RELAPSE AS A PHENOMENON OF STAFF BURN-OUT AMONG RECOVERING SUBSTANCE ABUSERS

By

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TO THE READER

The following paper is the second of a series of HCS monographs developed to further our understanding of occupational stress and professional burn-out in health and human service fields. While this study focuses on the substance abuse field, both the concepts and proposed tools for organizational analysis are broadly applicable to the entire range of human service organizations.

Special thanks and acknowledgements are due the persons who shared with me the intimate details of their personal and organizational histories. This paper would not have been possible without their courage and honesty.

It is my hope that the following pages will serve as a stimulus to further discussion and concern. I would welcome the opportunity to receive your comments, your criticisms, and your ideas. Correspondence can be sent to:

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RELAPSE AS A PHENOMENON OF STAFF BURN-OUT AMONG RECOVERING SUBSTANCE ABUSERS

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ABSTRACT

This study is based on interviews with recovering substance abusers (RSAs) who returned to the abuse of alcohol and/or drugs while working as counselors in alcohol and drug abuse treatment programs. Case histories and role analysis are utilized to illustrate the contention of the author that relapse is one of the most tragic apsects of staff burn-out in the substance abuse field. Ten (10) role stressors are identified that characterized the high stress work environment at the time of relapse.

The issue of burn-out will be addressed when we begin defining it as an organizational process and stop defining it solely in terms of the personalities of our casualties.

I. THE CONTEXT OF THE STUDY

This author in an earlier study on staff burn-out utilized a family systems model to conceptualize the process by which staff members become dysfunctional in and are extruded from human service organizations. It was contended that staff casualties increase as the "organizational family" becomes progressively closed. Three incestuous dynamics (professional, social, and sexual) were described which often result in staff burn-out and extrusion in small direct service organizations. Speculation was also made on the staff casualty process (identified as staff fall-out) in the large human ser-

vice bureaucracy. Staff burn-out was defined as an interactional problem that requires modification of both the high stress work milieu and the individual victim's style of stress management.

This study continues the author's interest in exploring the way in which internal relationships within an organizational group and the group's relationship with its outside professional and social environment effects the physical and emotional health of group members. The current study focuses on the alcoholism and drug abuse treatment field and was initiated to assess the extent to which relapse to alcohol/drug abuse by recovering substance abusers (RSAs)[2] working as counselors is a response to the high stress work environment. To initiate this study, the author communicated to a large number of alcoholism and drug abuse treatment programs, professional associations of alcoholism and drug abuse counselors, and self-help groups his desire to interview RSAs who had relapsed while working in the field. Twenty (20) individuals subsequently contacted this author and, following assurances of confidentiality, explanations of the purpose of the study, etc., agreed to in-depth interviews. Each of the interviews was conducted utilizing a format which approximated the following outline:

1. Family and social network history (during the section of the interview on relapse, I returned to this first area and diagrammed the family and social network at the time of relapse.)
2. Brief health history
3. Stress/Defense history

4. Alcohol/drug use history including treatment history.

5. Employment history (both general and in the substance abuse field).

6. History of employment in agency in which relapse occurred (including hiring process, initial orientation and training period, role clarity, supervisory supports, staff interrelationships, group process, etc.)

7. The relapse period (including areas of stress in work, social, and personal setting, the process of extrusion from the agency, etc.).

8. The Post-relapse period (extent of alcohol and drug usage, attempts at treatment, contacts with self-help groups, contacts with prior agency of employment, etc.).

9. Current activities and perspectives on the employment period and the relapse.

Six (6) individuals further gave permission to the author to contact family members, Alcoholics Anonymous (AA) sponsors (with the sponsors' prior permission so as not to violate anonymity), and staff members who were working with the individuals at the time of the relapse. An average of four (4) additional persons were interviewed from the social network of each of these six individuals. In addition to the above, staff from two programs were interviewed (at the program's request) where an RSA who had worked for the program relapsed and subsequently died in an alcohol or drug related incident.

In total, twenty-two (22) personal/organizational histories were constructed. Tapes from interviews on each personal/organizational history were reviewed to determine what organizational factors, if any, contributed to the individual's relapse either by failing to provide sufficient supports or by inadvertantly sabotaging the in-

dividual's recovery via administrative decisions and policies, organizational structures, interpersonal processes, etc. In eight (8) of the twenty-two (22) cases, no organizational sources of stress could be identified which could have contributed to the relapse. In these eight (8) cases, factors influencing the relapse were primarily attributed to personal and interpersonal crises outside of the work setting. In the remaining fourteen (14) cases, there were clearly identifiable stressors in the work environment that could have played a contributing or major role in the individual's relapse. An analysis of the stressors identified in these fourteen (14) cases will be the primary focus of this paper.

I have chosen to organize the information and insights gained from this study in the following manner. Section II will summarize a number of concepts about the phenomenon of staff burn-out and serve to place the conclusions of this study within a broader context. Section III will summarize three case histories and offer a straightforward analysis and interpretation by the author with a minimum of theoretical tools. Section IV will utilize a theory of role dynamics to conceptualize the aggregate results of the study.

II. STAFF BURN-OUT: SOME PRELIMINARY UNDERSTANDINGS

The following understandings about staff burn-out, stated in the form of propositions, have been developed by the author during the past three years. Some of the propositions summarize conclusions

of earlier research studies; others were developed out of the experience of conducting workshops on staff burn-out for human service workers. The purpose of this section is to develop a conceptual framework for understanding how high levels of organizational stress may produce dysfunctional behavior that has previously been described only in terms of the idiosyncrasies of personality or psychopathology.

Proposition 1: Staff burn-out is a deterioration of personal and interpersonal functioning directly attributable to continued contact with high stress work environments. Although the term "staff burn-out" has been primarily utilized in literature on the staff casualty process in the human services field[3,4,5], numerous concepts from management research and theory have been developed on the impact of the organization upon the individual which are directly applicable to this phenomenon.[6]

Corollary 1: Indicators of this deterioration of functioning can be categorized into the following areas:

1. Health indicators,
2. Excessive behavior indicators,
3. Emotional adjustment indicators,
4. Attitude indicators, and
5. Relationship indicators.

The table on the following page summarizes some of the frequently mentioned symptoms under each of these indicators.

Indicators of Staff Burn-Out*

Health Indicators	Excessive Behavior Indicators	Emotional Adjustment Indicators	Attitude Indicators	Relationship Indicators
Fatigue and chronic exhaustion	Increased consumption of caffeine, tobacco, alcohol, over-the-counter medications, psychoactive prescription drugs, illicit drugs	Emotional distancing	Grandiosity	Isolation from or overbonding with other staff
Frequent and prolonged colds	High risk taking behavior, e.g., auto/cycle accidents, falls, "high risk" hobbies, general proneness to accidents and injuries	Paranoia	Boredom	Responding to clients in mechanical manner
Headaches	Extreme mood and behavioral changes	Depression, e.g., loss of meaning, loss of hope	Cynicism	Increased isolation from clients
Sleep disturbances	Increased propensity for violent and aggressive behavior	Decreased impulse control	Sick humor--aimed particularly at clients	Using clients to meet personal, social, sexual needs
Ulcers		Increased feelings of guilt	Air of righteousness	Increased interpersonal conflicts with other staff
Gastro-intestinal disorders		Martyrdom	Hyper-critical of program and/or peers	Increased anger at clients
Sudden losses or gains in weight		Fear of "going crazy"	Expressions of hopelessness and frustration	Increased problems in marital and other interpersonal relationships away from work, including relationships with ones children
Flare-ups of pre-existing medical disorders, e.g., diabetes, high blood pressure, asthma		Increased amount of time day-dreaming/fantasy		
Injuries from high risk taking behavior		Constant feelings of being trapped		

* This table summarizes the indicators of staff burn-our most frequently mentioned by individuals who were interviewed during this author's studies. It is essential that these indicators be viewed as emerging from a breakdown in the relationship between the individual and the organization and not be viewed as a matrix of symptoms to be used for the clinical diagnosis of individual staff.

Corollary 2: The severity of the symptoms of staff burn-out are in direct proportion to the severity of organizational stress.

