.9%), East Asian ($n = 4$; 1.5%), Caribbean ($n = 3$; 1.1%), Hispanic/Latinx ($n = 2$; 0.8%), and Aboriginal Peoples ($n = 1$; 0.4%); there were 11 (4.2%) missing responses. The vast majority of the sample reported having a master's degree ($n = 205$; 77.9%), followed by a doctoral degree ($n = 28$; 10.6%) or bachelor's degree ($n = 15$; 5.7%); other participants reported having a post-graduate certificate, college/university diploma, or currently in a graduate program or an unspecified degree program ($n = 15$; 5.7%). Importantly, counselors in this study were not defined by their professional title, but by the act of practicing counseling or psychotherapy. Thus, although most of the participants had a master's degree in counseling psychology, our sample also included individuals from a variety of professional designations, such as social workers, clinical psychologists, and counseling psychologists.

Measures

The following measures were used in the survey to collect data on counselors' attitudes as well as variables that might predict or explain these attitudes. Unless otherwise stated, the specific measures were chosen based on their

Table 1. Descriptive Properties of Study Measures

Variable	n	Items	M	SD	Range		α
					Potential	Actual	
MCRS-SUD	263	9	43.13	7.51	9–54	17–54	.83
MCRS-MDD	263	9	44.16	6.67	9–54	16–54	.80
DPOPQ–Situational Constraints	261	16	42.12	15.84	16–112	16–84	.83
DDPPQ–Role Adequacy	262	7	38.94	10.07	7–49	7–49	.95
DDPPQ–Role Support	263	3	18.37	4.08	3–21	3–21	.91
Attribution–Control	259	1	2.53	1.60	1–7	1–7	— ^a
Attribution–Responsible	258	1	3.24	1.96	1–7	1–7	— ^a
Emotions–Afraid	263	1	0.62	0.77	0–4	0–3	— ^a
Emotions–Sorry	261	1	2.11	1.16	0–4	0–4	— ^a
Emotions–Angry	263	1	0.80	0.80	0–4	0–3	— ^a
Emotions–Disgusted	263	1	0.33	0.58	0–4	0–2	— ^a
Emotions–Sad	261	1	2.47	1.07	0–4	0–4	— ^a

Note. MCRS = Medical Condition Regard Scale; SUD = Substance Use Disorder; MDD = Major Depressive Disorder; DPOPQ = Drug Problems Occupationally Perceived Questionnaire; DDPPQ = Drug and Drug Problems Perceptions Questionnaire.

^aAlpha could not be computed, as these are single-item measures.

previous use in similar research. To address missing data in the Drug Problems Occupationally Perceived Questionnaire (DPOPQ; Albery et al., 2003) and Medical Condition Regard Scale (MCRS; Christison et al., 2002) sections, we used case mean replacement. Participants missing responses for no more than two out of nine items for the MCRS and three out of 16 items for the DPOPQ had their missing data replaced with the mean of their individual item scores on the scale in question; out of 83 data points collected, only one participant missed as much as 9.6% of the data. For all multi-item instruments, the alpha coefficient for their scores are presented in Table 1.

Work setting questionnaire. Participants were asked whether they currently worked in a clinic that specializes in the treatment of clients with SUDs and, if so, how long they had worked in this setting (in years and months). A third item, “How often do you work with clients with substance use disorders?” was also included; response options were *never or almost never, a few times a year, monthly, weekly, and daily* and were scored from 0 to 4.

Situational constraints. Situational constraints were measured using a modified version of the DPOPQ (Albery et al., 2003). The scale measures perceived

workplace barriers to working with the SUD population (e.g., “At my job, I am not permitted to work with SUDs”) and is the only such scale in the literature. We removed three items that were either ambiguous or seemingly unrelated to situational constraints (e.g., “I see drug-related problems as symptomatic of wider problems”) and added one item (“At my workplace, SUDs are never the focus of treatment”), resulting in a 16-item scale. Participants indicated their agreement with items using a 7-point Likert-type scale ranging from 1 (*strongly disagree*) to 7 (*strongly agree*). This response format was also used in other survey sections. Items corresponding to low situational constraints were reverse scored. Individual item scores were summed to create a total situational constraints score ranging from 16 (*low constraints*) to 112 (*high constraints*).

