OCCUPATIONAL STRESS COPING STRATEGIES UTILISED BY DRUGS AND SUBSTANCE ABUSE REHABILITATION COUNSELLORS IN THE SELECTED COUNTIES IN KENYA

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Abstract

Coping with occupational stress has become an important area for research in the last three decades. Coping strategies play a critical role in an individual's physical, behavioural and physiological wellbeing. Coping is thus a critical point of entry for protecting mental and physical health from the harmful effects of occupational stress. This paper explores the coping strategies utilised by drugs and substance abuse rehabilitation counsellors in selected counties in Kenya. The sample included 112 rehabilitation counsellors and 13 administrators working in five counties. The theoretical concept was drawn from Seyle' GAS, Person-Environment Fit and Transactional theories of stress. Descriptive survey research design was used in the study. Occupational stress survey questionnaire and an interview schedule was used as instruments to assess the coping strategies to combat occupational stress. Descriptive statistics (mean, standard deviation and percentages) were used to analyse the data. Results of the study revealed that Supervision, problem-focused, emotion-focused and social support were the most utilised coping strategies while escape avoidance was least utilised. The study further revealed that demographic and work characteristics influenced the way coping strategies were utilised.

Key words: Coping Strategies, Occupational Stress, Rehabilitation Counsellors, Kenya, Selected Counties

1.0 Introduction

Drugs and Substance rehabilitation counsellors are trained to provide an array of counselling-related services in partnership with clients who are addicted to address the social, psychological, environmental, vocational, educational and living needs in order to assist the individual in achieving optimal access and community integration. It has a long history of serving persons with disabilities as they work towards achieving their individual goals and are regularly exposed to stressful experiences in their occupations (Layne, 2001). Layne (ibid) stated that turnover occurs in rehabilitation counselling due to occupational stress that is detrimental to their wellbeing. Gachutha (2006) on the other hand noted that counsellors in Kenya experience occupational stress and burnout and there is need for coping strategies that can assist in appraising or dealing with the situation effectively.

Coping is an extremely important part of stress appraisal or management (Cole, 2007). Like stress, coping is a multidimensional and contextual construct. The term coping has often been used to refer to the individual's efforts to

deal with stress. Folkman and Moskowitz (2004) defines coping as the strategies, responses and resources that individuals use to combat stressors. Lazarus and Folkman (1984) on the other hand defines coping in the transactional model of stress as constantly changing cognitive and behavioural efforts to manage specific and/or exceeding the resources of the person. These definitions highlight the following factors related to coping. In the first instance, coping is a process and it is constantly changing as the individual evaluates ones efforts. Secondly, it is a learned way of responding to stressful circumstances. Thirdly, there has to be an effort on the part of the individual and fourthly, coping is an effort to manage the problem. In short, coping is a process of managing or appraising taxing work, expanding efforts to solve personal and interpersonal problems, and seeking to master, minimise, or tolerate stress.

Literature in the field of rehabilitation counselling has made numerous attempts to examine coping strategies being utilised in dealing with occupational stress (Crim, 2013; Victoria, 2012; Layne, 2001). According to Briggs and Munley (2008), therapists experience stress and have different coping strategies to handle their stress, which in turn may affect the therapeutic process. According to Folkman and Moskowitz (2004) coping strategies comprise two broad dimensions, namely problem-focused coping (action-centred forms of coping), and emotion-focused or cognitive coping strategies (involving mainly thinking rather than acting to change the person-environment (relationship). Problem-focused and Emotion-focused coping have been found to be effective coping strategies being utilized to combat stress. Problem-focused coping is defined as approaches that actively attack threat while emotion-focused coping is defined as approaches that manage the stress and emotions about threat (Gnilka, 2010; Briggs & Munley, 2008). Folkman and Moskowitz (ibid) suggest that the use of both of these coping strategies jointly can be beneficial for addressing or alleviating stressors.