Corollary 3: Staff burn-out is experienced by human service workers as a very primitive and devastating process. At the beginning of a recent workshop, I asked thirty human service workers their free associations to the words "staff burn-out." Their associations included: "trapped," "cornered," "hopeless," "death," "robot," "castration," "loss of meaning," "loss of energy," and "betrayal." I have frequently used the metaphor of "impotence" to describe the burn-out process because the term emotionally communicates one's loss of power and the loss of one's ability to impact his or her environment.[7]

Proposition 2: Although the term "burn-out" is primarily applied to the experience of indidivuals, organizations may also be said to burn-out when the aggregate level of stress within the work milieu prevents the completion of tasks essential to the survival of the organization.

Proposition 3: There are aspects to the burn-out process that are unique to individuals, to programs, and to particular professions.

Corollary 1: There are unique aspects to the phenomena of staff burn-out in the substance abuse field which may require different response strategies than those utilized in other fields of human service. This uniqueness comes from the nature of our clients, the nature of our service providers, and the short history of our field.[8]

Corollary 2: The fact that large numbers of workers in the substance abuse field have prior histories of stress management which include the excessive abuse of alcohol and drugs makes the study of relapse essential to an overall understanding of burn-out within the field.

Proposition 4: The experience of burn-out occurs along a continuum from minimal to maximal loss of individual functioning and from minimal to maximal repercussions on overall organizational effectiveness.

Corollary 1: The burn-out process may be described as both situational (acute) and cumulative (chronic).

Corollary 2: Experiencing early stages of burn-out is inevitable and is, in fact, endemic to the nature of human services work. This is due to the unavoidable incongruency between the needs of individual staff and the demands of the organization, and is also an inevitable consequence of prolonged confrontation with the emotional pain and turmoil in the lives of our clients.

Corollary 3: Although the burn-out experience is usually spoken of in negative terms, the early stages of burn-out may be extremely important in indicating to ourselves areas of needed change and development. The experience may indicate:

- areas of needed skill development;
- a need for time out periods (vacations, etc.);

- our need to take the next step in our professional development, e.g, school, job change, etc. (in response to feelings of boredom, being trapped, etc.);
- personal needs outside the work setting which are being neglected; or
- the need to re-establish a more equitable balance between one's work life and one's personal life.[9]

Proposition 5: While early stages of burn-out are inevitable, we can take responsibility for and control over our organizational structures and group processes to reduce the number of staff casualties resulting from the high stress work setting.

In the next series of propositions, I will summarize three approaches to staff burn-out in the substance abuse field and attempt to further define burn-out as an organizational process. These models are particularly important to understanding the response of our field to relapse by the RSA. The three models to be discussed include the clinical approach, the training approach, and the systems approach.

Proposition 6: The clinical approach to burn-out utilizes a process that is remarkably similar to the response of a family system to an acting-out adolescent, e.g., the worker is diagnosed as ill (becomes the identified patient); the illness is characterized as emerging from the personality of the victim (psychopathology); the victim is "worked with" to alter his or her inappropriate behavior (offered a treatment plan); or the victim is extruded (institutionalized) from the organization. In short, the problem of burn-out is defined as intrapsychic and responses involve treating the

personality (referring the individual for outside treatment or turning a supervisory relationship into a treatment relationship) or extruding the person from the agency.

Corollary 1: The clinical approach is marked by a number of severe deficiencies:

1. The approach individualizes what is essentially an interactional problem.
2. The approach fails to address the possible need to modify the high stress work environment, particularly the role conditions under which the person is working.
3. The stigma of the diagnostic process decreases rather than increases the worker's ability to mobilize needed external resources.
4. The approach increases the worker's feelings of isolation, paranoia, and loss of control and, in short, escalates the symptoms of burn-out.

Corollary 2: While the clinical approach is the most frequent response to the loss of functioning by workers, relapse in the substance abuse field is approached both clinically and punitively. The relapse victim is most frequently immediately extruded (our anger at the victim) and the postmortem is conducted as a sophisticated clinical case review (our need to define the problem as individual rather than interactional).

Proposition 7: <u>The training approach to staff burn-out defines burn-out as a problem of skill deficiency rather than one of psychopathology</u>. Prevention and remedial approaches to staff burn-out that emerge from this model rely on teaching workers more effective styles of stress management.

Corollary 1: The training approach to staff burn-out avoids most of the more detrimental aspects of the clinical approach but still does not adequately address the environmental causes of high stress levels. In spite of this limitation, the training approach is an essential element in any comprehensive response to the problem of staff burn-out.[10]

The systems approach to burn-out which is advocated by the author focuses on the manner in which organizational structures, internal organizational relationships, and the organizational group's relationship with its outside environment effects the physical and emotional health of group members. The etiology of burn-out is thus described as a problem of relationship rather than a problem of psychopathology. The role of the individual and the role of the organization in this relationship problem is elaborated in the following propositions.

Proposition 8: Each person brings to the work environment a unique system/or style of defenses to protect his or her self-esteem in response to high stress.

Corollary 1: This unique history of stress management determines the potential for burn-out in a high stress work environment.

Corollary 2: The particular type of burn-out an individual is most vulnerable too can also be predicted by reviewing this unique history of stress management, e.g., individuals with a history of somatatizing stress are likely to develop psychosomatic symptoms in response to high stress work situations, etc.

Proposition 9: As the individual enters and works in a particular organization, there exists a number of role conditions and factors which will effect the individual's physical and emotional health. These can be summarized through the use of the following terms:

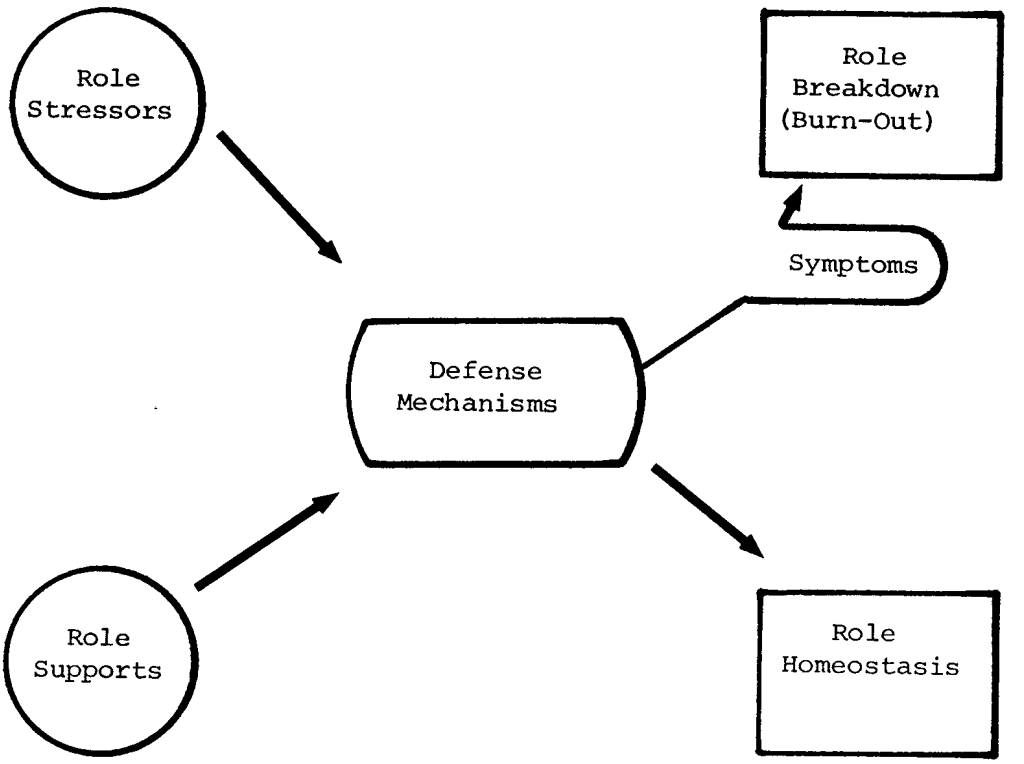
1. Role stressors can be described as the number and intensity of role conditions which threaten and decrease one's self-esteem and decrease one's ability to perform organizational tasks. Ten such role stressors will be described in detail in section III of this paper.

2. Role supports can be described as the number and intensity of role conditions which increase self-esteem and increase one's ability to perform organizational tasks.