MCRS. The MCRS (Christison et al., 2002) is an 11-item scale measuring attitudes towards working with specific patient/client groups (e.g., “Working with these clients is satisfying”). Although we found several attitudinal scales in the literature, the MCRS was the only scale to have acceptable psychometric properties. In this study, counselors completed the MCRS with regard to a client with a SUD (MCRS-SUD) as well as with regard to a client with MDD (MCRS-MDD). Scores were compared for MCRS-SUD and MCRS-MDD. Individuals with MDD were considered a good comparison group as counselors commonly see them and MDD is often addressed in counselor education programs. We modified the MCRS for use with counselors (e.g., changing the word “patients” to “clients”), removing one item with excessive missing data that was perhaps less relevant to the counseling profession (“Insurance providers should cover clients like this to the same degree that they cover clients with other conditions”), and one item that did not load on the unidimensional scale (“I wouldn’t mind answering an emergency phone call or email from these clients outside of my regular work hours”). This process resulted in a 9-item unidimensional scale. We used a slightly modified 6-point Likert-type scale ranging from 1 (*strongly disagree*) to 6 (*strongly agree*). Items corresponding to low regard were reverse-scored. The nine individual item scores were summed to create a total score, which ranged from 9 (*lowest regard*) to 54 (*highest regard*).

Attribution beliefs. This section included two items from van Boekel et al. (2014) regarding beliefs about addicted persons’ causative roles in their own addiction: (a) Someone with a SUD is in control of their disorder, and (b) someone with a SUD is responsible for their disorder. The response format was changed from a 5-point Likert-type scale to the same 7-point Likert-type scale used throughout most of the survey in which participants are asked to respond from 1 (*strongly disagree*) to 7 (*strongly agree*).

Emotional reactions questionnaire. This section was comprised of five items that asked participants to report how frequently they experienced specific negative emotions towards people with SUDs (e.g., “I feel angry at these people”). Three items (afraid, sorry¹, angry) were based on van Boekel et al. (2014), whereas two items (disgusted, sad) were added to enrich the data. A 5-point Likert-type scale was used, ranging from 1 (*never or almost never*) to 5 (*always or almost always*).

Drug and Drug Problems Perceptions Questionnaire (DDPPQ)—Role Adequacy. A modified version of the 7-item subscale, Role Adequacy (Items 1–7), from the DDPPQ (Watson et al., 2006) was used to measure role adequacy or what we think is best described as “confidence.” Participants were asked about their perceived levels of knowledge regarding substance use and its treatments and if they perceived this knowledge to be sufficient to carry out their jobs effectively. This section used the same 7-point Likert-type scale used throughout the survey. Individual item scores were summed to obtain a total confidence score, ranging from 7 (*lowest confidence*) to 49 (*highest confidence*).

DDPPQ—Role Support. The 3-item Role Support subscale (Items 12, 13, and 14) from the DDPPQ (Watson et al., 2006) was modified and used to collect information on the perceived availability of colleagues who can help to clarify professional responsibilities and assist with specific client-related issues or personal difficulties encountered in the workplace. The same 7-point Likert-type scale was used, as with other survey measures. Item scores were summed to obtain a total role support score, ranging from 3 (*lowest role support*) to 21 (*highest role support*).

Personal exposure to and experience with SUDs. This section was composed of four yes or no questions that asked if the participant had currently or previously known a coworker, family member, friend, or intimate partner with a SUD, and two questions that asked if the participant currently or previously had (a) a SUD or (b) a behavioral addiction (e.g., to gambling, sex, internet, or food).

Substance use information. Participants were asked about their current and past recreational use of five main groups of substances: alcohol, cannabis (e.g., marijuana, hashish, edibles), psychedelics (e.g., LSD, magic mushrooms, mescaline), party/rave drugs (e.g., MDMA, GHB, ketamine), and hard drugs (e.g., cocaine, crack, heroin, prescription stimulants/opioids, methamphetamine). There were three response options: *never*, *within my lifetime*, and *within the past month* that were scored 0, 1, or 2.

Background. This section asked for the participant's age, gender identity, primary ethnic/cultural heritage or ancestry, highest level of education, and the current setting(s) in which the participant saw clients. Two other items asked about number of hours of previous experience working with clients with SUDs and number of hours of previous SUD-related education. Finally, an educational interventions item was also included (i.e., "During this SUD education, which of the following educational activities were used by the instructor?"). Possible responses included: reflective activities (e.g., keeping a reflective journal, group discussions on stigma/biases, opportunities for self-reflection; Balich et al., 2015), practical exercises (e.g., giving up an unhealthy habit for a set amount of time, agreeing to abstain from a negative behaviour, and/or adding a positive behavior to your daily routine for a set amount of time; Balich et al., 2015), and direct client contact (e.g., working with substance addicted clients, attending an Alcoholics or Narcotics Anonymous meeting; May et al., 2002). Research has suggested that education that involves the previously mentioned types of interventions may be more influential on attitudes than strictly lecture-based education. Participants indicated in which of these educational interventions they had participated.

Procedure

Recruitment. Participants were recruited from across Canada and included individuals who self-identified as counselors working in the community as general counselors or substance use counselors as well as counseling trainees who were actively seeing clients. Administrators of counseling clinics, health authorities, professional organizations, and nonprofit organizations were asked to circulate the survey amongst their employees or members. Counseling training programs from across Canada were contacted via email and asked to distribute the survey amongst their students who were currently seeing clients in the field. We also sent individual and personalized emails to potential participants by retrieving their email addresses from publicly available online counselor databases. The Behavioural Research Ethics Board of the University of British Columbia approved this study. Data were collected using an online survey via Fluidsurveys. The survey took approximately 20 minutes to complete. Participants gave informed consent and could opt to enter into a draw to win one of ten \$10 Starbucks gift cards as an incentive to participate.