Coping responses may be adaptive/healthful or maladaptive and this requires that drugs, substance abuse rehabilitation counsellors, and the entire work-system understand and engage in constructive coping (Gnilka, 2010; Marzabadi & Tarkhorani, 2007; Lawson, 2007). Glinka (2010) revealed that the degree in which a person is stressed depends on the appraisal of the stressors or the coping strategies utilised by the person at stake. Mutai (2015) stated that individuals with greater coping resources in contrast to individuals with only a few coping resources are more capable of successful coping. Broome, Knight, Edwards and Flynn (2009) noted that the coping individuals are able to manage or modify stressful events such as organisational changes by maintaining the usual productivity level and quality of work. In contrast, the non-coping rehabilitation counsellor who experiences a loss of emotional control may respond by having arguments and disputes with management and colleagues. This can increase absenteeism, escalation of accidents and intent to leave the place of work (Nabirye, 2010). This could also adversely affect service delivery in drugs and substance abuse centres (Gachutha, 2006; Layne, 2001). This indicates that although work stress is inevitable phenomenon, rehabilitation counsellors and drugs and substances abuse centres must learn to cope with, manage occupational stress effectively and constructively whenever it arises (Brattberg, 2006).

1.2 Statement of the Problem

Drugs and substance abuse rehabilitation counsellors are at the hub of a complex process, coordinating the activities of a number of skilled professionals including doctors, nurses, administrators and others who are working to meet the needs

of the addiction client. This complexity of players and tasks, the time pressures inherent in the process and the presence of high personal human factors interact to make rehabilitation counselling a physically and psychologically demanding occupation in which it triggers occupational stress. Therefore, drugs and substance abuse rehabilitation counsellors' wellness is a prerequisite for quality service delivery in rehabilitation centres. It is therefore imperative to examine the coping strategies used by drugs and substance abuse rehabilitation counsellors in their working places.

1.3 Objective

(i) Establish the coping strategies that are utilised by rehabilitation counsellors in selected counties of Kenya.

1.4 Research Question

(i) Which coping strategies are utilised by rehabilitation counsellors in the selected counties in Kenya?

2.0 LITERATURE REVIEW

The topic of stress and coping strategies have received widespread attention due to the fact that excess stress is harmful to individual's wellness and organisations operations. Lazarus and Folkman (1984) argued that perceived stress depends on how one interprets and/or appraises the significance of the threatening and challenging event. Melgosa (2006) noted that while stress is an inevitable aspect of the human condition, it is actually coping that makes a big difference in adaptations outcome. Lazarus and Folkman (1984) describe three stress appraisals namely primary, secondary and tertiary. Coping strategies are behaviours adopted by the individual in response to reduce adverse effects of the appraised stressors.

Studies that looked at coping strategies among rehabilitation counsellors have mixed results. Kampfe, Charlene, Smith, Manyibe, Sales, Moore, Folkman. (2009) found that rehabilitation counsellors interns utilised problem-focused and seeking social support more frequently than self-blame, wishful thinking and avoidance coping strategies. Crim (2013) studied coping strategies utilised by addiction counsellors which included staying organized, taking short breaks, clinical supervision, professional therapy, thinking positively, relaxation and meditation techniques, humor, teamwork, effective leadership, maintaining cultural identity, establishing boundaries, and successful transition from work to home. Layne (2001) found out that coping strategies was not a significant factor in predicting turnover. Although empirical evidence shows that rehabilitation counsellors utilise several coping strategies, coping strategies among rehabilitation counsellors is scanty warranting a research in this phenomenon. In response to this scanty of information, this study sought to enhance understanding of the coping strategies among rehabilitation counsellors in selected counties in Kenya.

3.0 METHODOLOGY

Descriptive survey design was utilised to carry out this study in 14 drugs and substance abuse rehabilitation centres in five selected counties in Kenya which included Nairobi, Nyamira, Trans Nzoia, Uasin Gishu and Kiambu. Descriptive research is intended to obtain information concerning the current status of a phenomenon and to determine the nature of a situation that exists at the time of the study. A total of 112 respondents from the total population of 204 participated in the study. There were thirteen personnel administrators who participated in the interview out of 26 rehabilitation centres.

