

**COUNSELLORS' EXPERIENCES OF USING CREATIVITY IN COUNSELLING CLIENTS
WITH CONCURRENT DISORDERS: WHAT HELPS AND HINDERS**

by

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ABSTRACT

This study investigated the experience of concurrent disorders counsellors using creativity in practice. In any given year, one in five individuals in Canada experiences a mental health illness that can include a substance use disorder. Lifetime prevalence estimates of individuals with substance use disorders and severe mental illness(es) varies from approximately 40% to 60% depending on the sample. Individuals with concurrent disorders often also face additional physical health, financial, education, relational, housing, and criminal justice challenges. Ultimately these issues cost the economy more than \$50 billion per year. In an era of limited resources, the need for creativity in assisting individuals with concurrent disorders seems extreme. However, there is little research investigating how concurrent disorders counsellors use creativity with their clients, particularly with regard to what nourishes and impedes their creativity.

The results of this study provide insight into the factors that help and hinder concurrent disorders counsellors' creativity in practice. Eleven participants were interviewed using the Enhanced Critical Incident Technique. The study generated 298 incidents, including 167 incidents described as helpful to creativity in practice, 88 incidents perceived as hindering creativity and 43 wish list items. These incidents were grouped into 34 categories. The 12 helping categories were: personal factors, colleagues and collaboration, resources, education and training, client factors, autonomy, supportive management, client feedback, experience, personal or professional practice, meditation/mindfulness, and personal therapy. The 10 hindering categories were: client factors, personal factors, bureaucracy, imposed models,

unsupportive management, time pressure, lack of resources, colleagues, physical environment, and lack of special topics education and training. The 12 wish list categories were: special topics education and training, resources, alternative therapies, therapeutic space, integrated co-occurring disorders centre, services integration, supportive management, time, time with creative people, client factors, autonomy, and preventative work.

The findings show that personal and client factors along with colleagues, education and training, and management all play significant roles in helping and hindering concurrent disorders counsellors' creativity. Unique findings included meditation and personal therapy enhanced creativity, imposed models hindered creativity, and desires for increased services integration, and the creation of concurrent disorders centres with integrated services to enhance counsellors' creativity.

PREFACE

This research study was approved by The University of British Columbia Behavioural Research Ethics Board on September 21, 2011 (H11-02419).

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CHAPTER 1: INTRODUCTION

When I decided to embark on a career transition into counselling, I took an assessment course taught by the former coordinator of the concurrent disorders program at St. Paul's Hospital. This instructor opened my eyes to the rates of comorbid substance abuse and dependence with other Axis I and Axis II disorders. After her course, I accepted a position as an employment counsellor. I now think of career counselling as having a "drugs, sex and rock and roll" dimension as so many of my career counselling clients were using substances, had mental health concerns, and trauma backgrounds. I found myself being creative, stepping beyond the usual resumé, cover letters, labour market information, and interviewing that as an employment counsellor I was expected to contain myself to while still practicing professionally and ethically. I listened empathically to clients and their concerns regarding prescription medications and cognitive behavioural therapy (CBT), and encouraged them to talk with their doctors, nurses, and other counsellors about their concerns. I tracked down bankruptcy counselling services, housing information, and referrals to gambling addictions services as well as the Vancouver Mental Health teams. I encouraged clients to write fiction and poetry to help them process their feelings about job loss and other losses in their lives. I discussed nutrition, sleep, exercise and hydration. I took clients for walks in the park when things just were not progressing in order to develop relationships where clients felt they could disclose. I built "flex time" into my schedule to accommodate clients whose binge drinking meant they would likely be late to appointments, as late was better than not at all in my estimation. I listened to clients complain about having to see multiple service

providers and the frustration they felt because of ongoing staff turnovers. I was challenged almost every day by clients with mental health and addictions challenges. To meet those challenges, I delved deeply into my imagination and adopted an attitude of flexibility to try and provide the support I could ethically offer within my scope of practice; “business as usual” was not going to help my clients meet their goals regarding employment.

When I resigned to attend UBC’s counselling psychology program, one of my most challenging clients returned to see me. She was seeing her psychiatrist regularly as well as a holistic therapist, and she had been successful in obtaining the job she wanted. She thanked me and said that not once during our time together had she felt judged despite sharing with me some of the stories of strange things she saw. She said most people had given up on her. It became clear to me that counsellors, working with clients with concurrent disorders, could have a significant impact when the counsellors were flexible and creative.

I started to research literature on the use of creativity in counselling and creativity in counselling with clients with co-occurring disorders and found that little was available. There was a great deal of information about creativity and mental illness, some about creativity and addictions, but little about when the two co-occur. Most of what is in the literature equates creativity with the arts, but this seems limiting in the case of these clients given that they have so many barriers that require creative problem solving beyond the utilization of artistic methodologies. In terms of treatment, clients with concurrent disorders are often treated within the health care system, if they are treated at all, and therefore case management and empirically supported

treatments (ESTs) including illness self management, psychopharmacology, assertive community treatment, family psychoeducation, and supported employment comprise integrated treatment for co-occurring disorders; CBT and Motivational Interviewing (MI) dominate the counselling treatment practices (Drake et al., 2001; Mueser et al., 2003; Rosen et al., 2007; Hubble et al., 2010). The literature supports that these approaches are effective, for some. Many of my clients engaged in these treatments reported they felt they were dissatisfied and unengaged in the treatment process. Frese, Stanley, Kress and Vogel-Scibilia (2001) point out “the scientific, objective, evidence-based approach emphasizes external scientific reality, whereas the recovery model stresses the importance of the phenomenological, subjective experiences and autonomous rights of persons who are in recovery. The two models will conflict under many circumstances” (p. 1463). If clinicians should be striving to help people become independent, engage in meaningful employment and satisfying relationships, and ultimately achieve good quality of life, how do we reconcile the objective with the subjective? As a counsellor, trained in existentialism, I wonder what *else* can and perhaps should be done to help clients with concurrent disorders improve their quality of life, and what role creativity can have within both the evidenced-based and recovery models?

1.1 Definition of Terms

Before commencing research into counselling clients with co-occurring disorders and creativity, one must define what is meant by the terms co-occurring disorders and creativity.

Concurrent disorders.

The definition for concurrent disorders is fairly straight-forward in that the term refers to “any combination of mental health and substance use disorders” (Centre for Addictions and Mental Health (CAMH), 2002, p. 5).

Creativity.

In contrast, creativity is relatively ill defined with many different definitions in the vast canon of creativity literature. However, within the literature, there is a distinction between eminent, “big C” creativity, which is seen as rare but having major impact on the related domain(s), and everyday “little c” creativity, which is conceptualized as daily problem solving and adapting to change as required (Hennessey & Amabile, 2010). Although creativity in counselling could have a major impact on an individual client and those around him or her, generally we are referring to “little c” creativity within the counselling field. Carson & Becker (2004) argue that creativity is a mindset and a skill, which can be learned and improved upon.

Lumadue, Munk and Wooten (2005) wrote “creativity, as discussed within a mental health context, speaks in part to a therapist’s willingness and ability to responsibly and creatively think outside the box, while fostering in their clients their own creative and innovative capacities to consider and work through issues and problems” (p. 8).

For the purpose of this study, creativity will be defined using Glover, Ronning & Reynolds’ 1989 (as cited in Heppner et al., 1994) definition: creativity is a process that “involves the combination of information, often in unique and novel ways, that is ultimately used to elucidate or solve a client’s problem by extending the client’s experiential world in some way” (p. 78).

1.2 Statement of the Problem

At the policy level, mental health has been seen as one of the “orphan children” of medicare. As care has shifted to home and community based settings, The Commission on the Future of Health Care in Canada (2002) recommended that mental health care be deemed as medically necessary services under the *Canada Health Act* and therefore made available across the country. Prior to the 1970’s, many individuals with mental health concerns were treated in hospitals, but despite a shift to a flawed policy of deinstitutionalization amid assertions of increased integration (Mental Health Commission of Canada (MHCC), 2012), the fact remains that mental health care is still one of the least integrated health care services. Indeed MHCC acknowledges that work needs to be done to translate integration at the policy level into appropriate and effective collaboration at the direct service level which clients access. Complicating matters, the levels of Canadian governments have struggled over the last twenty years to balance operating budgets and reduce debts. With the federal government reducing transfer payments to the provinces who administer health services, the result has been unprecedented constraint and restructuring of health care budgets across the country (Naylor, 1999), which may play a role in increased integration. Working creatively seems essential when a major overhaul of the mental health care system including, additions, involving multiple systems is required.

The stakes are not small. In any given year, one in five individuals in Canada experiences a mental health challenge or illness that profoundly affects them, their families, their employers, their communities, and ultimately costs the economy more than \$50 billion per year (MHCC, 2012). There are social justice implications as well.

Individuals with concurrent disorders are often marginalized. Concurrent disorders affects groups of individuals who were already on the fringe of society before developing mental health and substance use concerns. For example, young First Nations individuals are exposed to alcohol and substance abuse far more when compared to other Canadians of the same age (Commission on the Future of Health Care in Canada, 2002). There are moral, social and economic imperatives to improve services for individuals facing mental health and addictions challenges.

At the direct service level, counselling clients with concurrent disorders can also be very challenging due to the complex nature of their concerns. In addition to mental health issues, substance use or dependence co-occurs and complicates matters further for client and counsellor. Furthermore, often these clients have other issues such as employment instability, housing instability or homelessness, and being in conflict with the law to name just a few (CAMH, 2002). While these clients are often treated in community based healthcare settings, they often require other services as well. MHCC (2012) noted that poor coordination of services, lack of understanding, and stigma leave individuals with concurrent disorders with significant challenges in accessing appropriate treatments, services and supports. They call for improved coordination among physical health, mental health, developmental, education, social services and justice stakeholders, and for the improved knowledge and skills of service providers. In light of the budget challenges, marginalization of mental health within the health care system, stigma and discrimination, and the very nature of concurrent disorders, if there was ever a client population where counsellors needed to draw upon their creativity to work effectively, this is the group.

In order to manage the complexity of these clients, all of whom are unique, it would seem that creativity would be necessary to effectively counsel them. Indeed, creativity is considered to be a valuable skill in counselling (Anderson, Ogles, & Weis, 1999; Raskin, 1999b; Amundson, 2009). Carson and Becker (2004) suggest that creativity is very important in an era of brief, short-term, solution focused approaches as a result of the funding pressures on health care systems and the desire of clients and funders, tax payers, governments, and insurance companies, to find quick solutions to complex problems. Given the valuable nature of creativity in counselling, it is not well understood and there is not much research regarding its role or effect in the process.

In addition, with the emphasis on ESTs and manualized therapy, it is possible that creativity may actually be discouraged in practice (Anderson et al., 1999). There is a great diversity of clients with concurrent disorders and their complex needs, so manualized EST approaches to every client will fail some of the time; whereas, taking the creative, flexible approach advocated by Amundson (2009) can involve the client in the process, and allow for collaboration between the client and their counsellor so that both parties are better able to “cut to the chase” (p. 114).

The problem therefore, with the need so great for innovation and creativity, and a call for EST approaches within the profession, is a lack of research investigating the role of creativity in counselling and its impact on the counsellor and on the client. That problem is too big for the scope of this study, so I narrowed the problem down to identify how counsellors define creativity and what are the essential factors that enable and impede their creativity in practice to establish a foundation for future investigations on the role of creativity in counselling clients with concurrent disorders.

Due to the exploratory and developmental nature of this research, as there is a lack of existing research on the specific topic, there is a need to utilize a qualitative research method to give voice to the counsellors practicing in the field of concurrent disorders, to understand their experiences, and shed light specifically on what helps and hinders their creativity.

1.3 Purpose of the Study

The purpose of the proposed study is to explore counsellors' experiences of using creativity in counselling clients with concurrent disorders, with specific attention paid to what facilitates and impedes counsellors creativity in order to contribute to the limited literature on the topic.

1.4 Research Question

The primary research question for this study is what helps and hinders concurrent disorders counsellors use of their creativity in practice?

CHAPTER 2: LITERATURE REVIEW

Before exploring how counsellors use creativity, it is important to understand the role that creativity plays within the context of counselling and its potential in working with clients with concurrent disorders. Chapter two will review the current literature with regard to concurrent disorders, creativity, the factors that help and hinder creativity, and finally creativity and its application with clients with mental health concerns including concurrent disorders.