Data Analysis

The mean, standard deviation, and distribution (skew, kurtosis, and presence of outliers) were examined for each variable. Data were collected on a number of variables addressing education and experience and work-related factors that

used multiple categorical responses. We used preliminary analyses of the data to determine if some categories should be combined. In each case, we tried to create fewer groups that ensured adequate (although not necessarily roughly equal) group sizes that still best represented any significant differences among the original groupings on the dependent variable. For example, the hours of SUD training variable originally contained five groups: 0 hrs ($n = 16$); 1–4 hrs ($n = 14$); 5–9 hrs ($n = 24$); 10–40 hrs ($n = 75$); more than 40 hrs ($n = 123$). We reduced the number of groups to three by combining the first three groups because the sample sizes for these groups were quite small and these groups did not differ from each other on the dependent variable; the three final groups did differ significantly from each other on the dependent variable.

Demographic information for the sample was described using means and standard deviations or frequencies and percentages. To address the first research question, counselors' attitudes toward hypothetical clients with (a) SUD (MCRS-SUD scores), and (b) MDD (MCRS-MDD scores) were compared using a one-way repeated-measures analysis of variance (ANOVA). If a significant difference was found, a series of one-way repeated-measures ANOVAs would examine differences at the item level using a more conservative alpha level of .01 (given the multiple tests and inflated Type I error rate). Eta-squared (rather than partial eta-squared) was used as the effect size measure.

The second research question focused initially on identifying variables that either showed a significant correlation with, or significant differences on, attitude (i.e., MCRS-SUD) scores using Pearson (r) and Spearman rho (r_s) correlation coefficients or one-way between groups ANOVAs, respectively. Given the number of variables examined, a more conservative alpha of .01 was used. For the ANOVAs, omega-squared (ω^2) was used as the effect size indicator, and the Games-Howell test was used for post-hoc comparisons. If the data violated the assumption of homogeneity of variances, as determined by Levene's test, Welch variance weighted ANOVAs were conducted using an adjusted omega squared as the effect size indicator. Pearson correlations were used with the following variables: time worked in an SUD clinic, role adequacy, role support, situational constraints, and age. Spearman rho correlations were used with the emotional reactions and attribution beliefs items. ANOVAs were used to examine the following variables: hours of SUD training, educational interventions, previous experience with SUD clients, frequency of working with SUD population, SUD clinic employment, substance use, personal experience with a SUD, and gender. To determine which variables significantly explained counselors' attitudes in the presence of the other variables, an ordinary least squares multiple regression was performed using the variables found to have significant bivariate relationships with, or differences on, MCRS-SUD scores. An alpha of .01 was used.

Results

Work Setting and SUD Experience and Training of Participants

Participants in this study reported seeing clients in a variety of settings, including private practice ($n = 171$; 65.0%), community nonprofit agencies ($n = 66$; 25.1%), health authority clinics ($n = 38$; 14.4%), postsecondary institutions ($n = 16$; 6.1%), elementary and secondary schools ($n = 15$; 5.7%), other publicly funded clinics ($n = 7$; 2.7%), employee assistance programs ($n = 7$; 2.7%), hospitals ($n = 9$; 3.4%), and residential drug and alcohol treatment centers ($n = 3$; 1.1%). Most participants did not work in clinics that specialized in SUD treatment ($n = 181$; 68.8%), although some did report working in such clinics ($n = 79$; 30.0%) from one month to 30 years, with a mean period of 7.6 years ($SD = 7.96$ years). Participants reported working with clients with SUDs *daily* ($n = 66$; 25.1%), *weekly* ($n = 84$; 31.9%), *monthly* ($n = 36$; 13.7%), *a few times a year* ($n = 53$; 20.2%), or *never or almost never* ($n = 24$; 9.1%).

Almost a quarter of participants reported having worked over 3,000 hours with the SUD population ($n = 62$; 23.6%); others reported working 2,001–3,000 hours ($n = 15$; 5.7%), 501–2,000 hours ($n = 42$; 16.0%), 201–500 hours ($n = 34$; 12.9%), 51–200 hours ($n = 46$; 17.5%), 1–50 hours ($n = 47$; 17.9%), and zero hours ($n = 4$; 1.5%); 13 (4.9%) participants did not respond to this item. Almost half of participants reported having more than 40 hours of SUD training ($n = 123$; 46.8%); 28.5% ($n = 75$) of participants reported having between 10–40 hours, 9.1% ($n = 24$) had 5–9 hours, 5.3% ($n = 14$) had 1–4 hours of SUD training, and 6.1% ($n = 16$) reported no SUD training; 11 (4.2%) participants did not respond to this item.