3.1 Instruments

3.1.1 Questionnaire

The questionnaire included demographic and work questions which included age, gender, educational qualifications, experience, clients served and number of hours worked per week. Respondents were asked to indicate what they usually do while coping with occupational stress. The response alternatives ranged from 1 (Not effective) to 5 (very effective). Pilot testing of the instrument was carried out in Nakuru County to establish the reliability and validity of the instruments using the Cronbach alpha coefficient which is a common measure for internal consistency. The reliability coefficient for the questionnaire was 0.72.

3.1.2 The Interview Schedule

The interview schedule was developed to provide the necessary qualitative data from the personnel administrators of rehabilitation centres. Qualitative data is necessary in a study to supplement the quantitative data (Kombo & Tromp, 2006). Mugenda and Mugenda (2003) emphasizes that in adapting qualitative perspective, the researcher appears to be concerned with understanding of the perceptions of the world and seeks insight into the area of study. Further Mugenda and Mugenda (ibid) indicate that when it comes to actual data collection methods, the differences between quantitative and qualitative are not distinctively clear cut. The purpose of the semi- structured interview was to bring out the broad perspective of the coping strategies among the rehabilitation counsellors. The data collected from the pilot study which was carried out in Nakuru County was used to compute the reliability of the instrument. Cronbach's coefficient alpha method was used to determine internal consistency of the items. The instrument showed a reliability coefficient of 0.74 and therefore, the instrument was considered sufficiently reliable and valid for the study.

3.2 Data Analysis

The data collected from the questionnaires was organized, coded and analysed using descriptive statistics including frequencies, percentages, means and standard deviations. Responses from interviews were tallied using systematic thematic analysis. The Statistical Package for Social Science (SPSS) software for Windows version 19.0 software package was employed to facilitate analysis of data.

3.3 Ethical Considerations

Permission and approval to conduct the study was obtained from National Commission for Science, Technology and Innovations (NACOSTI) and the administrators of the selected rehabilitation centres. Participants were informed of the purpose and the voluntary nature of the study in the informed consent letter and that the names were recorded on the instruments. Participants were assured that any response on any instrument would remain anonymous in the final presentation of the results, that no one other than the researcher and the raters would ever see the actual completed instruments, and that their responses cannot in any way affect their professional positions.

4.0 RESULTS

4.1 Coping Strategies Utilised by Substance Abuse Rehabilitation Counsellors

The survey instrument included items based on the ways of coping questionnaire. Respondents selected how often they had used the coping strategies listed to deal with the stressful events. The subscales in Table 1 give an indication as to what extent to which respondents employ various coping strategies ranging from low to high. Mean scores for coping strategies ranged from 2.43 (SD= 1.18) to 4.23 (SD=1.15) for the current study.

Table 1.

Rehabilitation Counsellors' ratings of Mean Scores and SD for Coping Strategies' Subscales

Strategies	M	SD	Coping
Clinical supervision	4.23	1.15	High
Problem focussed	3.87	0.56	Moderate
Social- support	3.76	1.12	Moderate
Emotion focused	3.65	0.11	Moderate
Escape avoidance	2.43	1.18	Low

The findings presented in Table 1 on the coping strategies used by the respondents reveals that majority of the respondents engaged in clinical supervision (M =4.67, SD = 1.17), social support (M = 3.76, SD = 1.12) and emotion focussed (M= 3.65, SD = 0.11). The finding concurs with other study findings (Crim, 2013; Victoria, 2012; Lent, 2011; Glinka, 2010) who assert that the counsellors utilise a variety of coping strategies depending on the level of perceived stress. The finding of this study also concurs with the results of Gachutha (2006) who found that clinical supervision was a strong moderator of stress and burnout among counsellors. Clinical supervision involves job performance and emotional support, creating a 'safe space' to discuss emotionally challenging issues (Gachutha, 2006). It encourages counsellors to engage in self-reflection. This might have been due to the training and socialisation into helping profession that encourages counsellors to seek supervision and engage in debriefing sessions in order to combat with either burnout or stress in their occupations. As rehabilitation counsellors engage in supervision, they get an opportunity to learn strategies that enable more effective intervention in future, and provide an opportunity of self-reflection. Supervisor and counsellor' relationship also works to enrich the counsellors' on going experience on the job, thus moderating or appraising sensitivities to perceived occupational stressors. It is concluded that rehabilitation counsellors in selected counties utilise clinical supervision more than other coping strategies.