2.1 Concurrent Disorders

As mentioned earlier, concurrent disorders consist of any combination of a mental health diagnosis and substance misuse (CAMH, 2002). The range of psychiatric disorders identified in the DSM IV-TR is too large to discuss here but a sample of disorders often discussed in co-occurring literature includes schizophrenia, mood disorders including bipolar disorder and major depression, and anxiety disorders including post-traumatic stress disorder (PTSD). The range of substances abused by clients with psychiatric disorders is also too large to discuss here but they include alcohol, caffeine, nicotine, gasoline, prescription medications including opiates and benzodiazepines, as well as illegal street drugs. The different combinations of mental health disorders and different combinations of substances used make clients with concurrent disorders some of the most challenging clients in the counselling profession.

In addition to their mental health concerns, consequences of substance abuse for clients with concurrent disorders can include: housing instability; symptom relapses unrelated to life stressors; treatment noncompliance including failure to take

prescribed medications, renew medications or attend therapeutic appointments; violent behaviour or threats of violence; sudden, unexplained mood shifts; suicidal ideation and suicide attempts; cognitive impairments including confusion, memory problems and difficulty planning; financial problems and poverty; criminal involvement and legal problems including theft, prostitution, shoplifting, disorderly conduct, driving while under the influence, and possession or trafficking of illegal street drugs; social isolation and social difficulties with family, friends and coworkers; employment difficulties including unstable work histories or chronic unemployment; and hygiene and health problems including personal hygiene, weight loss and medical problems such as HIV/AIDS, and hepatitis among others (CAMH, 2002; Mueser et al, 2003).

Lifetime prevalence estimates of substance use disorders in clients with severe mental illness(es) varies from approximately 40% to 60% (Mueser et al., 2003) depending on the sample; the variation has been attributed to factors including assessment methods, diagnostic criteria, settings and demographic characteristics (CAMH, 2002; Mueser et al., 2003). However, in some populations prevalence rates can be even higher; for example the prevalence rate of substance abuse and dependence, trauma and specifically PTSD has been found to be as high as 91% in Vietnam combat veterans (Boudeywyns et al., 1991; Davidson & van der Kolk, 1996; MHCC, 2009).

Veterans are not the only group facing significant challenges with concurrent disorders. For more than 200 years in Canada, legislation and policies designed to increase the assimilation of First Nations, Inuit, and Metis individuals to mainstream

culture have undermined their mental health. Residential schools and child welfare systems have interrupted or eliminated the ability of families and Elders to raise children and transmit traditional parenting methods, language and cultural knowledge. The resulting cultural genocide has contributed to high rates of mental health problems, addictions, concurrent disorders and suicide, which are linked to additional problems including family violence and involvement with child welfare systems and ultimately the criminal justice systems (MHCC, 2012).

Treatment of concurrent disorders.

Mueser et al. (2003) emphasize CBT and MI as evidence-based practices in their definitive text on working with clients with concurrent disorders. However, they write that treatment programs will, do, and must vary according to the clients and their needs. Despite their assertion that flexibility and adaptability are required, the concept of creativity does not appear in a prominent fashion in their writing.

General practitioners deliver the largest proportion of primary mental health care in Canada (CAMH, 2002; Hutchinson et al., 2001) so often clients with concurrent disorders never see a counsellor. Nevertheless, an integrated treatment approach involving interdisciplinary teams of psychiatrists, psychologists, social workers, occupational therapists and counsellors is considered best practice (CAMH, 2002; Mueser et al., 2003). Although the integrated approach is recognized in the literature as a best practice, many obstacles prevent this from actually happening and often for clients fortunate enough to receive treatment for both or more disorders, it is often from “separate, uncoordinated systems” (Kopelowicz & Liberman, 2003).

Clinicians own beliefs about the primacy of the disorders such as the mental health problem causes the addiction or the addiction causes the mental health problem can interfere with treatment, as few are trained in integrated treatment. Depending on their belief about the origins of the disorders, clinicians will sometimes refuse to treat until what they consider the primary disorder is treated first (Mueser et al., 2003). Another possibility is that clients are often only treated for one disorder (Kopelowicz & Liberman, 2003) as clinicians often do not assess for other disorders.

There is a diverse number of treatment settings in which clients can be seen. For example, withdrawal from substances can occur in a general hospital ward, a specialized hospital setting, a non-medical withdrawal setting, or in outpatient settings. Counselling can take place in schools, workplaces, community settings, hospitals, forensic settings as well as substance abuse treatment centres (CAMH, 2002). Coordinating different kinds of treatment between a different number of service providers can become extremely complicated. Often clients tire of telling their stories over and over again to different professionals and terminate treatment out of frustration and fatigue.

Some treatment programs, especially those founded on the disease model of substance abuse, require abstinence in order for clients to receive treatment. However, for some clients it is not possible to stay clean long enough to receive treatment. Harm reduction is being increasingly recognized by health care providers and researchers as effective in treating addictions and preventing diseases such as HIV/AIDS; consequently, needle exchange programs and transition housing are available in limited numbers in limited locations.

Although health care researchers and providers recognize the value of harm reduction approaches (B.C. Centre for Excellence in HIV/AIDS, 2009; Marshall et al., 2011), there is resistance from the Canadian federal government as evidenced by its court challenge of Insite, the safe injection site located in the Downtown East Side of Vancouver (CBC, 2011). There is an ongoing conflict between the ideology of treating addictions as a health care concern using harm reduction approaches supported by science, and the ideologies of abstinence-based models and the “war on drugs” despite declarations that the abstinence based legal policies involved in the war on drugs are a failure (Alexander, 2008; Bagley, 1988). Subsequent conflict between four major systems, the British Columbia government, the provincial health care authorities, the criminal justice system and the federal government, speaks to the significance of the challenges facing clients with concurrent disorders.

There is significant stigma attached to both mental illness and addictions. The stigma, intolerance and discrimination individuals with concurrent disorders experience from family, friends, colleagues, employers, members of the public, even at times from the very service providers working to assist them becomes another barrier to clients seeking treatment (MHCC, 2012). Bohart (1999) asserts that how one experiences oneself through interactions forms one’s sense, one’s feeling, of who one really is. If through countless interactions with friends, family, peers who use substances, and coworkers who stigmatize mental illness, then the client creates a pattern, a schema based on discrimination and stigma. It can take considerable time and effort to change self-concept and the accompanying thoughts, feelings and behaviours. Therefore, a client in these circumstances is not necessarily resistant or

unmotivated, s/he may be attempting, in part, to create a new schema, a new identity, and this process takes time.

In order to address some of the challenges clients with mental health and addictions face, MHCC (2012) recently released a national mental health strategy. Their vision is to promote mental health across the lifespan in homes, schools, and workplaces, and prevent mental illness and suicide wherever possible. Another goal is to reduce the impact of mental health problems and illnesses and improve the mental health of the population with promotion and prevention efforts in everyday settings where they see the potential impact being the greatest. In order to accomplish these goals, access to the right combination of services, treatments and supports, when and where people need them, must be established. They envision a full range of services, treatments and supports including primary health care, community-based and specialized mental health services, peer support, supported housing, education and employment that would need to be integrated and coordinated. What MHCC proposes would revolutionize the care for individuals with concurrent disorders. In order to accomplish this goal, creativity will be required by those professionals engaged in designing and implementing policy, programs and services.

2.2 Creativity

Clients with concurrent disorders have some of the most complex challenges, suggesting they have the most need for creative problem solving in their lives. There is some consensus creativity is necessary and integral to counselling generally, yet there is an absence in the literature on creativity in the counselling of clients with co-occurring disorders. How do we foster creative problem-solving skills in clients when

counsellors themselves may not experience factors that encourage creativity in their practice? Although creative thinking is supposedly desirable in many domains, creative individuals often go unrewarded and are even punished (Egan, 2007).

Creativity has had a long history of association with therapy and healing. Healthcare professionals have been known to use art, music, and writing since the Ancient Egyptians to prevent and treat mental health issues; the arts have been by utilized by African, Chinese, Japanese, Greek, Hebrew and Indian cultures. More recently, Freud, Jung, Maslow and May have advocated for the use of the arts in treatment. (Crawford & Patterson, 2007; Gladding, 2005; Henderson & Gladding 1998).

Research investigating creativity in practice is complicated by the elusiveness of the concept (Rosenthal, 2002) and its complexity as it seems to involve multiple components including imagination, play, openness and risk taking. Although for the purpose of this study, a definition of creativity has been provided, there is no universally agreed upon definition for creativity (Kottler and Hecker, 2002) perhaps due to the complexity of the construct. Salk “proposed that creativity rests on a ‘merging of intuition and reason’” (Damasio, 1994, p. 189), so let us begin with exploring intuition and creativity in the literature.

The role of intuition and flow in creativity.

Although Kottler and Hecker (2002) discuss the role of intuition, they do not explicitly incorporate it into conceptualization of the creative process. However, Bohart (1999) states the ultimate foundation for creativity is intuition. Bohart contends that people behave more mechanically when consciously guiding their behaviours

than when we allow ourselves to act spontaneously and intuitively. He goes even further to suggest that people function more effectively when they act without thinking. What Bohart describes, is Csikszentmihalyi's idea of flow which he defines as "the feeling when things [are] "going well as an almost automatic, effortless, yet highly focused state of consciousness" (1996, p.110)

The role of imagination in creativity.

When non-mandated clients present for counselling, are they not imagining at least the possibility of a different way of being? Imagination is the process of bringing to mind that which is not present to our senses in our immediate environment (Robinson, 2011) and has a role in the counselling process. Also, imagination constitutes another way of knowing (Brueggemann, 2001). However, Amundson (2009) points out that clients often present for counselling because they face a "crisis of imagination" (p. 30). Brueggemann notes that in order to create a vision of alternative possibilities, one must imagine possibilities before one can implement them (as cited in Leggo, 2005) in the counselling process. However, counsellors may also be, at times, faced with crises of imagination as they too must be able to imagine possibilities for clients as well as possibilities in the therapeutic work.

If imagination must come before implementation, then imagination is an essential part of recovery and therefore essential to counselling. An example of the successful use of imagination and creativity in trauma-focused groups would be the preparation of an imaginary gift for another member as part of feedback to others during termination. When giving feedback, group members do so empathically, imaginatively, and playfully (Herman, 1997) as they attempt to create a self through

fantasy. In previous therapeutic stages, imagination can be occupied by repetition of the trauma(s) and can be limited by a sense of hopelessness and helplessness. Self-regulation developed through earlier stages in the therapeutic process enables the therapist and client to utilize the client's ability to imagine and play as they experiment with skills, learning from experience to build up a tolerance for failure, and to enjoy successes. Rankin and Taucher (2003) have found the integration of art inventions increases the possibility for more effective and efficient therapeutic progress with traumatized clients with results including increased self disclosure, improved mood, less frequent distress, less loneliness, reduced anxiety and increased satisfaction with treatment (Pizzaro, 2004).

The role of play in creativity and counselling.

Engaging in creativity usually involves using the imagination and playing with concepts and ideas (Robinson, 2011), and living creatively is a healthy state; however, creative living can be lost and individuals can feel as though the meaning of their very lives is lost (Winnicott, 1971; Yalom, 1980). Winnicott also wrote on the role of play in treatment,

psychotherapy takes place in the overlap of two areas of playing, that of the patient and that of the therapist. Psychotherapy has to do with two people playing together. The corollary of this is that where playing is not possible then the work done by the therapist is directed towards bringing the patient from a state of not being able to play into a state of being able to play (p. 38).

If therapy's purpose is to help individuals return to a healthy state, then play and creativity play a significant role according to Winnicott. He further asserts it is only in

play that the person is able to be creative and take advantage of their whole personality. Now neuroscience is starting to support the importance of play in human wellness.

Creativity, play and neuroscience.

Neuroscience is beginning to explore play as a primary system and there is now discussion that “play may be the most underutilized emotional force that could have remarkable benefits in psychotherapy” (Panksepp, 2009, p. 21). Panksepp argues that it is unlikely that there is any stronger aid than the joyousness of play for working effectively with psychiatric distress. He advocates for music and the other arts to be included into all therapies. So neuroscientists are beginning to share psychodynamic therapists’ thoughts on creativity, imagination and play.