3. Role homeostasis exists when the individual experiences a relative balance between role stressors and role supports. The defense mechanisms of the individual operate constantly to maintain this balance. When this equilibrium is maintained, the individual performs tasks adequately and suffers no stress related disruption in physical or emotional health. In short, the individual functions without symptoms.

4. Role breakdown exists when there is a concurrent loss or deficiency in role supports and an overload of role stressors. When this condition occurs, the defense system fails resulting in the appearance of symptoms (charted earlier as indicators of burn-out) and task performance deteriorates.[11]

These factors can be summarized graphically as follows:



Proposition 10: The above model illustrates three levels of system intervention that can be utilized to reduce the staff casualty process:

1. We can teach individual staff (via the training system model) more effective stress coping techniques.
2. We can manipulate the work environment to reduce role stressors.
3. We can manipulate the work environment to increase role supports.[12]

Proposition 11: The overall character of the organizational system greatly influences the intensity of role stressors and the availability of role supports for individual staff. In an earlier study the author described the tendency for small direct service organizations to become "closed organizational families" marked by increasing numbers of staff member's personal, professional, social, and sexual needs being met within the staff group. It was emphasized that as the group became progressively closed, role stressors increase and role supports significantly decrease.[13] It is still the author's contention that the staff casualty process is highly influenced by the degree to which the organization is "open" or "closed."

I have attempted in the above propositions to take the issue of staff burn-out out of the realm of psychopathology and place it in its organizational context. Section II presents three case studies of RSAs who relapsed while working as counselors in substance abuse programs.

The organizational analysis of each of these three cases is meant to set the stage for a detailed discussion in Section IV of the particular role stressors which appear to play a contributing role in the relapse of the individuals interviewed in this study. Two major propositions will become apparent in the remaining pages:

1. Numerous cases of relapse by RSAs working in the substance abuse field can be viewed as a tragic and dysfunctional response to a particularly high stress work environment.

2. As long as the substance abuse field utilizes a manpower strategy that calls for the employment of large numbers of RSAs, the field has a concomitant responsibility to shape and influence program policies, administrative decisions, supervisory supports, etc., that are at best supportive and at a minimum not destructive to the recovery process.

III. A SELECTION OF CASE HISTORIES

Case #1: "Everyone in the community used to tell us 'If you get Lee sober, it'll be with magic 'cause nothing else has worked.'"

Lee was a notorious alcoholic and lifelong resident in this predominately rural county. His alcoholism had led him through the revolving doors of the local hospitals, jails, welfare agencies, ministers, social workers, and members of Alcoholics Anonymous (AA), all to no avail. During one of Lee's sojourns in the local jail, he was interviewed by a social worker from a new mental health center which had just started in the county and was offered the opportunity to check into a 90 day detox program at a nearby state hospital. Being an obvious way to extricate himself from jail, Lee immediately agreed and was subsequently admitted to the detox program. While in the detox program, Lee participated in minimal unit activities but did attend AA meetings. The social worker visited Lee on a number of occasions during the 90 days and brought back glowing reports to the other staff on Lee's progress. Upon Lee's return to the community he immediately con-

tacted the local AA group and maintained both contact with the group and sobriety during these first few months of his return. During the second month back in the community he was approached by the new mental health center staff and offered a job as a paraprofessional to work with alcoholics. Lee accepted this job assuming that working with alcoholics would decrease the odds of his drinking again. During the next 8 months there appeared to be no limits to Lee's energy on the job. His personal charisma made him a natural for recruiting large numbers of clients into treatment and made him a popular staff member at the agency. The explosion occurred during a weekend of the tenth month when it was discovered that Lee was drinking again and that he was sexually involved with a married client. Within 48 hours Lee was fired and left the community. Knowledge of the event rapidly spread into the community and affected the agency's reputation for a number of years. Lee drank almost constantly for several months following this incident, felt overwhelmed with remorse, and contemplated suicide on numerous occasions. Lee subsequently became re-involved with AA, obtained employment in a small business enterprise, and at the time of the interview with this author had maintained four continuous years of sobriety.

Organizational Analysis

This analysis is based on interviews with Lee, with two staff members who worked with Lee during the period described earlier, one board member of the agency, and Lee's AA sponsor at the time

of his initial hiring.

A. The Hiring Process: The probabilities of Lee encountering difficulties managing job related stress were very high from the outset considering the decision to hire Lee was impulsive and blatantly exploitive. Recalling the staff meeting in which the hiring of Lee first came up, the social worker who first interviewed Lee in jail recalled the following: "There was a lull in the meeting and somebody mentioned that all kinds of people in the county thought the center had magic because we had got Lee sober. I said half joking that we could turn Lee into a staff member and really show people what kind of magic we had. Before you knew it, we had decided to hire Lee--as a matter of fact he was offered a job the following day. . . It's horrible looking back but I guess we wanted Lee as a walking advertisement of our center. We did everything but put him in a picture window." The essential elements missing from this process include:

1. No assessment was made of the potential impact of the job on Lee's continued recovery.

2. No assessment was made of the need to prepare both Lee and the staff for difficulties encountered in integrating a paraprofessional into a staff of professional social workers and psychologists.

3. No assessment was conducted of Lee's skills in the area of human services nor was any assessment made of Lee's capability of handling the stress implicit in such work, particularly giving his short period of sobriety.

4. No plan was implemented which could have provided for a smooth transition between the status of client and staff nor was there an assessment of what services Lee himself might have needed to continue from the agency for his own personal health.

5. No plan was implemented to effectively orient and integrate Lee into the agency. The message was essentially: "Now you're on staff; go out and work with alcoholics."

B. The Employment Period: Lee functioned for months with no formal training provided and with minimal supervision. The importance of these two areas can't be emphasized too much. Lee reports of this period: "I don't know what the hell I was doing most of the time. But I figured whatever I lacked in quality I could make up for in quantity. I was working 75-80 hours a week and I figured if everyone was saying, 'Look at Lee, he works so hard,' no one would take the time to figure out how scared I was. I guess I also thought that if I kept busy all those hours, I wouldn't have time to think about drinking." The feeling that all Lee had to offer was his energy could have been addressed by:

1. the provision of formalized training in alcoholism counseling,

2. the provision of close clinical supervision as both a supportive and teaching process,

3. arranging for Lee's affiliation with a professional alcoholism counselor's alliance, and

4. arranging for Lee to meet regularly with other RSAs working in the field for purposes of mutual support and information exchange.

Lee's relapse to active alcoholism did not emerge from a vacuum. Numerous signs and symptoms of stress could have been responded to during the months preceeding the relapse. Lee's "workaholic" syndrome had begun to produce a number of health related problems and all persons interviewed agree in retrospect that Lee had been emotionally and physically exhausted for at least two months prior to his relapse. At least two AA members had expressed concern to staff of the center that Lee had stopped attending AA meetings and appeared well on his way to a "rip roaring dry drunk." In response, the director suggested to Lee that maybe he needed to hit a couple of AA meetings for "P.R. purposes." Lee's entire social network and nearly every waking hour revolved around work, and yet no mention was made to Lee of the need for separation between one's personal and professional life nor was any mention made of the need for Lee to have outside relationships and activities that could nourish and replenish himself from work related stress.

C. The Extrusion Process: The organizational process which was involved in Lee's extrusion from the agency is illustrative due to its similarity to a number of cases interviewed for this study. The organizational process was remarkably similar to the process by which acting out adolescents are extruded from the family system. Lee was immediately identified as the problem of the organization (the identified patient), defined as pathological

(we're o.k.; he's not o.k.), and extruded. A board member reflecting back on this period stated: "They (the center staff) were so concerned about what Lee's drinking would do to the agency's reputation and so concerned about getting Lee out of the community before he became a further embarassment, they fired him and didn't even ask if he wanted to get into treatment somewhere or wanted an AA contact."