Social support was the second most utilised coping strategy in this study. Research on the role of social support in mitigating the negative impact of stressors on personal well- being has received a good attention and generally attests to the importance of this factor (Eunha, 2006). Receiving support from colleagues, co-workers, and supervisors reduces the stress associated with rehabilitation counselling. It encourages counsellors to find clarity and perspective with regard to a stressful situation by assisting the respondents to gain perspective and avoid feeling alone in the situation (Crim, 2013).The finding of workplace social support is consistent with workplace practices in which it emphasizes the

role of interpersonal relationships between supervisors and subordinates. The current findings agree with who concluded that there is a direct effect of social support in reducing occupational strain in the environment and enhance an individual's well-being. This is because people often need emotional and informational support in dealing with emerging issues in the workplace and especially unfamiliar tasks or situations. Therefore, strong social ties and support often assist rehabilitation counsellors in terms of avoiding conflict with their supervisors and co-workers. Thus, cooperation between supervisee and supervisors is an important factor that can increase job satisfaction and decreases occupational stress or turnover (Knudsen *et al*., 2008; Gachutha, 2006). Although social support might be linked to the respondents' beneficial, it is likely to have a more positive impact when it is congruent with the individual's needs and desire (Lent, 2011).

Negative coping strategies such as Escape avoidance (M= 2.43, SD = 1.18) was the least utilised coping strategy in the present study. This finding is in line with Victoria (2012) who found that addiction counsellors utilised negative coping strategies minimally. Primary use of escape avoidance by some of the respondents may be a reflection of withdrawal from the stressors. Individuals who use escape avoidance may find a brief respite from stressful situations but continued use can lead to both mental health and physical ill health. Although the findings indicate that negative coping strategies were minimal, there should be a concern for the respondents who utilised them. While this study advances knowledge and fills the gap about the use of coping strategies, there is still a number of important areas to be explored in future research. Other measures of coping strategies need to be developed. One issue in particular is the level of specificity at which coping should be conceptualized and measured.

Although the respondents had high occupational stress, the better coping strategies employed might have reduced the effects of the stressors the participants experienced. This supports the present study's conceptual framework in which states that the extent to which occupational stressors induce stress will depend on coping strategies. The present findings also support the general transactional theory of Stress – Strain –Coping (Lazarus & Folkman, 1984). This appraisal model of stress notes that stress is a psychological state representing a difficult transaction between the person and one's environment. The outcome of a stressful transition is mediated by appraisal and coping. This model assumes that not all individuals have the same reactions to the same potentially stressful situations and that while the work environment may be a source of physical and psychological stress, individual differences affect both levels of appraisal as well as abilities to engage in coping mechanisms.

4.2 Coping strategies and Demographic Varables

Coping strategies were also assessed by demographic and work variables.

Table 2.

Rehabilitation Counsellors' Mean Scores and SD for Subscales of Coping Strategies by Age