Individual counsellors need to create new experiences for clients in specialized settings and creative play can provide these experiences (Winnicott, 1971). If the goal is to help clients live a good life then,

any therapist who can capture the therapeutic moment in mutually shared play episodes will have brought the client to the gateway of happy living. To the extent that the client can be held there, in both body and mind, the therapist will have offered one of the greatest emotional gifts that psychotherapy ... can ever provide (Panksepp, p. 17).

Creativity as an element of the therapeutic process.

Hecker and Kottler (2002) argue that creativity is not innate, rather it is a learned skill that can be developed over time and incorporated into psychotherapy. They add “frustration is probably one of the most popular mothers of creativity” (p. 8)

and Carson and Becker (2004) concur, emphasizing that most counsellors feel stuck with some clients some of the time and that creativity can be part of a process born of frustration or the need for a solution, facilitating a break through. Raskin (1999a) argues that much therapy results from in the moment improvisation which is germane to assessment, diagnosis, and therapy as well as to the counsellors practice and life. Indeed, Bohart (1999) concurs that moment-by-moment responses are by definition creative.

Some researchers identify four steps in the creative process (Carson & Becker, 2004; Kottler & Hecker, 2002). The first step is preparation in which conscious work is done to solve the problem. Step two is incubation, which is essentially a rest period; the period can be short or long. Step three is inspiration. Inspiration can occur for the client, or the counsellor or between the client and the counsellor. Inspiration involves divergent thinking where a new, novel approach to solving the problem emerges. Egan (2007) defines divergent thinking as “more than one way to manage a problem or develop an opportunity” (p. 258).

The final step is verification where the client and counsellor test the product of the inspiration. Verification returns us to convergent thinking wherein we use reasoning that synthesizes relevant data to make critical judgments and arrive at a conclusion (Carson & Becker, 2004; Gladding, 2005; Kottler & Hecker, 2002)

Gladding adds two steps to the four step creative process identified above. After incubation, he subdivides “inspiration” into ideation where ideas are created but not judged; he classifies ideation as a form of thinking. Next, he adds the concept of illumination, which he sees as a “breakthrough” in one’s thinking. Bohart’s “intuition”

is different from “illumination” in that intuition operates on an unconscious level; whereas, illumination or the “a-ha” moment requires consciousness.

Although Gladding, and others, emphasize divergent thinking as the central feature of creativity, he adds the idea of evaluation, which requires convergent thinking. Given that many define creativity as producing something novel and useful, divergent thinking is necessary but insufficient. Convergent thinking is required to critically evaluate all the possibilities generated in order to select and verify an appropriate intervention and know why (Robinson, 2011; Smith, 2005) one should responsibly and ethically utilize it with a specific client with specific concerns at a specific time.

2.3 Factors That Help and Hinder Creativity

There appears to be little discussion in the literature about creativity in counselling clients with concurrent disorders, and specifically the factors, which enhance or limit creativity in counselling practice. Given the limited literature, examining Amabile and Gryskiewicz’s (1987) Critical Incident Technique study investigating the helping and hindering factors of creativity in research and development scientists provides an initial framework. They found four general categories influencing creativity: environmental stimulants and environmental obstacles as well as helpful personal qualities and unhelpful personal qualities.

Specifically the helpful personal factors included: intrinsic motivation; ability and experience which included problem solving abilities, creative thinking strategies, talent and expertise, and broad and general knowledge in many fields; risk-orientation including being unconventional and willing to take risks, being flexible and attracted

to challenging situations; social skills including being able to establish and maintain good rapport, being a good listener, and being open to others' ideas; and other personal qualities such as curiosity, and being naïve or unbiased about problems helped the scientists' creativity.

In terms of helpful environmental factors, they found autonomy in how to work and meet constraints established by others; encouragement from management in terms of enthusiasm and support; access to resources such as people, funding, information and time; recognition and constructive feedback; being challenged in a realistic manner; other project management features such as political support for a project, shelter from outside pressures; and finally other organizational features such as cooperation and collaboration, good communication, mechanisms for considering new ideas, minimal bureaucracy and formal procedures along with few political problems.

The hindering factors also fell into personal and environmental categories. Lack of freedom in deciding how to do one's work was the single most cited type of hindering incident in their study. One participant described how the person was expected to follow a prescribed path as dictated and was not allowed to deviate. Other hindering environmental factors emerged including: organizational indifference; evaluation pressure; overemphasis on maintaining the status quo; resistance to innovation; lack of resources; managers who did not shelter individuals from outside pressures or were incompetent or did not understand; the lack of a collaborative atmosphere; overly formal and complex procedures and political problems.

The hindering personal factors they identified included: the lack of courage in

addressing a difficult problem, dealing with environmental factors, pessimism, being too cautious, risk averse, inflexible, and unhappiness; and a lack of skill or experience.

Amabile et al. (1996) further suggested that organizational encouragement, supervisory encouragement, work group encouragement, relatively high levels of autonomy in day-to-day work, adequate resources, and urgent, intellectually challenging work pressure positively influence creativity, while excessive workload pressure, internal conflict, conservatism and formal, rigid management structures hinder creativity.

In light of Amabile's and her colleagues work, researchers investigating matters directly related to counselling have identified how restrictions such as cautious or controlling administrators in managed care settings may inhibit or prevent creativity (Anderson et al., 1999; Carson & Becker, 2004). Indeed Mills (2011) found that unsupportive supervisors, the lack of collegial support, rules and expectations as well as institutions not valuing creativity all hindered career counsellors' creativity.

Additionally, in the case of clients with concurrent disorders, treatment decisions can be very complex using treatment algorithms that map decision points (Drake et al., 2001) and in a best-practices situation, are made by an interdisciplinary team. However, different team members, general practitioners, psychiatrists, nurses, psychologists, counsellors, and occupational therapists have different professional philosophies and, of course, their own individual philosophies. Finding space to introduce creativity into treatment where the team has to agree, can be challenging.

Furthermore, the very spaces in which counselling take place, the times allotted to sessions, scheduling and even the definition of the counselling problem may inhibit creative activities (Amundson, 2002). For example, the definition of addictions as a disease, emphasized in healthcare based treatment, could inhibit creativity because it narrowly construes both the cause and the treatment of substance use. It also denies alternate theories of addiction such as socio-cultural explanations of addiction for which there is considerable empirical support (Chi, Lubben & Kitano, 1989; Kandel & Andrews, 1987; McKirnan & Peterson, 1989; Mitic, 1990; Wallace, 1999).

Client and extratherapeutic factors.

Clients may help or hinder counsellor creativity (Anderson et al., 1999; Mills, 2011). Counsellors reported that clients who were willing to engage creatively in a collaborative manner and take risks fostered their creativity. However clients who wanted quick fixes, did not seem engaged, seemed resistant to provide information, or appeared to be resistant to creativity hindered counsellors' creativity (Mills, 2011).

Gladding asserted that creating can be perceived as fun, but for many individuals, that is not the case. Often people have negative feelings about their ability to be creative, for example around art, dance, music, singing or theatre. Amundson (2009) emphasizes that when utilizing approaches that involve creative arts activities like drawing, it is important to impress upon the client that it is not about the quality of the final product but more about the process in order to address client apprehension. At the end of the day, clients may refuse to participate and counsellors are ethically required to respect their clients' wishes.

The Stages of Change (Prochaska & DiClemente, 1982) model is used to describe a series of stages individuals go through to change behaviours and each of these stages is associated with client's motivational state related to their readiness to make changes (Hubble et al., 2010; Mueser et al., 2003). Clients in the pre-contemplative and contemplative stages can be labeled and seen as unmotivated. However, some researchers and practitioners believe that there is no such thing as an unmotivated client; effective therapists take the time to identify, understand and attend to client goals in order to collaborate and generate successful, client-centred outcomes. Counsellors should leverage clients' resources and strengths to promote therapeutic progress. Counsellors who focus only on problems and ignore strengths have been found to be less successful; whereas, counsellors who attended to client strengths from the beginning of counselling saw greater progress (Bohart & Tallman, 2010). Part of creativity therefore may be identifying what motivates clients and drawing upon their resources.

A resource that may be helpful with creativity is time and space. Amundson (2009) writes that time to reflect on events and to generate new responses are tied to creativity and problem solving skills. The time and space may not occur during session so the counsellor may not see the client progress in this way. Also, a challenge with clients with concurrent disorders is that they may use substances in between sessions, if not right before or right after sessions, which may interfere with finding space to reflect. One must be able to think clearly under challenging circumstances to solve problems effectively, but clients with co-occurring disorders may not be able to think

clearly because they are abusing substances or may be experiencing psychiatric symptoms that impede their ability to reflect.

In addition, the reflective activity may be painful or difficult because of disorganization, trauma, physical health problems such as traumatic brain injuries, cognitive dulling by prescription medications, or the use of street drugs. Clients may abuse prescription medications or street drugs precisely to avoid reflective activities.

Other clients factors that may affect both counsellor creativity or their ability to change may include their existing social support network, their socioeconomic status including employment, and life events. It is important to always start “where the client is at” (Hubble et al., 2010).

Gladding suggests limitations involving a specific population: artists. He states that artists may not benefit from the incorporation of the visual arts into the counselling process, indeed they may be counterproductive, because the use of the arts may be perceived as work. Also, they may not see counselling, with or without art, as a non-artistic process; therefore, incorporating the arts into the therapeutic process may be frustrating and distracting.

Models and techniques.

CBT and MI along with group therapy, psychoeducation, case management and family counselling are all recommended as best practices (CAMH, 2002; Mueser et al., 2003). However, Hubble et al. (2010) state that research data reveals that all treatment approaches are effective and call for the eradication of the “doctrine of specificity” which is the concept that specific treatments have differing or better outcomes for specific disorders. The APA calls for the use of the best research available in

combination with judgment and expertise and the patient's context and preferences (Bohart & Tallman, 2010). Clients are agentive and are not objects who present for clients to have something done *to* them. With the placebo affect known and the common factors research that exists that indicates that there is little difference between techniques, they can all be seen as helpful. In addition, technique only accounts for roughly 15% of client change with the important factor being the consistency with which the counsellor holds to his or her beliefs and values while encouraging client hope (Hubble et al., 2010). Therefore if creativity is a core value and belief, it may very well play a role in counselling effectiveness.

In terms of methods or techniques that aid in counsellor creativity, Mills (2011) found that counsellors used approaches like doodling or figurines to help them be creative. As stated earlier, collaboration played a role as well in aiding creativity.

Therapeutic relationship.

A positive therapeutic relationship is one of the best predictors of positive outcomes in counselling (Hubble et al., 2010).

The creative use of the relationship, by its very nature, resists attempts to be confined, standardized, therapy manualized, treatment packaged, predicted, controlled, tamed, neurotransmitted, behaviourally managed, protocol driven, manage care approved, and empirically validated. That is, it defies all attempts to subjugate its essence" (Anderson et al., 1999, p. 316).

In an era of manualized treatment in healthcare settings, such as the ones clients with concurrent disorders are treated in, creativity in the therapeutic alliance has not yet been measured and therefore is often discounted in evaluating client outcomes. Yet

Anderson et al. (1999) argue that creative therapists have a wider range of interpersonal responses they can use in working with clients to achieve a beneficial effect on the relationship. Mills' (2011) research found that counsellors who experienced trust in a collaborative relationship had benefits to their creativity.

Therapist factors.

Carson and Becker (2004) suggest that the counsellor's own inhibitions and doubts can inhibit creativity. Hazler (2002) writes "trying to do something creative as a therapist or educator is very threatening to the ego for anyone and even more so for those of us with a bank of self doubts" (p. 36). Fear of failure can inhibit the therapist, yet "creativity in therapy demands openness and experimentation" (Anderson et al., 1999, p. 325). With an emphasis on accountability, unwillingness to risk failure could impede counsellor creativity. Gelatt's (1989) concept of positive uncertainty applies to counsellors as well as clients. In order to successfully apply creativity "the counsellor has to have the courage of letting go and a readiness to stand in the openness in a kind of not-knowing situation and mood" (Hansen & Amundson, 2009, p. 38).