Case #2: <u>The Super Ex-Dope Fiend Folk Hero Set-Up</u>

Randy had been addicted to heroin for nearly six years prior to entering a therapeutic community (T.C.) for treatment. He had followed the usual career of the urban addict until an arrest for armed robbery had forced him into treatment. Randy responded well to the structure of the T.C. and within fourteen months had entered a training job to eventually move into a staff position within the program. At this same time the program was contacted by the director of a youth agency in a rural part of the state who was looking for a potential staff person to work with adolescent drug abusers. The T.C. was particularly interested in helping fill this position with one of their graduates since it would open up a new area for client admission and funding procurement. Randy was approached by the T.C. staff and arrangements were made to interview for the job. Within a month, Randy had been interviewed, accepted for the position, and had relocated to this small rural community. Randy was immediately caught up in a whirlwind of

activity in the new job. He was in constant demand for speaking engagements at local schools and community groups. The local drug using adolescents almost immediately turned Randy into a folk hero and there was a steady progression of these young people through Randy's office in the daytime and his home at night. Although the community responded warmly to Randy's initial entrance into the community, criticism began filtering back to the agency regarding such things as Randy's "swearing" in groups, his suggestion to some adolescents that they confront their parent's alcohol abuse, etc. Randy became embittered at some of this criticism particularly when rumors began which hinted that he was selling drugs to his clients. (These events occurred at a time in this state where anyone working in drug abuse was simultaneously suspected of dealing drugs and being a narcotics agent.)

The job related stress experienced by Randy peaked between the fourth and sixth months on the job. He began to experience problems relating to other staff and his expressed feelings toward the community became increasingly confrontive and negative. By the sixth month Randy was drinking to intoxication at least three to four nights a week and becoming increasingly isolated from the rest of the staff. On a weekend during the sixth month, Randy visited his home city and was found dead in a hotel room on the following Monday morning. He died of an overdose of heroin while under the influence of alcohol. It was never determined whether the death was accidental or suicide.

Organizational Analysis

This analysis is based on an interview with the entire staff group which worked with Randy and on interviews with two staff members of T.C. in which Randy was in treatment.

Both the T.C. and the agency in which Randy worked admitted significant omissions in the process by which Randy was placed in the job. One of the T.C. staff said of this process, "We really screwed up. All we saw was a chance to open up another area of the state for (the program); we didn't take the time we usually do to find out if this makes sense as far as the person staying straight. There were things we knew about Randy's progress which should have prevented us from encouraging him to take a job out in the boondocks where he would be almost totally isolated . . . his death hit us really hard. We now have a review committee of senior staff that must agree as a group before we recommend one of our people to work either here or in some other program." Omissions by the agency in the hiring and employment period included the following:

1. An adequate assessment was not made of Randy's skill level nor of his ability to sustain himself emotionally in an isolated area.

2. There was no clear orientation and training process. No job description was provided (which set Randy up to be all things to all people around drug abuse issues) and only minimal supervision was provided.

3. The agency did not provide an administrative/supervisory buffer between Randy and the community. This support and protection was needed to keep Randy "grounded" during both the euphoric period of his

early work period as well as the period of depression and anger which followed it.

4. No supervisory review occurred in response to Randy's decreased job performance, increasing problems with alcohol, and his increasing isolation from other staff.

In addition to the above, the agency staff modeled excessive alcohol consumption as a method of stress management to any incoming staff. Randy was rapidly pulled into the practice of joining staff after work to drink for several hours. While this method of stress management later proved deterimental to other staff (at least two other staff later developed significant problems with alcohol), it was particularly devastating to Randy.

Another practice of this agency, which was not atypical of the agencies involved in this study, was the extreme stereotyping of the RSA within the agency. Assumptions about Randy's expertise were made which were never checked out. Staff automatically assumed any RSA knew about pharmacology, laws pertaining to drugs, and how to handle medical/psychiatric emergencies precipitated by drugs. An illustrative example of this was the assumption by the agency that Randy did not need further training in drug abuse (in spite of the fact that Randy's prior history of heroin addiction and prior treatment experiences in a program developed almost exclusively with heroin addicts had only minimally prepared him to effectively deal with the hallucinogenic and stimulant drug abuse which was prevalent among the youth seen at the agency.) The constant reinforcement of the "ex-dope fiend" role and the failure

to provide access to training and supervison which could have broadened Randy's professional identify and skill was also part of this stereotyping process.

Case #3: "It's them (AA) or us (agency)."

Beth had developed a severe alcohol abuse problem following the sudden death of her husband in a traffic accident. After more than a year of almost constant intoxication, Beth was hospitalized and subsequently referred to a private alcoholism treatment program. She actively participated in AA during her course of treatment and became actively involved in AA upon her return to her community. She attended numerous AA meetings and most of her social network consisted of persons she had met within the fellowship of AA. During Beth's third year of sobriety, she took a job as a counselor in a halfway house for alcoholic women and worked there for almost a year until the program was forced to close due to funding problems. During this period Beth participated in numerous alcoholism counselor training programs and developed an excellent reputation as a counselor.

Shortly following the closing of the above program, Beth was hired as a counselor in a year old outpatient alcoholism counseling center. Her early impressions of the program were extremely positive as the staff seemed both dynamic and committed. The first signs of problems occurred during her third month of work following an intensive in-service training program for all staff. This week long training emphasized psychological approaches to treating alco-

holism, spoke of "curing" alcoholism, and was extremely critical of the "illness concept of alcoholism" in general and the approach of AA in particular. The program staff with the exception of Beth experienced a type of group conversion to the model advocated by the trainers. Over the next several months a number of significant events occured:

1. A large number of staff training events were scheduled for evenings and weekends to train the staff in the new ideology. These sessions were primarily growth groups which emphasized a high level of staff disclosure. These sessions decreased the amount of time Beth could spend in AA activities and were very stress producing as there was a great deal of pressure for her to "deal with the emotional traumas which caused her alcoholism."

2. Beth's affiliation with AA and her use of AA principles and philosophies with clients was subtly but continually discounted and criticized during this period.

3. As Beth began to experience increased stress concerning her own personal and professional beliefs, she came to increasingly rely on the emotional support of her supervisor. This eventually led to a romantic and sexual involvement which for a period of time provided a welcomed reprieve from the increasing stress experienced on the job. Beth recalling this period says: "I really believe if it hadn't been for (supervisor), I would have resigned. I knew my thinking was getting screwed up, but that relationship felt so good I didn't believe anything could throw me off balance and I still felt great about the work I was doing with my clients."

During the eleventh month of Beth's employment, the relationship with the supervisor ended bitterly (at the instigation of the supervisor) and Beth began drinking immediately. Although Beth made numerous AA contacts during the early months following her return to drinking, she had great difficulty maintaining sobriety. At the time of my interview with her, Beth had re-established her-

self within the AA program and had maintained continuous sobriety for the last year. She has not and reports she will not return to work in the alcoholism field.

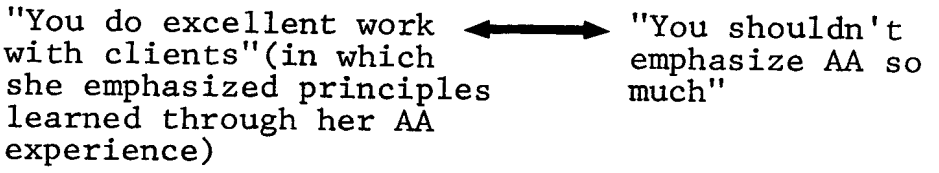
Organizational Analysis

This analysis is based on interviews with Beth and with three staff persons who worked with Beth during the period described earlier. None of the three staff interviewed still work for the program, and in fact report that the entire staff of the center has turned over. Beth was the first of many casualties which resulted from the very serious internal organizational problems that were to plague the agency.

The probability of Beth functioning effectively within the agency described should have been very high. She had four continuous years of sobriety, formal training in alcoholism counseling, a year's experience in counseling alcoholics, and an extensive network of personal support outside the agnecy. And yet within eleven months she had become victim to the very problem she was hired to address in her clients. The stresses placed on Beth within this agency can be catalogued as follows:

A. Contradiction in Personal/Program Beliefs: Beth experienced continuing contradictions between those personal beliefs which supported her continuing sobriety and those beliefs espoused by the program on the nature of alcoholism and the recovery process. This stress was in-

tensified by the following double message received from other program staff:



B. Breakdown of Personal Supports for Sobriety: The program's subtle disapproval of AA and the increasing time demands on evenings and weekends both decreased Beth's ability to maintain her previously active participation in AA. This was further exacerbated in later months by the time spent with the supervisor and an increasing expectation for socializing with staff away from work.