Counselors' Attitudes Towards Clients

Reliability estimates and counselors' performance on the study measures are shown in Table 1. Internal consistency reliability estimates ranged from .80 to .95. On average, counselors in this study reported somewhat positive attitudes toward working with clients with SUDs ($M = 43.1$, $SD = 7.51$; maximum score = 54); only 2.3% of the participants scored in the lower half of the possible score range. A one-way repeated measures ANOVA showed a very small but statistically significant difference between the MCRS-SUD and MCRS-MDD total scores: Wilks' Lambda = .981, $F(1, 262) = 5.03$, $p = .026$, eta-squared = .005. Counselors reported slightly more positive attitudes towards working with clients with MDD ($M = 44.2$, $SD = 6.67$) than they did towards working with clients with SUDs. To better understand the

Table 2. Mean Performance on MCRS-SUD and MCRS-MDD Items

Item	Mean MCRS-SUD Item Score	Mean MCRS- MDD Item Score	Results	η^2
1. I prefer to not work with these clients*	4.81 (SD = 1.51)	4.91 (SD = 1.49)	$F(1, 262) = 0.81$, $p = .369$	.001
2. These clients irritate me*	5.27 (SD = 1.10)	5.19 (SD = 1.14)	$F(1, 262) = 1.09$, $p = .298$	.001
3. I enjoy giving extra time to these clients	3.98 (SD = 1.52)	3.89 (SD = 1.49)	$F(1, 262) = 0.93$, $p = .335$	.001
4. These clients are particularly difficult for me to work with*	4.14 (SD = 1.57)	4.35 (SD = 1.55)	$F(1, 262) = 3.06$, $p = .082$	.005
5. Working with these clients is satisfying	4.74 (SD = 1.19)	4.75 (SD = 1.15)	$F(1, 262) < 0.01$, $p = .964$	.000
6. I feel especially compassionate toward these clients	4.84 (SD = 1.29)	4.86 (SD = 1.22)	$F(1, 262) = 0.02$, $p = .888$	.000
7. I can usually find something that helps these clients feel better	4.65 (SD = 1.20)	5.06 (SD = .91)	$F(1, 262) =$ 28.70, $p < .0001$	.04 (small effect size)
8. There is little I can do to help these clients*	4.91 (SD = 1.21)	5.22 (SD = 1.01)	$F(1, 262) =$ 17.07, $p < .0001$	.02 (small effect size)
9. Treating these clients is a waste of money*	5.78 (SD = .80)	5.93 (SD = .30)	$F(1, 262) =$ 11.42, $p < .001$	.02 (small effect size)

Note. MCRS = Medical Condition Regard Scale; SUD = Substance Use Disorder; MDD = Major Depressive Disorder. An asterisk (*) is used to indicate items that have been reverse-coded. Significant results are in bold. MCRS-SUD and MCRS-MDD item scores range from 1 to 6, with higher scores indicating a more positive attitude.

source of this difference, the mean scores of the nine corresponding individual items on the MCRS-SUD and MCRS-MDD were compared; the only small but significant differences in scores were found for items 7, 8, and 9 and favored the MCRS-MDD (see Table 2).

Group Differences on, and Correlates of, Counselors' Attitudes

Education and experience

Hours of SUD training. Participants were divided into three groups: Group 1 = 0–9 hr ($n = 54$); Group 2 = 10–40 hr ($n = 75$); Group 3 = > 40 hr ($n = 123$). There was a statistically significant difference in MCRS-SUD scores for the three groups: $F(2, 117.81) = 30.12$, $p < .001$, with a medium

effect size ($\omega^2 = .07$). Post-hoc comparisons showed significant differences ($p < .01$) among all three groups: 0–9 hours: $M = 37.3$, $SD = 8.10$; 10–40 hours: $M = 42.3$, $SD = 6.80$; > 40 hours: $M = 46.3$, $SD = 5.86$.

Educational interventions. Participants were divided into three groups reflecting which interventions (and roughly the extent of interventions) they had participated in: Group 1 = none ($n = 59$); Group 2 = reflective only, practical only, contact only, or reflective + practical ($n = 95$); Group 3 = reflective + contact, contact + practical, or reflective + contact + practical ($n = 109$). The results showed a statistically significant difference in MCRS-SUD scores among the three groups: $F(2, 133.32) = 15.75$, $p < .001$, with a small effect size ($\omega^2 = .04$). Post-hoc comparisons showed significant differences ($p < .01$) among only two of the three educational intervention groups: (a) Group 1: $M = 39.2$, $SD = 9.11$ vs. Group 3: $M = 45.8$, $SD = 5.79$ and (b) Group 2: $M = 42.5$, $SD = 6.99$ vs. Group 3.