	Clinical Supervision		Problem Focussed		Emotion Focussed		Social Support		Escape Avoidance	
Age	M	SD	M	SD	M	SD	M	SD	M	SD
20 -25	4.26	1.54	4.58	1.61	3.44	1.87	3.97	0.54	3.73	1.12
26 -30	5.25	0.72	4.43	1.49	2.77	1.06	3.54	1.73	3.82	1.85
31 – 35	5.56	1.74	4.19	1.53	2.27	1.88	3.69	0.79	3.23	1.92
36 – 40	4.53	1.78	2.42	0.93	4.02	1.75	2.53	1.22	2.03	0.92
41 – 45	4.55	1.84	2.32	0.76	3.20	1.50	2.50	1.83	2.79	1.14
46 – 50	4.79	1.99	2.03	1.27	3.25	1.60	2.72	0.11	1.58	1.11
51 – 55	4.36	1.62	2.23	1.33	2.36	0.56	2.82	1.13	1.58	1.28
Above 55	3.36	1.09	3.77	1.06	2.13	0.39	2.59	0.34	1.23	0.44

Differences in the use of coping strategies were found with regard to the age of the respondents as presented in Table 2. All age groups scored high in clinical supervision, while problem focused, social support and escape avoidance were utilised by the age group between 20- 35 and those who were above 55. Emotion focused was utilised by the age categories between 20 – 25 and 36 – 40. This was not in line with the findings of Layne, Hohenshill and Singh (2004) whose findings concluded that age was not a significant predictor of coping strategies. The current finding indicates that older respondents had lower coping mean scores than younger ones. This can be concluded that younger respondents utilised the coping strategies than their older counterparts. Their younger counterparts might be learning to cope with the stressors and the environment, thus their ability to utilise almost all strategies.

Results on gender and marital status about coping strategies were analysed and presented in Table 3. In gender category, female utilised clinical supervision, emotion focused, and social support. Male respondents utilised supervision, problem focused and social support. Escape avoidance was the least utilised coping strategy among the respondents. The issue on whether significant differences exist between female and male rehabilitation counsellors in their coping strategies has been debated in the literature over many years, without an definitive resolution. The findings of the current study concurs with the findings of Layne, Hohenshill & Singh (2004) which did not find any significant differences between female and male in their coping strategies. It was concluded that women utilised emotion-focused and social support because the two coping strategies tend to regulate emotional responses to the stressful situation while Male utilised problem- focused because it attempts to manage or alter the problem causing the stress.

Table 3.

Rehabilitation Counsellors' Mean Scores and SD for Subscales of Coping Strategies by Gender and Marital Status

	Clinical Supervision		Problem Focussed		Emotion Focussed		Social Support		Avoidant Coping	
	M	SD	M	SD	M	SD	M	SD	M	SD
Gender										
Female	4.30	1.96	2.64	1.39	3.73	1.03	3.76	1.95	1.78	1.98
Male	3.80	1.01	3.26	1.76	2.69	1.02	3.56	1.89	2.32	1.84
Marital Status										
Married	3.56	1.01	2.43	1.88	3.79	1.12	2.61	1.94	1.72	1.01
Singles	3.57	1.98	3.40	1.86	2.70	1.06	3.70	1.47	2.70	1.97
Divorced	3.41	1.92	4.16	1.99	2.25	1.76	2.83	1.74	1.88	1.51
Widowed	3.66	1.25	2.66	1.36	3.16	1.18	2.50	1.07	2.33	1.86

In the marital category, all respondents utilised clinical supervision while avoidant coping was the least utilised. Married respondents preferred emotion focused while singles utilised problem focused and social support. Divorced scored high in problem focused while widows scored high in emotion focused. The findings differ with Jackson's (2004) who found that there was no significant difference on how the counsellors felt regardless of their marital status. It was noted in the current study that the decision to employ a particular coping strategy was influenced by one's perceptions of personal control over the stressful situation. Where an individual perceives a stressful situation to be beyond their control, they were more likely to utilise emotion-focused coping strategies such as avoidant coping. Where the individual perceived an opportunity to alter the situation, problem-focused coping strategies was preferred.