C. Breakdown of Personal Defenses: The mandatory participation in staff growth groups which required that Beth verbalize the emotional traumas of her life severely weakened the defenses that had served Beth well in her period of sobriety. This breakdown of defenses left Beth very emotionally vulnerable.

D. Bonding to the Agency: Beth's relationship with the supervisor marked her final bond to the organizational group and her loss of outside supports. Beth's increased reliance on the supervisor for support in the face of increased stress allowed the supervisor to easily exploit the relationship for sexual purposes. (The supervisor had also been sexually involved in a similar

manner with other women staff).

E. Replication of Earlier Emotional Trauma: The sudden termination of the relationship with the supervisor replicated emotionally Beth's earlier loss of her husband and came at a time when she had few defenses left to cope with such a loss. Having lost other sources of coping, Beth regressed to the use of intoxication to medicate her emotional pain.

Beth had unknowingly entered what the author has in an earlier study called a "closed organizational family" marked by:

- the propagation of a rigid treatment ideology;
- the homogenization of staff;
- the reduction in professional and social contacts outside the program;
- the extrusion of staff who challenge program ideology;
- a shift in focus from the treatment of clients to the personal and interpersonal problems of staff; and
- the development of problematic social and sexual relationships between staff.

Beth's participation in the "closed organizational family" set up an "It's them (AA ideology/fellowship) or us (agency ideology/fellowship) decision." Her relapse was an inevitable consequence of a decision which brought increased acceptance in the organizational group but cut her off from the belief system and supports which had been the foundation of her recovery.

IV. ROLE STRESSORS ASSOCIATED WITH RELAPSE OF RSAs WORKING IN THE SUBSTANCE ABUSE FIELD

The three case histories presented in the previous section have hopefully prepared the reader for a more in-depth analysis of high stress situations endemic to the work environment of substance abuse programs which may inadvertantly sabotage the recovery of the RSA. In this section, ten role stressors will be identified:

- Role/Person Match
- Role Conflict
- Role Integrity
- Role Ambiguity
- Role Feedback
- Role Overload
- Role Boundary Position
- Role Connectedness
- Role Deprivation
- Role Termination

Each role stressor will be defined and examples will be given which are drawn from the author's experience and interview material upon which this study is based. I am particularly indebted in this section to the work of Kahn, Wolfe, Quinn, Snolk, and Rosenthal[14] whose classic work on organizational stress convinced me that a modified version of role theory would be an effective framework for summarizing the results of this study.

Role/Person Match

Role/person match is the congruency between:

a. An individual's knowledge and skill level and the knowledge and skill level required to perform tasks of a given role (e.g., counselor);

b. an individual's level of stress tolerance and the stress endemic to a particular role; and

c. an individual's style of stress management and the methods of stress management that are officially and informally sanctioned within an organization.

Several cases of Role/person mismatch were identified in this study. This mismatch took the following forms:

1. A favorite client was rescued. The author has noted this phenomenon in a number of alcohol and drug abuse treatment modalities, e.g, halfway houses, detox centers, therapeutic communities, methadone programs. In the absence of a viable aftercare plan, the client is moved into an entry level staff position. What initially appears as a way to continue to provide a client with a nurturing support system may prove disastrous due to the stress generated from the discrepancy between skill level and skill demands.

2. The treatment needs of the clients were sacrificed for the immediate staffing needs of the program. This was particularly evident in one program that was studied which recruited most of its staff from clients who had gone through the program. Following a period of high staff turn-over, the program "shortened" the treatment of several clients and moved them into staff positions to fill the void created by the loss of more experienced staff. These individuals possessed neither the skill nor the current level of adjustment to assume high stress roles within the organization.

3. The RSAs were assumed to possess a level of skills and knowledge by virtue of their prior status of addiction. This extreme stereotyping of the RSA, which was noted in case study #2, seems to be particularly prevalent in professional agencies (mental health centers, family service agencies, etc.) which are hiring paraprofessionals for new substance abuse services, outreach programs, etc. The level of stress for the RSA escalates as the discrepancy between real and assumed skills becomes increasingly evident.

4. The commitment of the RSA to help others in the recovery process was confused with competence in substance abuse counseling. The most committed RSAs may find themselves hired for their commitment and yet hopelessly overwhelmed with feelings of incompetence due to their lack of knowledge and skills to sustain their work with clients.[15]

The above examples indicate role/person mismatch based on knowledge and skills. The level of stress produced from this mismatch is further exacerbated by a failure on the part of the progrm to provide the RSA adequate training, access to professional organizations, and access to other professional development resources.

Another type of mismatch involves the individual's history of stress management and the stress involved in the particular role they are hired to perform. Two examples of this type of role/person mismatch will be summarized.

1. The RSA may be hired into an admittedly high stress role without an assessment of whether he or she could adequately respond to this stress over prolonged periods of time.[16] The RSA by definition has a stress management history that has included the excessive consumption of alcohol/drugs. Also by definition the RSA has developed through the recovery process a system of defenses that allows them to manage stress without the use of psychoactive drugs. What is critical in avoiding role/person mismatch is an assessment of the strength and flexibility of the defense system of the RSA. Many programs have set specific time periods of continual sobriety before an individual may be considered for a staff position.[17] While the existence of such a guideline and the differing periods of time proposed continue to be a subject of controversy, the fact that more than

half of the RSAs interviewed in this study relapsed with less than three years continuing sobriety adds some credence to the use of such guidelines. It is the author's contention that the strength and flexibility of the RSAs defense system is a time dependent process. The greater the period of continual sobriety the stronger the defense system becomes and the greater the repertoire of defenses against stress. To place an RSA with minimal sobriety time in a high stress role within a substance abuse program is to invite disaster, particularly when elements of the program structure may inadvertently violate the already fragile defense system of the RSA (see Role Integrity).

2. It is equally important that the individual's stress management abilities be compared to the specific role within the program. Different roles have varying degrees of stress and allow varying degrees of flexibility in responses to stress. It is not simply a question of whether a particular applicant can make a contribution to the field. The question is whether this specific applicant (skills, knowledge, coping abilities, personal supports, etc.) can simultaneously perform the tasks and maintain their personal health in this specific role. Examples of failure to ask this question were detailed in case histories 1 and 2.

Role Conflict

There are numerous areas in which the RSA may experience role conflict. I wish to focus on one particular type of role conflict that appears most problematic. This conflict occurs when the expectations placed on an individual in one role (e.g., counselor in a substance abuse program) are incongruent with expectations placed on the individual in another role (e.g., member of self-help group). To be in compliance in one role places one in conflict in the other role and vice versa. Three sets of conflicting roles will be summarized below.

1. Client Role--Staff Role

   As was discussed earlier, a number of individuals in this study moved suddenly from the role of client in treatment to the role of staff member/counselor within the same program. The lack of a clear transition, or "rite of passage" from one role to another left these individuals simultaneously in the role of client and in the role of staff. The behavioral expectations inherent in the respective roles were different and frequently in direct conflict. These individuals found themselves in a limbo status between roles, unable to fulfill either role adequately and unable to be fully accepted by either the client group or the staff group. Relapse provided a simplistic escape from the stress and conflict surrounding this limbo status.[18]

2. Staff Role-- Self-Help Group Member Role

Both the staff group and the self-help group may have mutual ambivalence if not hostility regarding the RSAs role in the "other" group. The conflict between these two roles was particularly significant to the RSAs interviewed in this study, as was evident in case study #3. The importance of this area is also well indicated by the fact that conflict between these roles often resulted in the RSA being split off from the self-help group. The role of the organizational group in driving a wedge between the RSA and the self-help group has been grossly overlooked. A number of programs subtly discount the RSAs continued need for self-help participation. Other programs, which are somehow threatened by the need of a staff person to look outside the program for help in the recovery process, attempt to blatantly discourage the RSAs participation in such groups.

The professional substance abuse field has contributed very little assistance to the RSA in developing a balance between their own personal recovery on the one hand, and their role as a substance abuse professional on the other. Alcoholics Anonymous has undoubtedly made the most significant contribution to the RSA working in the substance abuse field through its continuing dialogue on the "two hat problem."[19,20] This dialogue has helped large numbers of RSAs bring greater clarity and delin-

eation to what are ideally distinct but complementary roles.