Previous experience with SUD clients. Participants were divided into three groups based on hours of experience working with clients with SUDs: Group 1 = 0–50 hr ($n = 51$); Group 2 = 51–3000 hr ($n = 137$); Group 3 = > 3000 hr ($n = 62$). Despite the seemingly large range of hours of experience in Group 2, there were no significant differences among the smaller groups (51–200 hr, 201–500 hr, 501–2000 hr, 2001–3000 hr) comprising this group on MCRS-SUD scores. A statistically significant difference in MCRS-SUD scores was found for the three groups: $F(2, 114.96) = 37.85$, $p < .001$, with a medium effect size ($\omega^2 = .09$). Post-hoc comparisons showed significant differences ($p < .001$) among all three groups: Group 1: $M = 37.1$, $SD = 7.89$; Group 2: $M = 43.4$, $SD = 6.80$; Group 3: $M = 47.9$, $SD = 5.11$.

Work-related factors

Frequency of working with SUD population. Participants were divided into three groups: Group 1 = *never or almost never* ($n = 24$); Group 2 = *a few times a year to monthly* ($n = 89$); Group 3 = *weekly to daily* ($n = 150$). There was a large statistically significant difference in MCRS-SUD scores for the three groups: $F(2, 260) = 53.19$, $p < .001$, $\omega^2 = .28$. Post-hoc comparisons showed significant differences ($p < .001$) among all three groups: Group 1: $M = 33.7$, $SD = 7.58$; Group 2: $M = 40.4$, $SD = 7.00$; Group 3: $M = 46.3$, $SD = 5.70$.

SUD clinic employment. There was a significant difference in MCRS-SUD scores based on whether participants worked in a specialized SUD clinic

($n = 79$) or not ($n = 181$): $F(1, 220.70) = 51.88, p < .001$ with a large effect size ($\omega^2 = .16$). Those working in a specialized SUD clinic ($M = 47.1$; $SD = 5.02$) showed higher scores than those who did not ($M = 41.3$; $SD = 7.73$).²

Other work-related factors. MCRS-SUD scores were significantly correlated with role adequacy ($r = .54, p < .001$), role support ($r = .21, p = .001$), and situational constraints ($r = -.64, p < .001$), but not with time worked in an SUD clinic ($r = .05, p = .700$).

Personal factors

Substance use. Participants were divided into three groups based on the most recent time they had used the substance: *never*, *within my lifetime*, or *within the past month*. No statistically significant differences on MCRS-SUD scores were found among the three groups for alcohol ($n = 19, 76, 167$), $F(2, 259) = 2.26, p = .106$; cannabis ($n = 71, 157, 34$), $F(2, 259) = 0.09, p = .913$; psychedelics ($n = 157, 99, 6$), $F(2, 259) = 0.11, p = .894$; party/rave drugs ($n = 213, 45, 4$), $F(2, 259) = 3.01, p = .051$; or hard drugs ($n = 211, 50, 0$), $F(1, 259) = 0.10, p = .755$. One person did not respond to all five drug-use related items, and one person did not respond to the hard drugs item.

Personal experience with SUDs. Table 3 shows the results of whether or not participants' personal experiences with SUDs produced significantly different MCRS-SUD scores. Only experiences with a coworker, family member, or friend showed small, but significant, differences in MCRS-SUD scores.

Emotional reactions. The frequencies of feeling afraid of ($r_s = -.342, p < .001$), angry towards ($r_s = -.287, p < .001$), or disgusted by ($r_s = -.273, p < .001$) clients with SUDs were significantly and negatively related to MCRS-SUD scores. The frequencies of feeling sorry for ($r_s = -.026, p = .676$) or sad about ($r_s = -.036, p = .567$) clients with SUDs were not significantly related to MCRS-SUD scores.

Attribution beliefs. No significant correlation was found between MCRS-SUD scores and the belief that a person with an SUD is either in control of ($r_s = .018, p = .777$), or responsible for ($r_s = -.139, p = .025$), their disorder.

Age and gender. There was no statistically significant correlation between participants' age and their MCRS-SUD scores ($r = -.137, p = .027$). No significant male versus female gender identity difference in MCRS-SUD scores was found, $F(1, 255) = .01, p = .910$.