Conversely, Amabile and Kramer (2011) found that even small degrees of progress enhanced intrinsic motivation which helped creativity. Although they were not researching counsellors, it may be that their findings relate to the human condition and therefore the counsellor experiencing success, perhaps in witnessing client progress and success may help their creativity.

Mills (2011) study is one of the few studies examining creativity as a therapist factor. Although she examined the counsellors' perceptions of their own creativity, which was enhanced by their experience, knowledge and personal characteristics such

as curiosity, openness and dedication to clients, it would be interesting to know if the clients experienced the counsellors as creative and whether or not they reported positive outcomes. Further research in this area is warranted. Mills also found that some therapist traits hindered creativity as well, such as mood, lack of confidence and lack of sleep.

Less is known about therapist factors generally because there has been a decline in interest by researchers (Beutler et al., 2004). The creativity of counsellors could be one of the factors that influences outcome but more research is needed in this area.

Training.

Robinson (2011) argues that individuals grow out of creativity and/or are educated out of it, which is a severe limitation of creativity. However, Harrawood et al.'s (2011) use of experiential, creative activities including dance (Michaels, 2009), journal writing, and music and lyrics to train counsellors who will work with clients with addictions to understand substance cravings demonstrates that the use of creativity can be a powerful learning tool. If creative, experiential activities can be used in counsellor education programs to enhance creativity and demonstrate other ways of knowing for counsellors, it is not a great leap to think that similar activities, reconfigured for clients could assist them in recognizing and knowing themselves in different ways.

2.4 Creativity and Its Application with Clients with Mental Health Concerns including Concurrent Disorders

Gladding (2005) articulates advantages to incorporating creative arts into one's

counselling practice. Firstly, he suggests that using the arts allows for the incorporation of playfulness. Secondly, Gladding suggests that using the arts promotes communication. Gladding goes on to assert that adding the arts to ones practice can assist clients to “recognize the multiple natures of themselves and the world [because] the creative arts allow clients to express themselves externally in multiple ways depending on the strengths they discover in themselves” (p. 13). Creative arts therapies by its nature results in some creative product that is the client’s own “expression of self, whether it be a dance or a picture. Often, the first creations of a recovering addict are disclosures of extreme shame, anguish, and rage” (Johnson, 1990, p. 300). The externalization process of creative acts allow clients to conceptualize their challenges as outside of themselves and therefore changeable (Raskin, 1999b). It is in creativity that the person discovers her or himself (Winnicott, 1971; Yalom, 1980).

Another advantage identified by Gladding is that the arts may allow and encourage less or non-verbal clients to participate in the therapeutic relationship. He also sees the arts as a tool in promoting diagnoses, understanding and dialogue in the therapeutic relationship, which may be particularly useful when working with resistant or reluctant clients. Specific to the visual arts, Gladding emphasizes they are very flexible because they can be combined effectively and easily with other creative arts including movement and writing. Finally, Gladding cites the arts’ perceived objectivity; the arts can be seen as neutral, non-threatening and possibly fun so there is no or less resistance from clients.

Kottler and Hecker (2002) suggest that creativity in therapy could help increase

client creativity in their problem-solving abilities, which would certainly be advantageous. Foon (1988, as cited in Kottler and Hecker) states that to utilize creativity one must develop an internal sense of control for part of creativity involves breaking with convention. A key goal for many clients with concurrent disorders is that of self-regulation; therefore, developing creativity as a skill that requires self-regulation may very well be therapeutic and kill two birds with one stone. For it is not just creativity that is important, but the harnessing of it so that one can solve problems successfully.

Gladding's assertion that the arts may be seen as fun may be connected to Odell-Miller et al.'s (2006) implicitly stated advantage to utilizing the creative arts. They surveyed art therapists who anecdotally reported that clients with ongoing mental health issues seemed to achieve a good working alliance with therapists within the first six months of treatment more readily when art forms were used compared to verbal therapy only in some cases. These clients were significantly more likely to remain in treatment, to comply with prescribed medications and achieved better outcomes after two years, with medication, than clients who did not participate in arts therapies. Although I am arguing for the use of creative approaches, one has to be cautious with this information because 1. these assertions are anecdotal and 2. it might be fair to assume that art therapists are biased, for to say that the arts are ineffective would refute their entire practice and it is difficult to conceive how one might practice from a particular perspective if one did not believe in its efficacy.

Crawford and Patterson (2007) examined studies involving the use of creative arts therapies with clients with schizophrenia and discovered that attendance rates at

sessions, both group and individual, were high. Their conclusion regarding participation rates could also be tied to Gladding's assertion that one advantage is the neutrality of art, and Odell-Miller et al.'s (2006) finding that art can play an integral role in establishing an effective therapeutic relationship. If recruitment and retention in treatment is of primary concern with clients with concurrent disorders (Mueser et al., 2003), incorporating art into sessions could be a useful recruitment and retention technique.

Crawford and Patterson (2007) found the use of art therapeutically is associated with improvements in mental health and social functioning. They also found that there was some evidence that suggested that arts had a greater impact on negative and general symptoms including depression, lack of energy and motivation. They pointed out that negative symptoms are often less responsive to antipsychotic medications. If negative symptoms are a barrier to achieving the client's goal(s) in counselling in terms of energy and motivation and the application of art is more effective than antipsychotic medication within this context, then creative therapies could be an effective tool in the toolkit to augment other ESTs including CBT and MI.

Creativity and Counselling Clients with Concurrent Disorders.

There is some literature that explores creativity, particularly the use of creative arts, with clients who have mental illnesses and there is some literature involving the use of the creative arts with clients with substance abuse problems. However, a search for literature on creativity and counselling clients with co-occurring disorders yielded only two scholarly articles, both written by the same group of researchers (Drew, et al., 2007; Gee, et al., 2007) published in the same journal.

Drew et al. found that the creative use of the card game UNO in their case study with an adolescent in a mandated treatment program facilitated client self-disclosure, a necessary process in counselling. The use of the game also promoted the therapeutic alliance, one of the common factors, when the counsellor risked appropriate and ethical self-disclosure during gameplay. Indeed, the researchers reported that despite the mandated setting, the client expressed liking therapy, felt he was safe to challenge himself and felt connected to the counsellor. The researchers concluded these outcomes were due to the fact that the counsellor shared vulnerable moments and incorporated empathy at moments facilitated by the game.

Drew et al.'s third finding was that their UNO intervention increased client investment in the therapeutic process. Clients with co-occurring disorders are notorious as a group for being difficult to recruit and retain in counselling (Mueser et al., 2003). Drew et al.'s paper is an important work demonstrating that creativity in introducing novel techniques like card games has a role to play in counselling this population. Unfortunately, the problem with this study is that it was limited to a single subject.

Gee et al., also examined the use of having clients with co-occurring disorders create "Grief and Hope Boxes" to facilitate self-disclosure. Gee et al. argue that "using creativity creates a space for change and introspection" (p. 191) when clients struggle to disclose. This study is a variation on the theme discussed earlier in their other study; however, in this study, clients are actively engaged in a creative process where they are creating a product.

Although no known formal research has been undertaken on the program, the Ilisaqsvik Family Resource Centre in Clyde River, Nunavut provides counselling services by Elders, family, addictions and youth counsellors to almost 100 individuals monthly. More than 40 youth participated in an innovative hip hop program that played a role in reducing self-harm, smoking, and marijuana use, and as well as contributing to an decrease in crime rates and suicidal ideation (MHCC, 2012).

One size does not fit all.

If we accept that clients are unique individuals with different strengths, abilities, and ways of knowing and interacting in the world, then one consistent approach in counselling cannot possibly be successful in all cases. If this is the case, then creativity is necessary to be an effective helper in the counselling relationships especially with clients with as complex concerns as those with concurrent disorders. Shebib (2007) does not use the term creativity; rather he refers to “versatility” where he articulates the need for counsellors to work from a model to explore problems and help clients build solutions but that the model has to be adapted to each client. Versatility indicates that counsellors have several tools in the toolbox to choose from as they adapt to each client, refining their approach when something does not work until they find something that does. Gladding (2008) argues that “without creativity, there would not be counselling” (p. 99). Bohart (1999) posits that creativity is an inherent part of human behaviour and inherent to psychotherapy. Others say creativity is “essential” (Carson & Becker, 2004; Gee et al., 2007; Hecker & Kottler, 2002).

The limited number of articles related to creativity in counselling clients with concurrent disorders supports the notion that this study to investigate what helps and

hinders these counsellors to incorporate creativity into counselling processes will contribute to the field. In light of the paucity of literature, a qualitative approach is appropriate at this early stage of inquiry in order to illuminate the experience of counsellors.

CHAPTER 3: METHODOLOGY

Chapter three discusses the critical incident technique (CIT) research method, and procedures to be used in the collection and analysis of data in the proposed study. First, I will summarize the history of the method, the characteristics of the method, CIT's suitability for exploring the research question, and the underlying epistemology. Then, I will describe participant recruitment and selection, data collection and analysis, representation of the findings, and limitations. A discussion of rigour will follow.

3.1 The Critical Incident Technique

History of the method.

Critical Incident Technique (CIT) was developed during World War II by Flanagan (1954) during research of the Aviation Psychology Program of the United States Army Air Forces (Butterfield, Borgen, Amundson, & Maglio, 2005). CIT was originally used to identify critical factors required for success in jobs to create a functional description of an activity. Since Flanagan's article, CIT has moved from behavioural, task analysis and direct observation to retrospective self-report. CIT has been developed into a qualitative research methodology used to explore topics in many disciplines including education, industrial and organizational psychology, marketing, nursing, and social work, (Butterfield et al., 2005). Woolsey (1986) focused on utilizing CIT in counselling and psychology research (as cited in Butterfield et al., 2005). Woolsey identified CIT's strengths for investigating psychological constructs and experiences. These strengths include its ability to "encompass factual happenings, qualities or attributes, not just critical incidents ... its capacity to explore differences or

turning points ... its utility as both a foundational/ exploratory tool in the early stages of research, and its role in building theories or models" (Butterfield et al., 2005, p. 480).

Characteristics of CIT as an analysis method.

CIT shares commonalities with other qualitative research methods; however, there are features of CIT that separate it from other methods. The first is the focus on critical incidents (CIs) that aid in the facilitation of, or hinder an activity or the experience of an activity. The second is that CIT originated in organizational and industrial psychology. Thirdly, the researcher collects data primarily through interviews, followed by analysis, which involves identifying incidents and forming categories that emerge from the data. Lastly, CIT consists of the creation of categories with operational definitions and self-descriptive titles based on emerging patterns in the data (Butterfield et al., 2005).

CIT's main goal is to generate a categorization scheme that identifies and describes CIs in a meaningful way, while retaining comprehensiveness, specificity and validity (Butterfield et al., 2005). Flanagan (1954) defined an incident as a human activity that is complete and can be observed in a way that allows for inferences or predications (Butterfield et al., 2005). To be critical, the incident must be real and significantly affect the outcome of an activity (Butterfield et al., 2005). CIT has five components: "(1) ascertaining the general aims of the activity being studied; (2) making plans and setting specifications; (3) collecting the data; (4) analyzing the data; and (5) interpreting the data and reporting the results" (Butterfield et al., 2005, p.477). CIT collects descriptive data about CIs from the perspective of the participant (Butterfield, Borgen, Maglio, & Amundson, 2009). Finally, CIT allows for the consideration of the

cognitive, affective, and behavioural dimensions, including how incidents are managed, and the perceived effects (Butterfield et al., 2005).

Suitability.

CIT enables researchers to investigate “effective and ineffective ways of doing something, looking at helping and hindering factors, collecting functional or behavioural descriptions of events or problems, examining success and failure, and determining characteristics that are critical to important aspects of an activity or event” (Butterfield et al., 2005, p.476). In addition to critical incidents, CIT reveals facts, experiences, turning points, and qualities (Butterfield et al., 2009). It is an appropriate and helpful technique in the beginning phases of research, when little is known about a topic (Butterfield et al., 2009) like creativity in counselling clients with concurrent disorders. The systematic nature of CIT that many researchers demand for credibility’s sake, and its flexible and exploratory attributes (Butterfield et al., 2009), make it particularly well-suited to this proposed study. Creativity in counselling clients with concurrent disorders as a research topic is almost non-existent, so there is almost no understanding of what facilitates or obstructs these counsellors from engaging in creative practices. Thus, this study sought to utilize CIT to explore and gather data on the factors that help and hinder concurrent disorders counsellors in capitalizing on creativity in their practices.