Table 4

Rehabilitation Counsellors' Mean Scores and SD for Subscales of Coping Strategies by Educational Qualifications

	Clinical Supervision		Problem Focussed		Emotion Focussed		Social Support		Avoidant Coping	
Qualification	**M**	**SD**	**M**	**SD**	**M**	**SD**	**M**	**SD**	**M**	**SD**
Doctorate	3.74	1.04	3.64	1.69	3.50	1.95	3.57	1.65	1.71	0.77
Masters	3.82	1.12	3.58	1.06	3.71	1.05	2.58	1.15	1.64	1.06
Degree	3.65	3.51	3.51	1.93	2.68	1.08	2.82	1.97	1.65	1.92
Diploma	3.41	1.93	3.47	1.84	4.00	1.12	3.82	1.06	2.64	1.02
Certificate	2.72	1.67	2.90	1.81	3.82	1.13	3.63	1.96	3.00	1.89
Form four	1.97	0.74	2.45	1.86	3.71	1.01	3.66	1.91	2.55	1.92

Coping strategies among rehabilitation counsellors and their academic qualifications were analysed and presented in Table 4. All education categories utilised clinical supervision and problem focused coping strategies except certificate and form four holders. Emotion focused was utilised by all categories except degree holders while social support was utilised by doctorate, diploma, certificate, and form four holders. Avoidant coping was utilised by certificate and form four holders. The reason why certificate holders utilised avoidant coping strategy could be attributed to them ignoring the issue of stress that often results in activities that aid in the denial of the problem. This finding is not consistent with the findings of Victoria (2004) and Jackson (2004) who did not find any significant associations between coping strategies and qualifications. The reason why the respondents in this study showed a difference might be that only trained, accredited and licensed counsellors are employed in rehabilitation centres in the West (Crim, 2013; Victoria, 2012) unlike the Kenyan situation in which counsellors with different level of qualification are recruited. It can also be suggested that the form four leavers who were likely to be in recovery from their own addiction might not be able to utilise fully positive coping strategies. This could be attributed to them not having gone through professional training as opposed to their counterparts. Although they bring their expertise into the profession, there is need for them to go through professional training that could assist in coping or appraising occupational stress. The present study suggests that different types of coping strategies have different effects on the stressors and stress levels, and their use buffers or moderates stressors.

Table 4.

Rehabilitation Counsellors' Mean Scores and SD for Subscales of Coping Strategies by Experience

	Clinical Supervision		**Problem Focussed**		**Emotion Focussed**		**Social Support**		**Escape Avoidance**	
Experience	**M**	**SD**	**M**	**SD**	**M**	**SD**	**M**	**SD**	**M**	**SD**
1 – 5	4.40	1.39	4.19	1.32	3.83	1.18	3.78	1.11	2.47	1.29
6 – 10	4.52	1.32	4.64	0.86	3.47	1.32	2.52	1.06	2.82	1.23
11 – 15	3.88	1.28	3.71	1.15	3.88	1.36	3.82	1.07	1.76	1.14
16 – 20	5.00	1.19	3.50	1.93	2.01	1.18	3.45	1.23	1.70	1.14
21 – 25	4.89	1.76	3.33	0.43	2.30	0.67	3.74	0.68	1.25	0.31
26 – 30	4.55	1.97	3.45	1.86	2.71	1.18	1.66	1.91	1.55	1.92
Above 30	3.56	0.45	3.96	1.62	2.97	1.68	2.75	1.44	1.26	1.19

Mean scores for coping strategies in relation to experience of the respondents were analysed and presented in Table 4. All the respondents presented higher mean scores in clinical supervision and problem focussed strategy. Emotion focussed strategy was utilised by those who had experience between 1-15 years, social support was utilised by those who had worked between 1-5 and 11-25 years. Escape avoidance was the least utilised. The findings are not in agreement with the findings of Layne, Hohenshill & Singh (2004) and Layne (2001) who stated that there were no significant differences between experience and coping strategies. The finding of this study could be interpreted to mean

that more experienced respondents had learned stress coping strategies in the course of their interaction with their workplace, thereby enabling them to effectively employ them while dealing with the stressors.

Table 5.