Table 3. Differences on the MCRS-SUD by Personal Experiences With SUDs

Experience	Group	Group size	Descriptives	Results	ω^2
Coworker	No	146	$M = 41.70$, $SD = 7.64$	$F(1, 261) = 12.51$, $p < .0001$	.04 (small)
	Yes	117	$M = 44.92$, $SD = 6.97$		
Family member	No	80	$M = 41.19$, $SD = 7.75$	$F(1, 261) = 7.93$, $p = .005$	.03 (small)
	Yes	183	$M = 43.98$, $SD = 7.25$		
Friend	No	88	$M = 41.09$, $SD = 7.98$	$F(1, 261) = 10.13$, $p = .002$	.03 (small)
	Yes	175	$M = 44.16$, $SD = 7.06$		
Intimate partner	No	173	$M = 42.95$, $SD = 7.17$	$F(1, 261) = 0.29$, $p = .592$	.003
	Yes	90	$M = 43.48$, $SD = 8.15$		
Participant SUD	No	226	$M = 42.79$, $SD = 7.44$	$F(1, 261) = 3.35$, $p = .069$	.009
	Yes	37	$M = 45.22$, $SD = 7.68$		
Participant behavioural addiction	No	204	$M = 42.98$, $SD = 7.76$	$F(1, 261) = 0.40$, $p = .528$	.002
	Yes	59	$M = 43.68$, $SD = 6.61$		

Note. Significant results are in bold. MCRS = Medical Condition Regard Scale; SUD = substance use disorder.

Predictors of Counselors' Attitudes Towards Clients With SUDs

Table 4 shows which variables with significant differences on, or bivariate relationships with, MCRS-SUD scores continued to significantly explain these scores in the presence of each other. The assumptions of normality, linearity, and homoscedasticity were met. The model did not exhibit signs of multicollinearity (variance inflation factors = 1.20–6.66). After controlling for other variables, only frequency of working with SUD clients—*weekly to daily* (as compared with reference group *never or almost never*; $\beta = .31$, $p = .008$), lower situational constraints ($\beta = -.38$, $p < .001$), and less frequent feelings of anger with such clients ($\beta = -.16$, $p = .002$) remained as significant predictors of positive attitudes of counselors towards working with clients with SUDs. The model predicted about half of the variance in MCRS-SUD scores: $F(18, 221) = 14.57$, $p < .001$, $R^2 = .54$, $R^2_{adj} = .51$.

Table 4. Predictors of Counselors' Attitudes

Variable	<i>B</i>	<i>SE B</i>	β	<i>p</i>
10–40 hours of SUD training (as compared to reference group: 0–9 hours)	–0.30	1.17	–.02	.80
Over 40 hours of SUD training (as compared to reference group: 0–9 hours)	–0.10	1.35	–.01	.94
Educational interventions (reflective only, practical only, contact only, reflective + practical) (as compared to reference group: no interventions)	0.74	1.06	.05	.49
Educational interventions (reflective + contact, contact + practical, reflective + contact + practical) (as compared to reference group: no interventions)	1.75	1.18	.12	.14
51–3000 hours experience working with clients with SUDs (as compared to reference group: 0–50 hours)	–0.39	1.17	–.03	.74
Over 3000 hours experience working with clients with SUDs (as compared to reference group: 0–50 hours)	0.19	1.54	.01	.90
Working with clients with SUDs <i>a few times per year to monthly</i> (as compared to reference group: <i>never to almost never</i>)	2.65	1.51	.17	.08
Working with clients with SUDs <i>weekly to daily</i> (as compared to reference group: <i>never to almost never</i>)	4.73	1.77	.31	<.01
Working in an SUD clinic	–0.53	0.94	–.03	.57
Role adequacy (confidence)	0.09	0.06	.12	.13
Role support	–0.04	0.09	–.02	.65
Situational constraints	–0.17	0.03	–.38	<.0001
SUD experience with a coworker	0.68	0.81	.05	.40
SUD experience with a family member	0.26	0.82	.02	.75
SUD experience with a friend	–0.02	0.84	–0.001	.98
Emotional reactions—afraid	–0.62	0.53	–.06	.25
Emotional reactions—angry	–1.51	0.48	–.16	<.01
Emotional reactions—disgusted	–0.47	0.72	–.04	.51

Note. Significant results are in bold. *B* is the unstandardized beta or regression weight. *SE B* is the standard error for the unstandardized beta. β is the standardized beta. SUD = substance use disorder.

Discussion

SUDs are a serious health issue across the globe, with far-reaching social, economic, and humanitarian consequences (Wood et al., 2003). Levels of SUD treatment entry are low (Grella et al., 2009) and research on treatment-seeking for mental illness suggests that the fear of being stigmatized by healthcare professionals may be partially to blame (e.g., Schomerus & Angermeyer, 2008).

When people do seek treatment, greater perceived discrimination in interactions with healthcare workers is associated with early treatment dropout (Brener et al., 2010; van Boekel et al., 2013) which, in turn, is associated with increased risk of relapse (Salamina et al., 2010). The addition of counseling to a patient's SUD treatment regimen has been shown to significantly increase treatment retention and, consequently, their chances of recovery (Salamina et al., 2010). Moreover, it is important to recognize that even counselors not specializing in SUDs are increasingly likely to see clients for whom SUDs are an important part of their life experience or background that may need to be taken into account during the counseling process. For example, a client may seek counseling for anxiety and to explore family-of-origin issues but their history of SUD is still a relevant and an important factor for the counselor to be aware of and take into consideration throughout the counseling process.