Enhanced CIT (ECIT), which conforms to the traditional aspects of CIT but adds context, wish list items, and credibility checks, was used in this study. Contextual, demographic questions were posed at the start of the interview to provide background information to situate the CIT data (Butterfield, et al., 2009). I also asked participants

about a wish list (WL) to gather data about possible “people, supports, information, programs, and so on, that were not present at the time of the participant’s experience, but that those involved believed would have been helpful” (Butterfield et al., 2005, p.267). Finally, nine credibility checks were incorporated into the data analysis to increase the trustworthiness of the study. The purpose of the credibility checks and their details will be described in the epistemology and rigour sections below.

Epistemology.

CIT hails from the social constructivist tradition (N. Amundson, personal communication, May 8, 2012). As such, it is an approach used to understand multiple participant realities and the meanings created by them in specific contexts, in this case their counselling practices. Consequently, in this worldview, meaning is subjective, varied and multiple (Cresswell, 2009; Geelan, 1997; Phillips, 1995). In addition, because constructivism relies on open-ended questions and this study utilizes a semi-structured questionnaire to provide a framework, I, as the researcher, co-construct reality and its meaning between myself and the participants. Consequently, it is important for me to acknowledge that I have studied concurrent disorders and completed part of my training for my Master’s degree as a concurrent disorders counsellor. Some of the participants saw me as a colleague, others as a student, and others as a researcher. During the interviews, my goal was to “elicit rich and detailed descriptions of the participant’s experience, then to develop clear descriptions of categories that organize their experience into meaningful and useful patterns” (Morley, 2003, p. 31).

Although researchers using CIT attempt to add an element of objectivity by

identifying concrete incidents and counting them, they still emerge from the subjective experiences of the participants and the researcher. With the resulting co-construction of meaning, to ensure the utility of the categories, validation checks involving the participants, two independent judges and two experts were employed to establish trustworthiness; more details about this process will be described in the Rigour section. However, it should be noted that the independent judges and experts bring their subjective experiences to the process, reinforcing that meaning is socially constructed.

3.2 Participants

In CIT studies, the number of participants in a sample is determined by the number of CIs reported in the interview and whether the incidents represent sufficient coverage of the activity being investigated (Butterfield et al., 2005). Therefore, participant interviews continue until data exhaustiveness or saturation occurs. Exhaustiveness is defined as the point at which participants no longer describe new CIs or WL items, therefore no new categories are needed (Butterfield et al., 2009). Eleven counsellors participated in this study, who provided enough critical incidents and wish list items to meet the criteria for data exhaustiveness.

Participant recruitment and selection.

Initially, a faculty member of the Co-Occurring Disorders program at Douglas College sent an email to contacts who would to participate in the study. However, no volunteers emerged, so networking to generate a snowball sample commenced. Eleven participants were identified and screened by email. All volunteers met the inclusion criteria. Participants were professionals who currently counsel clients with concurrent disorders. The participants all had Master's degrees in counselling psychology, social

work, or leadership with extensive experience in addictions or psychiatric nursing along with working with clients with concurrent disorders. All interviews were conducted in English.

Participant demographics.

Six women and five men currently counselling clients with co-occurring disorders were interviewed for this study. All of the participants spoke English as their first language. All eleven participants had Master's degrees: six had M.A.s Counselling Psychology, two had M.Ed.s Counselling Psychology, one had an MSW, and two had M.A.s Leadership with backgrounds in substance abuse counselling and psychiatric nursing and over twenty years of experience with the client population. The participants' ages ranged from 31 to 65 years, with the average age being 47. All participants worked in health care settings, with one working in a residential health care setting, three in forensic psychiatry, and seven in community health care. The average years of experience in health care was 14.9, while their average years of experience working with clients with co-occurring disorders was 7. The average number of years in their current positions was 6.5 with one outlier who had worked in her area for 23 years. Some of the participants had multiple roles and responsibilities. Two specialized in group counselling but saw clients individually as well. One specialized in outreach and engagement, and three had administrative functions including clinical supervision and coordination duties in addition to their counselling responsibilities. One of these participants counselled clients 40% of the time and completed administrative responsibilities 60% of the time, while the remaining two participants with administrative functions were primarily counselling.

Participants of all cultural backgrounds were welcome to participate in the study; however, no visible minorities emerged in the sample and demographic information about culture was not collected. All participants appeared to be Caucasian which may be due to the nature of snowball samples, or decision making process to enter the field of concurrent disorders, or perhaps career decision making of individuals choosing to enter the counselling profession. The possible role of culture will be discussed further in the Limitations section.

3.3 Data Collection

Data collection involved eleven in-person interviews and follow-up contacts. The duration of interviews varied from forty-five minutes to two and a half hours; these interviews were the primary source of data. All participants reviewed the informed consent form (Appendix B). Each signed two copies and retained one copy ensuring that they understood the purpose of the study, confidentiality, privacy, and their rights as research participants.

A semi-structured interview protocol provided a standardized framework for each interview, which is included as Appendix A. The protocol consisted of a contextual component followed by open-ended questions in order to allow participants to provide detailed descriptions of how they view and use creativity in their counselling practice, as well as what factors help and hinder their creativity. Although a protocol was used, I asked clarifying and follow-up questions as the interviews progressed to ensure clarity and completion of answers. At the end of the interviews, the participants completed a demographic questionnaire that was used to describe the participant sample.

During the interviews, participants described their definitions of creativity, how they use creativity in their work with clients and colleagues, and what factors help and hinder their creativity in practice. Participants also reported wish list items, describing items that they did not possess or thought they did not have enough of that could benefit their experience of creativity in practice.

All interviews were recorded and hand written notes were taken during the interviews. All interviews were completed in person, with ten interviews taking place in the participant's office, and one occurred in the participant's home at the participant's request.

Four interviews were followed up in person for the purposes of clarification, participant cross-checking, and data validation. The remaining seven follow-up contacts for data validation occurred by email. Details of the participant checks are described in the rigour section.

3.4 Data Analysis

In order to examine the data, the audio recordings of the interviews were transcribed and the interview transcriptions were read and organized. The CIs and wish list (WL) items were extracted from the data in groups of three randomly selected transcripts. The batches will consist of randomly selected interviews (Butterfield, et al., 2009). From the first three interviews, helping and hindering CIs and WL items were identified. The emerging patterns, themes and similarities that emerged among the CIs and WL items were categorized (Butterfield et al., 2009). The remaining transcripts were examined, and helping CIs, hindering CIs and WL items were identified and placed into existing categories. New categories were created when CIs and WL items

emerged that did not fit the existing categories. Categories were modified, renamed, merged together and broken apart in order to create a richer understanding of the research data, to reduce overlap, and to distinguish between categories.

Borgen and Amundson's (1984) (as cited in Butterfield et al., 2009) 25% participation rate was also taken into consideration when identifying incidents, creating categories and re-assigning incidents. Once the lists of categories that represented the CIs and WL items were established, descriptive titles with operational definitions were assigned to each category.

Data interpretation included the following nine credibility checks: descriptive validity, interview fidelity, exhaustiveness, independent extraction of CIs, exhaustiveness, placing incidents into categories by an independent judge with expertise in creativity, participant cross-checking, participation rates, expert opinions, and theoretical validity (Butterfield et al, 2009). These credibility checks have been explicated in more detail in the rigour section.

3.5 Rigour

Trustworthiness is essential in demonstrating rigour in qualitative research as the audience relies on this quality when making decisions using the information provided (Haverkamp, 2005). It is especially important in a health care field, like co-occurring disorders treatment, where random control trials are the gold standard (Wampold, 2010). Consequently, trustworthiness and rigour were established in this study through the implementation of nine credibility checks outlined in the Enhanced Critical Incident Technique (Butterfield et al., 2005).

Descriptive validity.

All interviews were taped in order to have an accurate account of the participants' experiences. Professional transcribers transcribed all interview audio recordings, the transcriptions were independently proofed and then I listened to the recordings again and compared them to the proofed transcriptions. Then I worked directly from the transcripts to analyze and interpret the data. Participant cross checking, described in more detail below, was utilized to provide participants with the opportunity to verify the soundness of the categories and confirm the extent to which they reflected their experiences.

Interview fidelity.

An expert in the CIT method reviewed three samples of the interviews to ensure that the CIT methodology and interview protocol was followed, and that I did not ask leading questions.

Exhaustiveness.

CIs and WL items and categories were documented in order to identify the point at which exhaustiveness occurs in the data. Exhaustiveness was achieved at eleven participants.

Independent extraction of CIs.

An independent coder with expertise in creativity and research using CIT independently extracted CIs and WL items from a randomly selected 25 percent sample of the transcripts. The purpose of this credibility check is to "calculate the level of agreement between what the researcher thinks is a critical incident and what the independent coder thinks is a critical incident" (Butterfield et al., 2005, p. 486). There

was 100 percent agreement between what I identified as a critical incident and what the independent coder identified as a critical incident.

Placing incidents into categories.

Twenty-five percent of the incidents were randomly chosen and shown to an independent judge with expertise in the critical incident technique and creativity in counselling. Then the independent judge placed each incident into the existing categories. The agreement rate between the researcher and the independent judge for the helping incidents was 95.1% after discussion. For the hindering incidents, agreement was 100% after discussion of one incident, and finally the agreement rate for wish list items was 100% with no discussion.

Participant cross-checking

Participants were contacted a second time after the data from the interview was analyzed to allow them to review the CIs and WL items that were extracted from the data and the corresponding descriptive categories created. Participants provided input and commented on whether the incidents represent their experiences, as well they clarified some CIs and categories. In total, nine participants provided feedback, and all nine agreed that the incidents and categories accurately reflected their experiences. Four participants who completed their cross-check in person actually described new incidents and a subsequent verification took place. Two participants did not respond to the follow-up verification email, and therefore did not provide feedback.

Participation rates.

Participation rates were calculated for the categories using the 25 percent criteria established by Borgen and Amundson (1984, as cited by Butterfield et al.,

2005). The rates are reported in Tables 1-3 in the Findings chapter.

Expert opinions.

The categories were submitted to two experts in the counselling field in order to determine whether the categories were useful, surprising, or if there was anything that might be missing. One expert holds two Master's degrees in counselling and had conducted research in creativity using the critical incident technique. The other expert was a registered psychologist with a Ph.D. in counselling psychology, had expertise and experience working with clients with co-occurring disorders, and he had utilized CIT to conduct research. Both experts found the categories meaningful and helpful. The expert with research experience investigating creativity in counselling was not surprised by any of the categories; however, the registered psychologist was surprised that experience with art was not mentioned. The expert's surprise reflected the commonly held association between creativity and the arts.

Theoretical validity.

Theoretical validity was checked by stating the assumptions underlying the study and reviewing the assumptions within the framework of the current research literature to see if the assumptions were supported. Second, the categories were compared to the relevant literature in order to reveal if support exists. Exploration of the emergent categories in comparison to the relevant literature forms part of the Discussion chapter.

3.6 Ethics

Haverkamp (2005) emphasizes the essential nature of an ethical relationship between the researcher and the participants due to the vulnerability of the participant;

it is the researcher's responsibility to promote participants' welfare and protect them from harm. In order to meet my ethical obligations, a number of issues were considered in conducting this study.

An informed consent form was created outlining the purpose of the study to ensure participants were aware and understood their role in the study during the interview, analysis and publication process. Having been trained as a counsellor, and as a member of both the Canadian Counselling and Psychotherapy Association (CCPA) and the American Counselling Association (ACA), I am aware of the role of confidentiality in both the counselling and research process, and I must adhere to those organizations' codes of conduct. Consequently, I was aware of potential harm for the participants should they possibly share confidential and sensitive information regarding their clients and colleagues, particularly since the CIT method asks for participants to provide examples. This potential for harm did not emerge as a concern in the interviews as all participants understood and agreed to the nature of confidentiality in the study, and they maintained client confidentiality. Additionally, most participants seemed to enjoy the interview process with some speaking for much longer periods than was needed as they wanted to fully share their experiences. Some commented that the opportunity to discuss their creativity was helpful to them.