3. Staff Role--Family Member Role

The excessive time and emotional demands of work in substance abuse programs frequently places the worker in conflict with the emotional and time demands placed upon them by their families. Unfortunately this situation is often polarized to the point that either the family or the job are sacrificed. This is particularly true in programs which encourage rather than confront overproduction by staff.

In summary, role conflict may result in two behavioral patterns that may prove equally devastating to the RSA:

- The RSA may withdraw through decreased personal involvement in the job.
- The RSA may escalate his or her time and emotional commitment to the job while cutting off outside supports (self-help groups, families) which may leave the RSA particularly vulnerable to the high stress work environment.

Role Integrity

Role integrity, as applied in this study, is the congruence between the values and belief system of a program (regarding the nature and treatment of addictions) and the belief system of the RSA (regarding his or her own personal recovery). Role integrity also involves a program's respect for the unique defense structure the RSA has developed to maintain his or her continuing sobriety.

While the ideology of a treatment program may be open to intellectual debate, the belief system of the RSA is a matter of personal survival. For a program to consistently undermine this belief system and to place the RSA in a role that demands espousal of beliefs contrary to their personal beliefs is to risk disrupting the very foundation of the RSA's recovery. This is particularly true for the RSA early in the recovery process. Dr. John Wallace has described the importance of this belief system for the recovering alcoholic as follows:

> "The Sober member of AA needs his ideological base. He can ill afford the dispassionate, disinterested, and, indeed, almost casual play upon words and ideas of the inquiring academic intellectual. He recognizes intuitively that he needs a stable and enduring belief system if he is to stay sober."[21]

Dr. Wallace has also proposed the existence of a "Preferred Defense Structure" (PDS) which the recovering alcoholic utilizes to maintain sobriety during the first three to five years of recovery. The PDS utilizes the same defenses that maintained drinking (e.g., denial, rationalization, projection, etc.) to maintain sobriety. For example, the blatant denial of numerous problems confronting the recently sober alcoholic may be essential if relapse is to be avoided. Dr. Wallace further contends: "Therapeutic efforts that confront the alcoholic PDS prematurely and too heavily will increase the probability of further drinking

rather than reduce it."[22] I concur with Dr. Wallace on the existance of the PDS and contend that program practices which undermine the PDS of staff who are RSAs increase the probability of relapse by these particular staff.

In case #3, which was described earlier, Beth had developed a PDS which had helped maintain her sobriety for four years. The program described forced Beth into a series of encounter groups under the auspices of required staff training which grossly violated her PDS, leaving her without the emotional mechanisms to support her sobriety. Within the framework of AA Beth had:

1. identified the single thread that had made such havoc of her life (First step of AA: "We admitted we were powerless over alcohol--that our lives had become unmanageable," [23] the disease concept of alcoholism, etc.);

2. developed a belief that the pieces of her life could be reassembled (second step of AA)[24];

3. set aside much of the emotional pain and feelings which had fueled her drinking until she had maintained some period of sobriety, (third step of AA, "Let go-let God," "Turn it over to God--you can't handle it," "First things first," "One step at a time," etc.)[25]; and

4. taken on a framework of recovery which would allow her at her own speed ("Easy does it") to deal with her past emotional traumas, defects of character, etc. (Fourth, Fifth, Sixth, Seventh, Eighth, Ninth and Tenth Steps of AA).[26]

Beth's PDS was violated in the "training groups" by both contradicting the above (e.g., disease concept of alcoholism) and by disrupting the crucial sequence of the above steps. This process could be stated rhetorically as follows: How long would the

fellowship of AA have lasted if the fourth, fifth, eighth, and ninth steps of AA had been collapsed into a single step and made the recommended beginning of the recovery process?[27]

Dr. Wallace in his discussion of the PDS goes on to note the paradox that:

> "the very same defenses that enabled the alcoholic to drink, as well as achieve abstinence, must ultimately be removed if long term sobriety is to be maintained. However, in many cases such growth must take place over periods of time ranging from two to five years of abstinence."[28]

The existence and possible fragility of the PDS adds a note of warning to our early discussion on the practice of hiring RSAs with relatively short periods of abstinence.

There is an African proverb which says: "Before a man is asked to give up a thing he cherishes and holds most dear, he must be given something of value to take its place."[29] While this proverb has obvious reference to the treatment of clients within our programs, I suggest that it articulately summarizes the proposition that if we are to tamper with the PDS of RSAs working in our programs, then we had better have something of value to take its place.

Role Ambiguity

Role ambiguity refers to the lack of clear and consistent information necessary to perform one's role in the organization. Role ambiguity may involve a lack of:

1. knowledge of role expectations (what tasks are to be performed),

2. knowledge of the degrees of importance to the organization of varying tasks (priorities),

3. knowledge of the steps necessary to satisfactory completion of tasks (methods, style),

4. knowledge of the accountability structure (who is the person directly responsible to), and

5. knowledge of the consequences of satisfactory and non-satisfactory role performance (rewards and punishments).

Role ambiguity consistently emerged as a source of stress for the RSAs in this study. This was particularly true for those persons with minimal training and experience in the field. A common pattern was for the RSA to produce a large quantity (measured by hours on the job) of work in a number of task areas--hoping that this shotgun approach to role performance would meet the undefined expectations of their supervisor.[30] The stress generated from role ambiguity was closely related to problems in two other areas (role feedback and role overload) which will now be discussed.

Role Feedback

Role Feedback refers to the availability of regular information from one's supervisors and peers on:

1. the adequacy of role performance,

2. methods of improving role performance, and

3. the adequacy of the personal and interpersonal adjustment to the total work milieu.

The most critical communications are those which enhance self-esteem, those which support role adequacy, and those which provide the worker with an early warning of stress related symptoms.

When continuing role feedback was not available to the RSAs in this study, they tried to make up for their lack of confidence in the quality of their work by increasing the quantity of their work (number of hours on the job). In short, they traded confidence in their competence for confidence in their commitment. The long term consequences of this were an inevitable chronic exhaustion and deterioration in both task performance and personal self esteem.

Perhaps one of the most critical aspects of this study concerns the availability of feedback to the RSA on his or her overall adjustment to the work setting. Relapse rarely occurs in a vacuum. Numerous early warning signs were exhibited by the individuals in this study. In most cases there was a slow deterioration of functioning which occurred over months, and yet supervisors and peers sensitized to such symptoms in clients seemed blind to such symptoms in other staff or there were no permissions in the program to convey feedback to one another on such an issue. The lack of availability of regular "strokes" in the work setting and the lack of personal feedback on stress management (responsible concern) were two of the supports missing in the programs in which the RSAs in this study were employed.

Role Overload

Role overload, as stated earlier is a frequent consequence of role ambiguity and an inadequate level of role feedback. Role overload may be the result of organizational role/task assignments that are humanly impossible to complete within ascribed timelines or it may be a method of over-compensation by the individual due to fears concerning adequacy of job performance. The personality of the overachiever (workaholic) has been extensively noted in literature on staff burnout. I wish to identify in the following discussion some of the organizational factors that contribute to the overextension of individual workers.

Role overload or the overextension of the individual is frequently a by-product of the over-extension of the organization. Limits are not set on workers because no limits have been set on what the agency can and cannot realistically accomplish. An agency which tries to be all things to all people is inevitably filled with staff who must do the same.

The stress from role overload is often intensified by double bind communications to the worker. The double bind communication has been studies extensively by family systems theorists for its potential role in the etiology of schizophrenia.[31] An example of an extreme double bind communication within the family could be illustrated by the following double message from a mother to her eighteen year old son:

"You need to leave home, get a good job, and develop a life for yourself." ⟷ "If you leave, I'll die."

Double bind communications to the RSAs in this study that tended to reinforce role overload are illustrated below:

1. "You need to slow down and take it easy."	⟷	-Increased work responsibilities. "Give it to ____. She'll get it done." -Promise of promotions if the quality of her work continues.
2. "Why don't you get away for a weekend and visit some friends."	⟷	-I'm sorry ____, but can you cover the house this weekend--Bob has to go out of town for a funeral."
3. "You need to get a boyfriend and some friends that don't work here."	⟷	-Scheduled hours and responsibilities leave little time, let alone energy, to develop outside of work relationships.