Rehabilitation Counsellors' Mean Scores and SD for Subscales of Coping Strategies by Clients Served per Day

	Clinical Supervision		Problem Focussed		Emotion Focussed		Social Support		Escape Avoidance	
Caseload	M	SD	M	SD	M	SD	M	SD	M	SD
Below 10	3.04	1.48	2.83	1.28	3.15	1.14	3.45	1.36	2.25	1.42
11 – 20	3.47	1.26	3.55	1.13	4.08	0.99	3.79	1.09	1.25	0.65
21 – 30	4.30	1.15	4.30	0.94	2.50	1.73	3.25	0.96	1.51	0.71
Above 30	4.51	0.52	3.60	1.07	2.71	1.41	3.66	1.91	1.55	1.02

Coping strategies and clients served per day were analysed and presented in Table 5. The findings of the study shows that all the respondents utilised clinical supervision, problem focussed and social support. Emotion focussed was utilised by those who had less than 20 clients while escape avoidance was minimally utilised. The findings of the study concurs with the findings of Crim (2013) and Victoria (2012) who concluded that rehabilitation counsellors regardless of the number of clients would resort to professional help, followed by problem focussed and social support. The current study suggests that all respondents rather approach than avoid their emotional reactions by means of utilising clinical supervision, eliciting social support and Problem-focused. Rehabilitation counsellors' well-being is paramount as it dictates the counselling outcomes.

Table 6.

Rehabilitation Counsellors' Mean Scores and SD for Subscales of Coping Strategies by Clients' Contact Hours

	Clinical Supervision		Problem Focussed		Emotion Focussed		Social Support		Escape Avoidance	
Contact Hours	M	SD	M	SD	M	SD	M	SD	M	SD
Below 10	3.38	1.57	2.22	1.30	2.66	1.32	3.16	0.92	3.33	1.37
11 – 20	3.51	1.25	3.44	1.25	2.77	1.21	3.81	1.07	1.31	0.35
21 – 30	4.62	1.32	2.68	1.10	3.79	1.29	4.03	1.08	2.82	1.10
Above 30	4.33	1.15	2.66	1.15	2.33	1.15	3.66	1.15	2.66	0.57

Mean scores for coping strategies and number of clients' contact hours was analysed and presented in Table 6. All respondents utilised clinical supervision and social support strategies. Emotion focussed was utilised by those who had contact hours between 21-31 while escape avoidance was utilised by those who had below 10 contact hours. The findings are in line with the results of Crim (2013). It can be concluded that those who used emotion focused were trying to reduce the negative emotional responses associated with stress while it does not solve the source of the

distress. Those who used avoidance were trying to avoid dealing with stressors. Rehabilitation centres should actually look at the number of contact hours in relation to clients' caseload in order to support the wellness of rehabilitation counsellor from stress.

The overall findings of the study was inconsistent with the literature on the Transactional Model of Stress and Coping which implies that an individual will appraise a stressful situation and utilize one coping strategy. According to Lazarus and Folkman (1984), this theory suggests that appraisal of whether or not an event can be changed. The interaction of the three coping strategies utilized among the respondents indicated that adaptive patterns are multifaceted. These results may be due to the complexity of additional stressors in the rehabilitation centres in which positive coping strategies may appear promising. It is worth noting that, despite of positive coping strategies utised by rehabilitation counsellors, the stress prevalence is still moderate to high level from the sample population.

5.0 Conclusion.

With regard to coping strategies, majority of the respondents engaged in positive coping strategies and a few engaged in maladaptive strategies. The findings indicated that majority of the respondents engaged in clinical supervision, social support and self-care as coping strategies while positive reappraisal and escape avoidance were the least coping strategies utilised. The findings further demonstrated that the appraisal of stress was related to background and work characteristics.

5.1 Recommendations

Rehabilitation centres need to extol the uniqueness of working conditions of rehabilitation counsellors by strategically refocusing on coping strategies. Perhaps, it will be interesting to explore on this matter further in the future studies. However, occupational stress prevention programs that help drugs and substance abuse rehabilitation counsellors to not only cope with stress but to develop more positive qualities such as a sense of meaning, gratitude, and fulfilment in work are especially important areas for further research.

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