Another ethical consideration in any study is ensuring the validity of the data and the subsequent interpretations in order to accurately represent the participants' experiences. To ensure accuracy, I organized the data into the categories with my interpretations and shared the relevant information with each participant. I invited them to add, remove or change the information to increase the accuracy of the

findings and interpretations. Nine participants reported that my categories and interpretations were accurate. One participant asked to have a helping factor involving supportive management removed. Another participant tempered a statement involving a politicized organization that often plays a role in his field. I decided not to use the statement at all in order to prevent any potential harm to the participant. Finally, a third participant provided further explanation regarding comments about colleagues that hindered this person's creativity. Quotes related to these incidents were not used in the writing of this thesis in order to prevent harm to the participant. It should also be restated, that of the eleven participants, two did not respond to the second contact to verify the data.

CHAPTER 4: FINDINGS

Having examined all the data, 298 incidents were described by participants consisting of 167 helping incidents, 88 hindering incidents and 43 wish list items. The incidents were then organized into the following helping, hindering and wish list categories listed and described below.

4.1 Helping Critical Incident Categories

After speaking with all of the participants for an average time of almost 2 hours per participant, 167 helping incidents were reported and separated into twelve categories. All categories are reported, and all categories met the twenty-five percent participation rate established by Borgen and Amundson. Also, it should be noted that in many examples, the incidents described involved two or more categories.

Table 1. Helping Categories

Helping Categories	Number of Incidents	% of Helping Incidents	Number of Participants	% of Total Participants
1. Personal Factors	45	27.0%	10	90.9%
2. Colleagues and/ or collaboration	27	16.2%	10	90.9%
3. Resources	24	14.4%	9	81.8%
4. Education and Training	16	9.6%	9	81.8%
5. Client Factors	20	12.0%	7	63.6%
6. Autonomy	16	9.6%	7	63.6%
7. Supportive Management	15	9.0%	7	63.6%
8. Client Feedback	8	4.8%	7	63.6%
9. Experience	13	7.8%	6	54.5%
10. Personal or Professional Practice	9	5.4%	6	54.5%
11. Meditation/ Mindfulness	15	9.0%	4	36.4%
12. Personal Therapy	3	1.8%	3	27.2%
TOTAL NUMBER OF HELPING INCIDENTS: 167				

Personal Factors.

Incidents regarding personal factors formed the largest helping category, with 90.9% of the participants reporting 45 incidents. Participants described in detail how one or more aspect of their personalities, communication styles, attitudes, emotions, philosophies of care, orientation towards risk, not fitting into the norm, being a highly sensitive person, levels of confidence, and their reputations within their organizations positively influenced their creativity.

Inherent aspects of the participants are important to almost all of them because they promote their creativity. Some of these inherent personal qualities included being present, open, flexible, adaptable and curious. One participant stated, “part of the creativity would be to leave options open and kind of let it manifest how it's supposed to manifest.” Another participant reported how being open and willing to take a risk allowed her to be creative with a client with schizophrenia experiencing active symptoms,

I was always a little bit trepidatious [sic] as to how to approach [hallucinations]. “What do I do with this? ... Do I just, ... take it all as she says it or should I be concerned?” ... So I made it very comfortable for her to tell me all sorts of her ... hallucinations or whether she thought they were hallucinations or not Oftentimes she didn't think they were hallucinations but they didn't pose her any ill effects so I could be kind of creative in the way I think. I mean, I don't know that it's very conventional to really delve into that with somebody who's schizophrenic.

Traditionally, a counsellor might challenge the client regarding the reality or lack

thereof of the client's experiences. However, this participant found that she enhanced her creativity through her openness and willingness to risk deviation from standard practices.

One participant spoke more directly about ethical risk-taking, open to the ambiguity of doing something different and accepting the possibility that something might not work in practice as being helpful for his creativity. He stated,

I think I take risks in terms of how I work with people often. Anything that isn't ... linear and safe is potentially risky... For me risk just means, in terms of a therapeutic relationship, just possibly being wrong, ... possibly making a mistake. And that happens. And just accepting that and recognizing that, yes, I might make mistakes, but, ... what are the possible benefits? And I would always check that out with [the client] ahead of time... I would never just plunge ahead...My ... M.O. in working on that is to say... "this might be very difficult, we might get into territory that's uncomfortable, it's important... for you to recognize where you need to stop and to let me know". And so that's ... boundary setting.

The above is an example of how the counsellor's personal willingness to take risks and be okay with something not working enabled him to practice responsibly. Interestingly, the above example was the only explicit incident where someone used the word risk-taking. Interestingly, although others alluded to risk-taking or experimentation, no one else identified with those terms.

Another participant explained at length how not using the traditional practice of being guided by a patient's chart and being open, flexible and adaptable to what

happens in the here and now during counselling sessions enhanced his creativity. The participant stated,

It's kind of not looking at the chart that comes in to decide what the need is.... I think being creative is responding to whatever is present rather than predetermining what needs to be done. It seems like creativity occurs in the present moment, right? ... I guess I would say that the creativity is to not lock in that this man needs to deal with recovery, but to try to stay with where he is, and where he was dealing with the symptoms and staying with them to see whether they dissipate after a significant time of not using, or if there [is] some underlying problem that needs to be addressed with medication or therapy or something.

In the above incident, the participant described how openness, being in the moment, and adopting an attitude of not knowing enabled him to be creative.

Two participants described curiosity in conjunction with empathy, as the basis for their creativity. One participant reported, "to me it's the empathy and the compassion trying to show through ... So again, the whole thing about what's it like for you, ...curiosity ... trying to find out a little bit more of what's going on with clients". Curiosity was featured prominently in the findings with seven participants referencing it as a personal feature that enhanced their creativity.

Another participant, with a sense of humour, talked about how his openness, initiative and his willingness to work collaboratively facilitated his creativity and generated opportunities to be creative. He stated "if you're going to do this job, it's good to have loose boundaries and an overdeveloped sense of entitlement. Because you ... sort of invite yourself to start doing things".

Humour, playfulness and a desire to make counselling fun appeared in the data as helpful personal factors. One participant found finding the space between practices and “playing” in those spaces helpful to his creativity; “because it’s concurrent disorders, there’s the best practice for depression, best practice for substance abuse, and they will naturally have their little inconsistencies and incongruities, and that’s the space where I play...because that’s where I get to adapt”. For this participant finding gaps and exploring the opportunities within them, and then being playful and adaptable, enhanced his creativity.

Another participant displayed openness to the very nature of what counselling was. She found being open and flexible regarding what the tasks involved in counselling enabled her to be more creative. She describe an incident thusly,

this week I was speaking with a woman and she ... is so overwhelmed with all these things that she has to do in her life... she needs support to do these things as well. And I said, "you know, you can get staff support to do these things, but also, just so you know, I can do these things with you too. We don't always have to meet in my office. If the most pressing and important thing for you today is to go to the bank, cash a cheque and then pay off something, then I will do that with you." ... It's just not sort of sitting here and talking about, you know, how are you feeling today?

Her openness, flexibility and adaptability to emerging client concerns helped her to be flexible with her clients.

Colleagues and/ or collaboration.

Colleagues and/or collaboration also had a participation rate of 90.9% with 27

incidents reported. Case consultations, working on projects collaboratively to create new services, being challenged in a supportive manner by individuals working in a medical model, having new people with fresh ideas and who remind participants of their own creativity enter the work environment, and brainstorming were some of the examples of how colleagues and working collaboratively helped participants be creative.

An example of work group collaboration was reported by one participant working in an environment that had previously only offered individual counselling and does not, based on the participant's comments, see the population served as having trauma issues:

When I came in here I said ... I want the majority of patients to be in groups and I want to develop groups, and I took that on and now we have a continuum of groups... Me and [name] did the M.I. group and I put together all the materials, and she gave me her expertise and then we just started [to] pilot it ... And then me and [name] did the Active group, piloted that, got that going and then [name] did all the relapse prevention, and I did the Seeking Safety to get like a trauma lens in and my next stop is ... I'm going to push for a mindfulness group. So I want a whole array of treatment programs, that was my vision coming in was to have an array of groups.

I: That didn't exist before.

P: None of them existed before.

I: So, you talked about [name] and, and [name], did they help you be creative?

P: They gave me material ... they gave me their knowledge ... [Name] is the M.I. expert, so she gave me all the M.I. stuff and I made it into ... a group. [Name] did a lot of research on active treatment with me, and then I put it together.

The above example illustrated how the participant came together with colleagues to collaborate, sharing resources, knowledge and ideas, which enhanced her creative abilities to generate new interventions in her work setting.

Another participant provided an example of how creative colleagues in the health care system inspired new ideas and their subsequent collaboration resulted in new services:

It's helpful to know a little bit about the person you're working with, as a colleague maybe you know across town in the other clinic or somewhere else, because that enhances the creativity again... I was asked recently to start a concurrent education group for [site]... I knew from a couple of contacts I've had with their occupational therapist out there that if I did it with her, to use the established methods of creativity she's used to engage those clients, folded into my knowledge base we could come up with something together that might have a chance of working, and so far it seems to be working. Because I knew a little about my colleague, you know, whose creative mind can I borrow when mine runs out of ideas.

The participant went on to elaborate more on his belief regarding collaboration that guides him and forms the foundation of his creativity in practice:

it's important to be a bit creative about how you deliver something... to ensure that you engage the client.... Really, when I think about the stuff I've done that would be described creatively at least by my definition, ... flexible and adaptable ..., I think I try to do more creative stuff about how I try to encourage the two halves of our mental health and substance use system to work ... because it's that big picture thing that's got to work before we can work with the clients.

The participants emphasized how important collaborating with colleagues was to enhancing their creativity. In some cases colleagues who they identified as creative, colleagues who possessed knowledge they did not, and even colleagues who did not necessarily subscribe to the same model of client change but sparked their imaginations helped their creativity.

Resources.

Resources was the third most significant category with a participation rate of 81.8% and 24 incidents reported. Resources ranged from material supplies like pens, markers, furniture, books, sports equipment, videos, old papers from graduate school, other individuals' conference posters, and tapes. Participants also cited technological resources such as iPods and having the ability to access social media such as Youtube or research via the internet, and television shows such as *In Treatment*. Human resources such as health care professionals working in different fields such as occupational therapists and alternative therapists were also mentioned as helping factors. Finally, financial resources in the form of access to funding and larger budgets were also mentioned.

One participant detailed how books helped her be creative in generating new interventions.

I went to [a bookstore] and I was looking at all the books. And there was, there was some, pretty, pretty good choices there. But yeah, I went with ... Alan Berger's *12 smart things to do when the booze and drugs are gone* and he wrote that book for people that he considers early recovery to be the first 1 to 2 years... And people love it. And the book was not written to be done in a group. It's not a workbook, it's not a group book. But, I just set it up so that it is a group.

This participant essentially took what existed, which provided her with a launching pad for her creativity, and she combined it with her knowledge and experience to generate a new program in her setting. The above incident illustrates how participants used resources as a basis for their creativity to create something new and effective in their setting.

Another participant described how having material resources, including art supplies and a musical instrument at hand, enhanced her creativity and enabled her to generate a safety plan for a client who had relapsed and become suicidal. She described the incident,

I said, ... "what are you interested in? What would you like to do? I've got colouring things... Do ... you play music at all?" She said, "oh, the keyboard, yeah, I've been wanting to play that." ... So off she went and she played the keyboard for almost an hour.

Access to material resources enabled participants to generate creative solutions they could offer to their clients.

Interestingly, two participants also identified the lack of resources and funding within the health care system as helping their creativity as it was the restriction that forced them to be creative to find effective solutions with minimal resources. One participant reported,

I never ... try to imagine offering any kind of a service that really requires much in the way of things that cost a lot of money, because you know healthcare budgets these days are all spread pretty thin, so, ... you work with the materials at hand, and in a way, that's kind of an advantage again because the less you have to work with the more creative you had to be.

It seems that the restriction of resources served to help this participant to be more creative because creativity was required to generate solutions with limited or no funding to purchase new or different materials. In this light, resources and sometimes the lack of resources stimulated some participants' creativity.

Education and training.

Education and training emerged as a category as 81.8% of participants mentioned 16 incidents that illustrated how education helped their creativity. Participants reported a range of helpful incidents that promoted their creativity including: aspects of their graduate level training in counselling, specific training in motivational interviewing, existential analysis, holistic health therapies, going to workshops that inspired participants to incorporate specific practices into their work, as well as self-education which included reading specific texts.