That over-extension of the RSA may emerge from the organization itself is further noted by the following two points:

1. In several of the programs studied, professional staff had clearly defined (in some cases over-defined) their territory in the work area leaving the paraprofessionals (frequently RSAs) to manage all tasks not assumed by the professionals.

2. In three of the residential programs studied, I found the following situation:

   - Professionals worked a 40-45 hour week, working weekdays on an approximate 8:30 - 5:00 schedule.
   - The RSAs interviewed from these three programs

were routinely scheduled from 60 - 70 hours per week, worked primarily evenings and nights, and regularly worked weekends. The scheduled evening and weekend hours left little time for the RSAs to develop outside of work social relationships and scheduled hours also conflicted with their attendence at AA meetings and in one of three cases, Narcotics Anonymous meetings.

Role overload has two disastrous effects upon the RSA. It produces a state of chronic exhaustion which weakens the defense structure of the RSA and it cuts the RSA off from outside sources of nurturing which may be essential to the RSA's continuing recovery.

Role Boundary Position

Boundary refers to the line which separates an organizational system from its outside environment. An individual may hold a boundary position within the organization which places them in contact primarily with members of their own organization. An individual who functions quite well in an interior role may function poorly in a boundary role and vice versa.

The importance of this relative position emerged from two of the individual histories in this study. In both cases (case #2 summarized earlier is one of the two), the individuals moved from an interior role in a therapeutic community (TC) to a boundary role in a community agency. The boundary role produced an initial period of euphoria (the super ex-dope fiend folk hero set-up) but was followed by a period of intense conflict and rejection. Within the TC there had existed a structure to keep these individuals "grounded" in response to both elation and rejection.

The checks and balances of the TC were missing in the boundary role within the community agency and, in short, each RSA was given enough rope to hang themselves.

It is important that the RSA who has come through treatment in a TC or halfway house and moved into a staff position in that setting, should not be placed in a boundary role in a community setting without substantial supervisory supports. This is particularly true for the RSA who has moved from the relatively closed world of addiction to the equally closed world of the addiction treatment culture. Boundary roles demand skills beyond those required to operate within either of the above cultures.

Role Connectedness

Role connectedness refers to the degree of attachment between organizational members. This area will be discussed only briefly since the author has written extensively on this area in two other papers on staff burn-out.[32]

Role connectedness can be viewed as a continuum from over-attachment (the closed organizational family) to an almost total absence of attachment (the too open organizational family). Both ends of this continuum may present problems to the RSA.

The over-attachment between organizational members breaks down the balance between ones personal and professional life and leads to members meeting increasing numbers of their personal, professional, social, and sexual needs within the boundaries of the staff group.

Loyalty to the group, expressed by agreement with group values and the amount of time spent with group members, becomes the primary criteria for group membership. The danger of over-connectedness for the RSA is that it frequently cuts off outside sources of replenishment that have both supported the recovery process and served as a reprieve from job related stress. When these outside sources of replenishment are cut off, the RSA becomes highly vulnerable to the stress endemic to the work setting.

The isolation and detachment of the RSA from organizational group members may also be problematic. Two cases in this study (one in an outreach role, the other in a satellite office) had minimal contact with other staff. Although they were both in fairly high stress roles, neither had the supervisory and peer supports available to other staff of their agencies.

Role Deprivation

Role deprivation refers to the process by which significant role responsibilities are either suddenly or progressively taken away leaving the person with minimal or in some cases no responsibilities. The person is, in effect, retired while on the job. That such a move would create a loss in status, a loss of self-esteem, and increased isolation from other staff is obvious.

Given the self-esteem needs of the RSA, such forced retirement may precipitate a personal crisis where the RSA is overwhelmed with feelings of worthlessness, rejection, or bitterness at the experi-

ence of having been used. As the RSA struggles to regain his or her esteem, mini staff meetings occur to decide "what to do" with them. The exagerated efforts of the RSA to maintain his or her visability and personhood are construed as further evidence of the RSA's inability to handle responsible job assignments. The character in Ralph Ellison's The Invisible Man could have been speaking for the RSAs in this position when he said:

> "I can hear you say, 'What a horrible, irresponsible bastard'? And you're right. I leap to agree with you. I am one of the most irresponsible beings that ever lived. Irresponsibility is a part of my invisibility; any way you face it, it is a denial. But to whom can I be responsible, and why should I be, when you refuse to see me."[33]

Role Termination

Role termination refers to the process by which the organization brings to a close an individual's responsibilities in a particular role or brings to a close an individual's membership in the organization.

The author, in another study,[34] has detailed the importance of providing permissions, procedures, and processes by which individuals can leave our organizations with their self-esteem intact and carry with them a sense of fulfillment about their past work. The aspect of permissions for early exit from the agency which the author discussed in that earlier study is particularly applicable here. Two of the individuals in this study had attempted to resign from their agencies within the first three months of their employment but were talked into staying by affirmations of the

quality of their work, promises of training and increased supervision. I feel it is essential that our agencies respect the RSA's judgement on what I have called "Role Person Mismatch" and that we allow the RSA permission (guilt-free) to exit from the field. We need to operationalize the often stated belief that "not everyone is cut out to do this work."

The discussion of role termination would be incomplete if I did not mention the termination process surrounding the relapse of the individuals in this study. Three of the programs responded, in this authors view, in an admirable manner. They dealt with the RSA in a firm but caring manner. They responded to the relapse both as a personal and program issue offering support to the RSA and dealing with the relapse in an honest and straightforward manner. The personal but firm support of staff contributed to the fact that the relapse period in all three cases was relatively short. Two out of three of the programs also processed the level of stress all staff had been functioning under and implemented a number of changes to reduce the causes of stress and increase staff supports.

In most of the other programs, the RSA was responded to administratively (fired), but not personally. The communication to staff and clients occurred through the rumor mill and not through direct communication. Staff were discouraged from having any contact with the RSA and there was an unwritten rule that the incident was not to be talked about. Some of the individuals interviewed had had no

contact with program staff since the day they were fired. The program seemed most concerned about the impact of relapse on the program's reputation in the community.

It should not be surprising that most programs flounder helplessly in response to the relapse of one of their staff when one considers that as a field we have not even publicly opened dialogue on this issue. It is my hope that this paper will in a small way provide an opening for that dialogue to begin.

Summary

This paper has attempted to heighten the reader's awareness of forces within the work milieu which may play a contributing role in the relapse of RSAs who are employed in the substance abuse field. Ten sources of role stress were identified and applied to the RSA based on the author's understanding of the addiction recovery process. Relapse was viewed as a potential response to continued contact with high stress work environments that subvert the individual's defense structure and cut off sources of support that are critical to the recovery process. This view significantly broadens the most common conceptualizations of relapse which are based primarily on the notion of the "addictive personality." The view proposed in this paper is that sources of stress endemic to the work environment may play a contributing and a critical role in the relapse process. Relapse is thus identified as one of numerous dysfunctional responses to work related stress that have been included within our understanding of "staff burn-out." The implication of this study to the substance abuse field is obvious: as long as

the field continues to utilize a manpower strategy that calls for the employment of large numbers of RSAs, the field has a concomitant responsibility to shape and influence program policies, supervisory structures, etc., that are at best supportive and at a minimum not destructive to the recovery process.

The second major implication of this paper which is broadly applicable to the human services field is that an analysis of role supports and role stressors can serve as an excellent vehicle to identify organizational factors which contribute to staff burn-out. The ten role stressors described in this paper produce staff burn-out among the whole range of human service workers. They are by no means unique to the RSA working in the substance abuse field. The unique tragedy of relapse is that the victim falls prey to the very process her or she has commited themselves to help eliminate in the lives of their clients.

It has long been my contention that the ability of a human service organization to effectively nurture its clients can only be as good as that organization's ability and willingness to promote the health of its service providers. It is my hope that this paper will help support the movement to build service systems that promote the health of both staff and clients.

Notes and References

1. William L. White, Incest in the Organizational Family: The Unspoken Issue in Staff and Program Burn-Out. (Rockville, Maryland: HCS, Inc., 1978).

2. The terms "Ex-Addict," "Recovered Alcoholic," and "Recovering Alcoholic" have been lumped into a more generic term of "Recovering Substance Abuser (RSA)." Unfortunately we have no term which brings together all those in the recovery process irrespective of their particular drug choice.