In the present study, we found that, on average, our sample of counselors in Canada reported somewhat positive attitudes toward working with clients with SUDs and very few reported negative attitudes. Furthermore, we found only trivial differences in counsellors' attitudes towards working with clients with SUDs versus MDD. An item-level analysis revealed that participants did not report any differences in enjoyment, difficulty, satisfaction, levels of irritation, or compassion in working with these two client groups. Instead, any differences that emerged focused more on beliefs about the treatment of the disorder in question and the prognosis of said treatment. A similar finding was reported by van Boekel et al. (2014) with medical professionals. These findings reflect the current reality that SUDs are notoriously difficult to treat and levels of treatment dropout and relapse are very high, whereas the treatment of MDD has a long and proven track record along with a much higher success rate. It is possible that counselors with more positive attitudes towards working with clients with SUDs may have been more likely to agree to participate in the study than counselors with more negative attitudes, given that our sample was not randomly selected and was voluntary. Further research is needed that uses random sampling or compares counselors from specific areas of specialization (e.g., addiction, couples/family, employment).

It is important to consider what variables might be associated with more or less positive attitudes towards working with clients with SUDs. Counselors who harbour negative attitudes towards clients with SUDs may unwittingly reveal their assumptions and prejudices to their clients, thereby interfering with the development of a collaborative therapeutic relationship and disempowering the very clients they seek to help (Curtis & Harrison, 2001). A counselor who is pessimistic about the outcome of treatment may treat their client differently, either consciously or subconsciously, and this may have a deleterious impact on the counseling process. It is also possible that a lack of

confidence regarding treatment of SUDs may cause a counselor to feel more apprehensive or anxious around clients with SUDs, thereby undermining their capacity to provide counseling services to the best of their ability. Although counselors may feel skilled at concealing any negative attitudes they might hold, research has shown that counselors may display microaggressions towards clients from marginalized groups without necessarily being aware of this behavior, and these microaggressions can damage the therapeutic relationship and lead to poorer outcomes (Sue et al., 2007).

Bivariate Relationships With Counselors' Attitudes

As expected, almost all of the variables examined were found to have significant bivariate relationships with counselors' attitudes towards working with clients with SUDs; this fits with the extant literature on health professionals' attitudes more generally. There were a few variables, however, that did not show statistically significant relationships. In some cases, this involved variables in which findings in the literature were mixed (e.g., age). In other cases, the lack of significant bivariate relationships could have been due to small sample sizes or social desirability bias (e.g., personal substance use, having an SUD in the past). There may also be other aspects of substance use or previous addictions that affect attitudes that we did not measure, but could have affected our results. For example, the ease or difficulty of a counselor's own recovery may impact their capacity to empathize with a client's experience of recovery.

Two out of the five emotional reactions, "sorry" and "sad," were not significantly related to attitudes. A possible reason for this result with the "sorry" item is that there is some ambiguity in this word; it was reported by some participants in the comments section that this item could be interpreted as being related to either pity or compassion, and that they were unsure how to respond. Regarding the "sad" item, it is possible that participants also interpreted its meaning as being related to pity, thus yielding a similar result to the "sorry" item.

Although previous experience with a coworker, friend, or family member resulted in significantly more positive attitudes towards working with clients with SUDs, previous personal experiences with an intimate partner with an SUD or one's own SUD or behavioral addiction did not. It is possible that these more intimate experiences are more intense, impactful, traumatic, and conflicted than such an experience with a friend, coworker, or family member, and have a less predictable impact on attitudes. More research is needed to explore the impacts of these more intimate experiences on attitudes.

Neither of the attribution beliefs (i.e., control and responsibility) were significantly related to attitudes. Our results were consistent with previous research with healthcare professionals for control but not for responsibility (van Boekel et al., 2014). In both studies, a low negative relationship between responsibility and attitudes was found but our use of a more stringent alpha level explains our different conclusions.

Predicting Counselors' Attitudes Towards Clients With SUDs

It was of particular interest in this study to determine which variables would continue to show significant relationships with counselors' attitudes in the presence of the other variables that were significant at the bivariate level. We found that more frequent contact with clients with SUDs, fewer workplace situational constraints, and less frequent feelings of anger towards such clients remained as significant predictors of more positive counselor attitudes. Research by van Boekel et al. (2014) also found contact and anger to be significant predictors in medical professionals but they did not examine the role of workplace barriers. It is important to acknowledge the role that shared variance among some of the possible predictor variables may have played in determining the results of the regression. For instance, frequency of working with clients with SUDs likely has shared variance with variables such as previous SUD training, educational interventions, hours of experience, and working in an SUD clinic. Similarly, the situational constraints variable likely has shared variance with role adequacy and role support. Frequency of working with SUD clients and situational constraints were the more immediate and salient influences; this may be one reason that they remained as significant predictors in the regression, while the other variables, although still important, did not.