One participant reported attending a workshop that inspired his creativity. The participant stated, "I was at this workshop and whoever the presenter did a meditation

and a light bulb went on and I thought, why don't I do that with my group?" This counsellor found the experience of attending training workshops exposed him to new and different ways of doing groups, which in turned helped him to be creative and implement new ideas into his group design and practice generally.

Client factors.

Client factors had a 63.6% participation rate with 7 participants reporting 20 incidents where clients were helpful to their creativity. Helpful client factors included their desire for direct feedback, their distrust of professionals, client resistance to interventions and anger expressed in sessions, the level of experience of clients in terms of therapy, the client's readiness to change, specific behaviours around their use of technology, seeing clients succeed, client resilience and courage, and the limitations of the clients in terms of their mental health or cognitive abilities.

One participant found that capitalizing on clients' behaviours stimulated her creativity. She described an incident where she reached out to a client using a traditional method,

So I phone her and she doesn't answer. I phone again. I phone again. Doesn't answer. And then all of a sudden, ... I remember us walking down the street and her texting. And this was my very first text message. And she answered ... it took me 20 minutes to send a text. I have to do this....

The participant felt an urgent need to follow up with the client because this client had been suicidal and then discharged. Because the participant remembered the client's use of texting, she was inspired to try it herself. Without seeing the client text, she

might not have learned to use the technology, so it was the client who stimulated the opportunity for the participant to be creative.

Another participant discussed how client readiness to change positively impacted on his creativity. He described the incident thusly,

I had a client who was referred to me, schizophrenic, big time pot smoker. And just as he was coming to see me he had made that decision to stop smoking pot, because he was realizing it wasn't very healthy.... And then what he did for himself was, he came to realize, he allowed himself five cigars, he went from smoking pot to cigars and went to -- instead of smoking a pack of cigarettes, went to five cigars a week. And so that was his own, he created his own work, sort of use of harm reduction as well.

The participant found that because the client was ready to make a change and actively engaged in the therapeutic process, the counsellor's creativity was enhanced. He could see the results of his creative endeavours in how the participant responded to the therapeutic process and he could adapt to the client's own creative solutions creating a virtuous circle of creativity that enhanced the counsellor's own creativity.

Clients' readiness for change played another role in enhancing a different participant's creativity. She reported how seeing clients ready to participate in other activities and succeed outside of therapy enhanced her creativity. She described how a participant won a scholarship and enrolled in a college, how several clients were successfully engaged in pre-employment programs, and how some clients participated on the World Homeless Soccer Team. She said clients' successes inspired her: "it just makes me think of more things that ... we could get ... them involved with".

Witnessing clients make progress enhanced her creativity because she felt encouraged and inspired to generate new opportunities for clients.

The flip side, client resistance to participating in activities, was also represented in the data. A participant described how he often liked to use journaling as a technique with his clients. However he stated, "I've had recently a client who doesn't like writing. She shuddered when I... suggested doing it, you know. So I said, ... "try a tape recording of what's going on with you." Although the participant normally had clients write on paper, he rolled with the client's resistance and used it to enhance his own creativity, generating a new approach for him, the use of audiorecording as a form of journaling, to meet the needs of the client, maintain the therapeutic alliance, and creatively further the client's therapeutic process.

Autonomy.

Like client factors, autonomy had a 63.6% participation rate with 7 participants reporting 16 incidents where having autonomy and having freedom within their practice as counsellors helped their use of creativity. Autonomy was separated from supportive management, which is needed for the participants to have autonomy, because it was how clients used their autonomy, not just that management gave it to them, that helped their creativity. Examples of autonomy included being free to develop programs including groups, to work in any modality participants thought was clinically appropriate, setting ones own schedule including the duration, frequency and timing of appointments, conducting sessions outside the facility if appropriate, and being able to go for walks and stretch when needed.

One participant described how she had the freedom to set her own schedule in

terms of client sessions. She was able to schedule longer appointments, which allowed her to be more creative because she had more time to implement different approaches rather than feeling limited to dialogue based interventions:

[in our setting] we have a lot of autonomy as far as what counselling approach we use, how we work with a client, how we structure our sessions. I prefer to have at least an hour and a half with clients. Most therapists ... it's fifty minutes with the client, ten minutes for notes. Mine is an hour and a half to two hours with the client and then my notes. So I like to do a lot more in-depth, ... get the relationship going, get them talking, do some therapy, and then wrap up. I find it takes more than an hour to do that. So then I can also implement more ... things in the session, not just the talky stuff If I was expected to see clients back to back every hour, I would not be very effective.

This participant was very explicit on how autonomy and the freedom to establish her own schedule enabled her to be creative. Because she could work with clients in session lengths that exceed the industry norm, she was able to implement more than just talk therapy interventions. As a result, she felt that autonomy was crucial in helping her creativity.

Another participant described the autonomy her employer gave her. She was able to create her job duties in the manner she saw fit because management gave her the autonomy to do so. That freedom helped her to draw upon her creativity to develop creative interventions that worked with her specific population.

P: There was no position when I started here.

I: So you got to basically create your own position?

P: Exactly. The rules were there, "...this is what we want you to do." And away you go. With the new position you don't know ... what's what....I just started to develop stuff that seemed to be working.

The autonomy she described would not have been possible without supportive management, which emerged as the next significant category.

Supportive management.

Supportive management also had a participation rate of 63.6% percent with seven participants reporting 15 incidents. Supportive management includes support in implementation. For example, employees may have the autonomy to develop a creative intervention or participant in creative policy development, but management support would be required to actually implement it.

Supportive management included trusting participants and allowing participants to use the models and interventions they deemed clinically appropriate; allowing participants to engage in their job duties as the participants saw fit; permitting collaboration with other organizations; implementing policies that recognized clients' needs, specifically around relapses, allowing smoking, and allowing pets, therefore freeing up participants' energies to focus on other client concerns; not dictating schedules; engaging in dialogue with the participants; and protecting participants from interference from other managers and stakeholders.

The protective factor as enhancing creativity emerged as a prominent feature of this particular category. One participant reported,

we have an addictions manager that sort of watches over us and we have child and youth mental health folks that are sort of all in the mix, right? But ultimately we report to our supervisor and she has always stood by us, always.

The above participant described an incident where she broke from regular protocol but her supervisor protected her. It was the confidence she felt as a result of the consistent and ongoing support that enabled her to be creative in her practice.

Another participant described support at a more global level. He discussed how imposed models were sometime problematic, but in opposition to public and other stakeholders negative reactions that could have hindered his creativity and effectiveness, he said,

I'm protected by the health authority having enough gumption to say... this is what works, we're in the business of healthcare, we want to be the best at it and this is the paradigm that does the best job. So, [health authority] ... they've got my back basically is how I see it ... because we know this stuff works.

With healthcare being publicly funded, there is a political aspect to care. The stigma around mental health and substance use can cause stakeholders to attempt to interfere in the delivery of services. Both of these participants illustrated how supportive management was key in creating space that enabled them to use their creativity in practice.

Client feedback.

Client feedback as a helping factor was reported by seven participants, representing a participation rate of 63.6%, who reported eight incidents. Client feedback was described both as verbal feedback such as "it helped me when you did

.....” or being told something was not very good, non-verbal feedback comprised of facial expressions and body language, and also observing clients responses to the therapeutic process.

Explicit client feedback was described as being helpful and very straightforward: “feedback from a client that would help me be creative ... ‘It helped me when this happened.’ ... Oh, great, okay, well, what ... else can we do with this to make more of this happen?”

One participant described client feedback in terms of responsiveness to therapeutic process:

What helps me in being creative is feedback and information from the people that I'm working with. Attending to adjustments ... that my clients make ... in whatever it is that they're working on based on what we do ... I pay attention to things that work, and I think ...how can I take this concept and move with it ... in a positive direction ... It's not the same for each person.

The participant observed client progress and used it to guide his creativity in generating interventions that would further the therapeutic work between the client and himself.

Experience.

Experience was reported as being helpful by 54.5 % of the participants describing thirteen incidents. Experience included events that happened, though not necessarily regularly, that now helped to enhance the participants’ experiences of creativity. Past experiences ranged from learning to play the guitar to the participants’ own recreational use of alcohol. One participant shared that going through his own

recovery process helped him be creative in that he used the experience to engage clients, establish rapport and communicate concepts. He also used his recovery experience to establish credibility with the client, which helped them.

One participant shared how her history of social drinking enabled her to be more creative:

I've dealt with a lot of people that have been intoxicated and so I have no problems with that. I've been intoxicated so, you know like I know what I know sort of a little bit what they're feeling. And so I can be a little bit more creative in that sense. It's not so, so stark and, and medical and weird.

This participant felt that her previous recreational use of substances helped her understand the clients' experience and enabled her to be more creative because she would empathize. Two other participants shared how their own use of substances and subsequent recovery processes aided their creativity because they could, again, empathize with the clients' experiences.

Interestingly, the experiences reported were almost always personal that the participants drew upon to enhance their creativity. Only two participants indicated that their previous professional experience helped them with their creativity. One participant cited how working with a specific employer who specialized in the most difficult of client cases aided her creativity because it prepared her to be able to address the clients complex concerns. Another participant described how she had worked in a range of addictions-focused environments such as detox and a residential setting which enhanced her creativity.

Personal or professional practice.

Personal or professional practice(s) were reported by six participants representing a participation rate of 54.5%. Participants cited nine incidents where their

practices aided their creativity. Practice was defined as something that was done on a regular basis over a sustained period of time. In some cases, the practice may have started out originally as a personal activity, but participants had incorporated it into their professional activities. Practices fell into subgroups such as environmental practices, intervention practices, internal practices and professional practices.

One participant described his practice of creating therapeutic environments to enhance client engagement and encourage progress. This person described how he increased his creativity by designing a therapeutic office space. By using his creativity, he was better able to engage his clients, which further enhanced his creativity in practice. For example, he reported,

I've had these big burly Harley Davidson tattooed dudes ... come into my office and I'd have my soft music playing and the water element and they'd say, "it's really nice in here," and they'd get calmer, it just slows them down. ... I think it helps them just relax and open up a bit more.

This incident involving environmental practice is important to consider as helping counsellor creativity, as the nature of the physical environment emerged as a hindering factor.

Other participants cited specific types of "go-to" interventions that they used to enhance their creativity, to creatively engage clients and encourage therapeutic progress. One participant described how the use of drawing helped her to creatively engage youth and explain therapeutic concepts in a manner that would be received by her younger clients. She stated, "I'll draw diagrams... Most of the kids don't ... do well with handouts... So we have to do it in a different way, so I'll draw a picture". This

person also regularly uses music to enhance her creativity. She finds that the music and exploring lyrics enhances her ability to creatively engage with clients and increase both the effectiveness and efficiency of the therapeutic process. She described an incident thusly,

this is a kid that ... when I met him he ...had been tossed out of his home, ... I think he pulled a knife and said he was going to kill himself or his mom, I'm not sure ... So he's living in a safe house and so he was really... in trouble, like really a lost soul... So I asked him when I went in to see him the first time, ... "I see you're listening to your iPod there, ... what kind of music you got on that iPod?" And he tells me ... and I said "do you have a favourite song that you like?" and he says, "yeah, actually, I do." And I said, "well, maybe what I'll do is I'll get it on YouTube or on iTunes and I'll come in and maybe we'll listen to it together next time". And he says, "yeah, sure, that would be great"....

[Participant shows Investigator lyrics] Then we do thisI bring the lyrics and I say, "okay, just underline, ... anything to stands out to you in the song." So this is his copy and this is mine. I did not underline. Now, sometimes I do, but that day I did not... So he talks very openly about his anger. His older brother, why his older brother left him, his parents are lying to him and he feels very let down by them. And he's falling into the footsteps of his brother. And, I mean, some of the words here, "the one thing that made me feel alive, anger, from paranoid to paralyzed. I go from feeling extremely pissed to not feeling a thing." ... That's session two. So it's a fabulous way of hooking in with kids, in a very non-judgmental sort of, it's like super duper powerful... This is where you

get to ... how do you get, in session two? You don't get there. This was important to him. Here is the other one. We had a good laugh about that... I said, "scorch?...oh, God. What are you going to do, are you lighting things on fire? Is that what that means"? He says, "no". And I said, "oh, God I hope not. I said we got whole [other] issues if you're going to be a pyromaniac." ... And we had a good laugh about it. He told me that afterwards, ... "oh, no, I feel burnt, I feel like I'm getting burnt," on all levels. Wow. So it helps --That's music.