3. Herbert J. Freudenberger, The Staff Burn-Out Syndrome. (Washington, D.C.: Drug Abuse Council, Inc., 1975.) (Hereinafter "Freudenberger, 1975.")

4. Christina Maslach, "Burned-Out." Human Behavior. Vol. 5, No. 9, pp. 16-22, September, 1976.

5. Seymour Shubin, "Burn-Out: The Professional Hazard You Face In Nursing." Nursing. 78 Vol. 8, No. 7, July 1978.

6. See the following:

   A. C. Argyris, Understanding Organizational Behavior. (Tavistock, 1960).
   B. C. Argyris, Personality and Organization. (New York: Harper, 1957.)
   C. Robert Golembiewski, Behavior and Organization. (Chicago, Rand McNally & Company, 1962.)
   D. Robert L. Kahn, Donald Wolfe, Robert Quinn, J. Snoek, and Robert Rosenthal, Organizational Stress. (New York: John Wiley & Sons, Inc. 1964.) (Hereinafter "Kahn, 1964.")

7. The metaphor of impotence not only captures the loss of passion and energy produced by burn-out, it helps explain the power games and problematic sexual relationships that occur when programs experience a high rate of staff burn-out. These behaviors are, in fact, attempts to re-establish potency in the exact arena where one feels impotent--in the work setting.

8. These three aspects are discussed in more detail by the author in the following:

   William L. White, A Systems Response to Staff Burn-Out. (Rockville, Maryland: HCS, Inc., 1978.) (Hereinafter "White 1978B")

9. I am indebted to Mr. Ron Arkin, Center for Education and Manpower Resources, Ukiah, California for my understanding of

the importance of the early burn-out experience as a vehicle for personal and professional growth.

10. Training approaches to staff burn-out could be even more essential if management courses placed greater emphasis on systems approaches to burn-out, e.g., how to structure the agency environment to promote the health of workers.

11. These symptoms which I have described in the aggregate as staff burn-out are both symptomatic of a breakdown of coping mechanisms and are, in fact, a further attempt at defense against the high stress situation. While excessive alcohol usage is on the one hand a possible symptom of high stress, it is at the same time an attempt to medicate that stress, an attempt to return the individual to psychological homeostasis. The symptom will not dissipate until either the environmental stressor is alleviated or the individual discovers alternative defenses which provide relief from stress.

12. A number of these strategies are identified in White, 1978B.

13. White, 1978A

14. Kahn, 1964

15. Many members of Alcoholics Anonymous and Narcotics Anonymous have learned that successful Twelfth Step work does not in and of itself provide the necessary skills to sustain oneself in the full time profession of addiction counseling.

16. For additional comments on the need for screening of RSA's for both skill level and stress management abilities, see:

    James McInerney, "Alcoholics Anonymous members as Alcoholism Counselors" in The Paraprofessional in the Treatment of Alcoholism, edited by George Staub and Leona Kent (Springfield, Illinois: Charles C. Thomas, 1973.)

17. See AA Guidelines for AA Members Employed in the Alcoholism Field. (New York: General Service Office of Alcoholics Anonymous, N.D.) (Hereinafter "AA Guidelines); "Several years of good, uninterrupted AA sobriety should be behind you before you tackle any paid alcoholism job. AA's who answered our questionnaire agreed. Five years was mentioned most frequently, but a couple of people said three." p.1.

18. A careful reading of Dan Waldorf's Careers in Dope (Englewood Cliffs, New Jersey: Prentice-Hall, Inc. 1973) provides some added insight into the issue of role conflict. We could oversimplify and say that there is an addict career, an addict in treatment (client) career, a professional ex-addict career (staff), and the possibility of an alternate career

following treatment. The limbo status between client and staff career may force the individual back into the addict career. Relapse is then viewed as not simply a resumption of chemical intoxication but a reversion to a previous career that the individual was able to perform. This reversion in the face of role conflict could only be checked by the effective integration into a staff role or "re-entry" into a new career.

19. AA Guidelines

20. Vera L. "AA's Employed in the Alcoholism Field: The Two Hat Problem" presented at the 49th AA Anniversary International Convention, July 4-6, 1975, Denver, Colorado.

21. John Wallace "Tactical and Strategic Use of the Preferred Defense Structure of the Recovering Alcoholic" (New York: National Council on Alcoholism, 1974) p. 7 (Hereinafter "Wallace, 1974.")

22. Wallace, 1974. p. 6.

23. See either:

    A. Alcoholics Anonymous (New York: Alcoholics Anonymous World Services, Inc., 1955) (Hereinafter "AA, 1955.")
    B. Twelve Steps and Twelve Traditions (Alcoholics Anonymous Publishing, Inc., 1953).

24. AA, 1955 "2 - Came to believe that a Power greater than ourselves could restore us to sanity."

25. AA, 1955 "3 - Made a decision to turn our will and our lives to the care of God as we understood Him."

26. AA, 1955 "4 - Made a searching and fearless moral inventory of ourselves.
    5 - Admitted to God, to ourselves and to another human being the exact nature of our wrongs.
    6 - Were entirely ready to have God remove all these defects of character.
    7 - Humbly asked Him to remove our shortcomings.
    8 - Made a list of all persons we had harmed, and became willing to make amends to them all.
    9 - Made direct amends to such people whereever possible, except when to do so would injure them or others.
    10 - Continued to take personal inventory and when we were wrong promptly admitted it."

27. My statements on AA here apply equally to NA (Narcotics Anonymous.) Although a full discussion is beyond the scope of this paper, I am convinced there exists a preferred defense structure for the recovering addict that is strikingly similar to that Wallace describes for the recovering alcoholic.

28. Wallace, 1974, p. 6.

29. Cited in Stephen Pittel, "Addict Aftercare: Essence or Afterthought?" Contemporary Drug Problems. Winter, 1977, p. 511.

30. For additional discussions that have applicability to the area of role ambiguity for the RSA, see:

    A. Alexander Bassin, "Taming the Wild Paraprofessional," Journal of Drug Issues. Fall, 1973.
    B. Arthur Pearl and Frank Riesman, New Careers for the Poor. (New York: The Free Press, 1965.)

31. See Virginia Satir's Conjoint Family Therapy (Palo Alto, Ca: Science & Behavior Books, Inc., 1967 pp. 35-37) for a concise description of the double-bind communication.

32. White, 1978A
    White, 1978B

33. Ralph Ellison, The Invisible Man (New York: Signet Books, 1947) p. 16.

34. White, 1978B

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THE STAFF BURN-OUT PAPERS

William L. White

HCS, Inc. is pleased to announce the availability of three (3) monographs concerning the phenomena of staff burn-out in the field of human services. These monographs were prepared by William L. White, M.A., following more than three years of research on the topic.

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This monograph utilizes the conceptual models in the above monographs to describe mechanisms of stress reduction that can be implemented programmatically to reduce the staff casualty process. The way in which persons enter an agency, potential mechanisms of on-going staff support and the manner in which persons leave an agency are examined in detail. Specific strategies are recommended for preventing the over-extension of staff; providing "strokes" and re-energizing experiences for staff; preventing the professional, social, and sexual closure of the staff group, and preventing the isolation of members from the group. Suggestions are also offered on how supervisory staff can respond effectively to severe staff casualties resulting from burn out.

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William L. White has presented workshops during the past year for a wide variety of human service organizations, including:

Illinois Dangerous Drugs Commission
Indiana Dept. of Mental Health
Oklahoma Health and Welfare Assoc.
Eagleville Hospital & Rehab. Center
West Virginia Dept. of Health
Wisconsin Bureau of Alcohol & Other Drug Abuse
The National Manpower & Training System (National Insitute on Drug Abuse) Staff Development Workshop
Minnesota Chemical Dependency Program
Ohio Dept. of Mental Health and Mental Retardation
Virginia Dept. of Mental Health and Mental Retardation
The Alcohol and Drug Problem Assoc. of North America
Minnesota Education and Training Consortium

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We will forward additional information on workshop design, costs, etc.

- -

STAFF BURN-OUT WORKSHOP

Agency _____ Contact Person _____

Address _____ Title _____

_____ Phone _____

_____

Primary purpose of agency _____

_____

# of staff in agency _____ Problems which you wish to see addressed in the workshop _____

_____