Frequency of working with the SUD population as a significant predictor of attitudes is in line with the contact hypothesis (Williams, 1947), which holds that stigmatizing attitudes held by members of a nonstigmatized group towards a stigmatized group are a result of ignorance, and that contact between the two groups will disconfirm stereotypes held by the in-group, thus improving their attitudes. The finding that situational constraints remained a significant predictor of counselors' attitudes highlights the important role that workplace environment and supports play. Further research is needed to investigate which workplace constraints are most salient in predicting counselors' attitudes and how these constraints can be effectively ameliorated. Such research could help to illuminate the path towards creating workplace environments that foster the development of more positive attitudes amongst counseling staff.

Interestingly, increased self-reported frequency of feeling angry toward individuals with SUDs was a significant predictor of more negative attitudes. Anger is a strong emotion that can hinder the counselor's ability to think in the moment, may engender feelings of shame, and subsequently result in the counselor lashing out at the client and/or hiding their feelings from clients and colleagues (Honda, 2014). These feelings and how they are dealt with may negatively affect the therapeutic alliance, produce feelings of rejection or stigmatization in the client, and have a negative impact on the counseling process. Feelings of anger have been identified as a relatively common experience during what may be described as difficult clinical moments, but these types of moments are often not addressed in clinical training and have not been well examined in the literature (Honda, 2014). Further research is needed that explores the causes, experience of, and context of anger amongst counselors, which may, in turn, produce recommendations that: (a) improve counselor self-care, self-compassion, and coping skills; (b) normalize these experiences and address them in training, supervision, and consultation; and (c) develop ways of addressing these feelings that have a positive impact on the counseling process and client.

Limitations

There are several limitations to this study. First, the sample was not a randomly selected and representative sample of the counselor population, which limits the generalizability of the study findings. Despite recruitment strategies designed to encourage participation from across Canada and from both urban and rural locations, it is likely that a large proportion of participants were from Vancouver, a city known for its progressive substance use policy as well as its relatively tolerant residents. Other participants in the study will more likely have come from other metropolitan locations in Canada and, as such, rural counselors are likely underrepresented in the sample. Participants were also self-selecting, given that study participation was voluntary, making it likely that counselors or counseling trainees who already had an interest in SUD counseling (and therefore may have more positive attitudes) would be more inclined to participate. Given that the majority of our participants were female and of European heritage, our results are more reflective of their attitudes towards clients with SUDs and the variables related to their attitudes. It would have been beneficial to run separate regressions for men and women, however, the low number of men in our sample did not permit this analysis; such an analysis could be a focus in future research with larger group sizes. Another limitation is that there are few measures that,

in their entirety, are appropriate for use with counselors; thus, we had to modify several measures for use in this study. Although these measures showed good reliability estimates with this sample, the modifications mean we are unable to directly compare results from this study with previous studies that used the measures in their original form. Finally, although we can argue that negative counselor attitudes may hinder the therapeutic relationship and thus treatment outcomes, we cannot argue that attitudes alone are a major determinant of treatment outcomes.

Implications for Practice, Advocacy, Education/Training and Research

This study informs us about Canadian counselors' current attitudes towards working with clients with SUDs and the importance of providing supports to counselors to help ensure better service to clients for whom substance use is a factor. We found that counselors' attitudes were somewhat positive and were slightly more positive towards working with clients with MDD but any differences were confined to items related to treatment delivery and outcomes. This finding reinforces that we still have much to learn when it comes to SUD treatment, and that further research into this topic is warranted. It was clear to us when recruiting our sample and conducting this research that many counselors tend to think of clients with SUDs as needing specialized SUD treatment (e.g., addictions counseling) and not necessarily envisioning SUDs as an area they need to understand and incorporate when counseling clients on other presenting issues (e.g., depression, stress, relationships) or when dealing with challenging moments in the counseling process with such clients. This observation underscores the importance of making SUD education part of mainstream counseling training. Some interesting directions for further research, training, and practice include examining attitudes across a more representative group of counselors, investigating the most effective forms of SUD education, increasing exposure to clients with SUDs, examining situational constraints in greater depth, and examining the types of emotional and professional supports that should be offered to counselors working with clients with SUDs, and how to best implement these supports to allow for their greatest impact.

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Notes

1. This item was mistranslated from a copy of the original Dutch survey used in van Boekel et al. (2014) and should have been “pity” instead of “sorry.”
2. Because the SUD clinic group included a few participants who had been there for only a short period of time, we re-ran these analyses excluding those who had been at the SUD clinic for less than 1 year. The results were essentially unchanged: $F(1,190.43) = 45.74, p < .0001$, with a large effect size ($w^2 = .15$); the SUD clinic group showed more positive attitudes ($n = 71; M = 47.0, SD = 5.15$) than the non-SUD clinic group ($M = 41.3, SD = 7.73$).

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