I: So the creativity helps you get to the deeper issues faster?

P: Yeah, I think so.

I: So you can work faster in a fewer amounts of sessions because --

P: Yeah, by just being open to going in a different way, using music ...

I: So in some ways it's more efficient?

P: It could be, yes. Yes, absolutely. You know, although you have to be careful with the music right? Because it's not -- it's not about easy listening and having a fun session listening to music, it's about the therapeutic aspects of what does it say. So I wouldn't ... play it every session. But, yes, as a way to getting to that next level of where can we talk... because some kids... find it very difficult, how do you talk therapy with kids who maybe, ... don't want to talk? ... How do you reach them? They're like, "I'm not frigging talking to you".

She was able to engage a client with complex needs and achieve a significant level of depth in her estimation, and for that matter in mine, in only two sessions by being open to possibilities, using resources like technology which will be discussed further,

being direct in asking the client straight out about fire starting and using her sense of humour all resulted in her using her creativity in the first two sessions with this client. She also identifies how the use of music and art is not always appropriate in session, illustrating that counsellors need to and do use their clinical judgment about the use of creativity in sessions to make therapeutic decisions about how and when to use it responsibly and ethically.

Another participant regularly used analogies to explain concepts in a meaningful way to clients. In some cases he would draw the analogy such as Figure 1. where he would talk to clients about how substance use was the “drug monster” that would take over their lives. He found that the use of analogy and the drawing of these analogies enhanced his creativity.

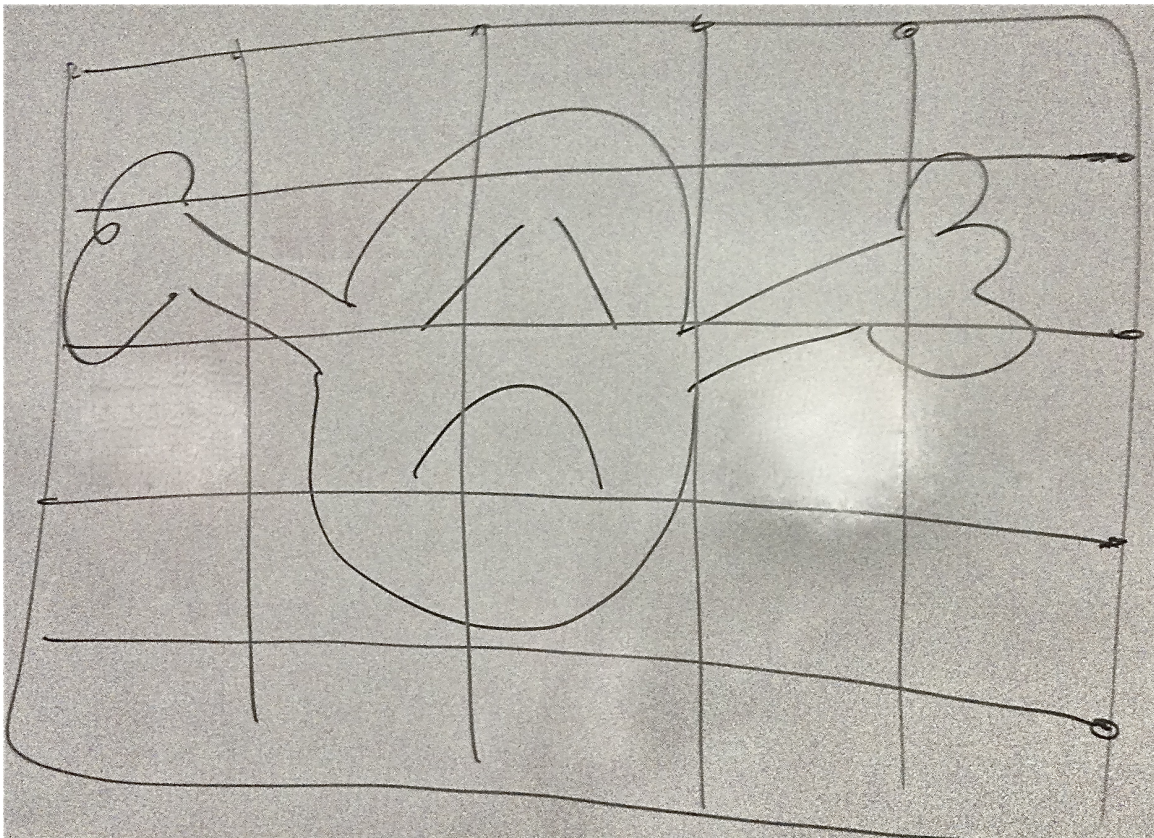


Figure 1. Photograph of a drawing of the “The Drug Monster” analogy. This figure

demonstrates how a participant utilized analogy and drawing as practices to aid his creativity to engage clients and effectively explain concepts.

This participant would also use games regularly to further enhance his creativity; he used the games as analogies. He demonstrated his use of games during the interview by playing catch with a stuffed monkey, a deliberately chosen metaphor used symbolically to represent the “monkey on one’s back”. He illustrated how habitual behaviours become ingrained even after someone stops, and using simple games helped him to creatively convey his messages.

Another participant reported on how he used journaling personally to increase his creativity and then he incorporated the practice into his toolbox of interventions that he uses with clients. To explain how journaling enhanced creativity, this participant stated, “I think for some [clients], the fact that they're [journaling] ... brings them to a different awareness and then they can talk about it and then we go from there”. The participant expressed that the same process of bringing himself into awareness helped with his own creativity.

One participant described an incident reflecting how his regular internal practice of self-reflection enhanced his creativity in terms of relating to clients and engaging them. Another participant described how she found brainstorming with colleagues and with clients as helpful to her creativity as it helped her enhance the divergent thinking component of the creative process.

Finally, another participant discussed the professional practice of writing case notes to aid in conceptualization. Her case notes helped her gain clarity around the client and the progress in the counselling relationship, which enabled her to generate

creative possibilities for future sessions.

Meditation/mindfulness.

Meditation and mindfulness as a helping factor for promoting creativity was deliberately separated from personal and professional practice because on its own, it met the participation rate criteria with 36.4%, representing four participants, who cited fifteen specific incidents where meditative and mindfulness practices enhanced their creativity. In addition, the use of mindfulness and meditation appears both in the addictions and the co-occurring disorders literature so its presence as a category is a fit. This fit will be discussed later in the Fit with the Literature section.

One participant described how meditation enhanced creativity because it helped minimize the impact of rumination and help with focusing and completing the tasks at hand,

I do meditate every day, most every day, and I find that when I stop to sit I become acutely aware of how busy my head [is], often in conversations with people who are not here, and it's almost always based on an underlying feeling that I have not gotten something done. So it kind of stops just the treadmill response to distress so that I can actually deal with what the issue is. So the creativity will be it short-circuits the perseverating so that I can do what actually needs to be done.

Another participant cited his yoga practice as being helpful in promoting creative solutions to clients' concerns around chronic pain: "it's ... knowing how beneficial yoga and deep breathing and relaxation can be, to do it more... that is

creative. I try to do that with my clients, recognizing ... their breathing and suggesting yoga”.

Another participant revealed how her use of meditation enhanced her creativity, while yet another participant described how her interest in Buddhist psychology and her application of mindfulness practices in session, being open and being present, enhanced her creativity because it meant she could be open and flexible in response to the clients. The openness, adaptability, being present and focused was common amongst the four participants who reported the incidents that formed this category.

Personal therapy.

Personal therapy was cited as being helpful to participants’ use of creativity by three participants, representing a 27.2% participation rate. Participants found their own therapy helpful because they either experienced personal shifts in issues of concern and/or they experienced interventions used by their therapist that they then incorporated into their own practice such as the use of Miller, Duncan, Brown, Sorrell, and Chalk’s (2006) outcome rating scale. For example, one participant reported seeing a therapist helped enhance creativity because the therapist encouraged the participant to be more playful in his relationship with his spouse. The participant stated, “last year I was seeing a therapist and it was helpful... he was saying ... what if you were to be more ... playful in your expression and did this....I [thought]... that’s interesting ...he’s...finding a solution that’s light”. The participant felt empowered to incorporate playfulness and lightness, despite the “heavy” concerns of his clients, which gave him more options and enhanced his ability to generate and implement more creative

interventions after having a therapeutic experience with his own therapist.

I separated out personal therapy from both experience and personal or professional practice because on its own, the category met the participation requirement. No participant described being in ongoing therapy so it did not match the operational definition of a sustained practice as the personal or professional practice category did. In addition, because countertransference can have a negative impact on the therapeutic relationship, on clients and on counsellors themselves, it seemed prudent to draw attention to the fact that three of the participants identified personal therapy as being beneficial for enhancing their creativity. In turn, they saw therapy as enhancing their effectiveness as counsellors. Finally, both experts, when reviewing the categories for meaning and utility encouraged me to include it as they saw it as being a helpful and meaningful category.

4.2 Hindering Critical Incident Categories

During the interviews of the eleven participants, 88 hindering incidents were reported which were separated into ten categories. All categories are reported and all ten hindering categories met the twenty-five percent participation rate. Also, in many examples, the incidents described involved two or more categories.

Table 2. Hindering Categories

Hindering Categories	Number of Incidents	% of Hindering Incidents	Number of Participants	% of Total Participants
1. Client Factors	17	19.3%	8	72.7%
2. Personal Factors	20	22.7%	7	63.6%
3. Bureaucracy	16	18.2%	7	63.6%
4. Imposed Models	9	10.2%	7	63.6%
5. Unsupportive Management	7	8.0%	6	54.5%
6. Time Pressure	10	11.4%	5	45.5%
7. Lack of Resources	8	9.1%	5	45.5%
8. Colleagues	7	8.0%	5	45.5%
9. Physical Environment	5	5.7%	5	45.5%
10 Lack of Special Topics Education and Training	7	8.0%	4	36.4%
TOTAL NUMBER OF HINDERING INCIDENTS: 88				

Client factors.

Client factors emerged as the largest hindering category with 72.7% of the participants reporting 17 incidents that exemplified how some client characteristic or behaviour(s) hindered their creativity. The incidents reported included clients' attitudes towards counselling generally, their attitudes towards certain kinds of therapies, their lack of willingness to consider alternate possibilities or to even change, their unwillingness to meaningfully engage with the counsellor, their lack of resources to act on recommendations from their counsellor, time they spent complaining about mundane matters separate from their presenting issues, challenging the counsellor in an unhelpful manner, clients who return home to families who use substances, or the severity of their mental health issues themselves and the clients' own biases towards diagnoses.

One participant illustrated how clients' predetermined attitudes hindered her creativity, "they come in sometimes with a predetermined idea. 'I just want medication. Counselling sucks. What's the point of talking to you? Just get me a doctor.' Okay. You know, or they just aren't open to trying different things." The participant felt her creativity was limited because the client would not give her a chance to engage them in the counselling process.

A different participant explained the origin of some clients' fixed behaviours. He stated,

[Clients] spend loads of time looking up their diagnosis and stuff and all of these other things and then question why I'm going this way and going that way.... they get too enmeshed with it almost, and they're not willing to look at anything else. So in that regard it can get in the way.

Clients' use of the internet, which is not always a reliable source of information, at times generated resistance within the clients. He felt slowed down by the questions and found, at times, it was difficult to help clients to move past what they read. Consequently, the combination of the clients' use of information and the questioning, resistant behaviour hindered the counsellor's creativity.

Another participant cited how the impact of the severe nature of the clients' mental health impacted interaction within sessions and subsequently on her creativity:

It's very difficult to know sometimes what [the clients] relate to. They're so blunted and often very non-verbal that you have to look for very subtle cues that they've responded or they have a preference for one thing over another.

That blocks creativity. And their passivity, they're not going to fight to the team

to have this type of treatment; whereas someone in the community would say, you know, "I want to [this] type of therapy, this is what I like".

The very nature and severity of the client's illness, combined with the effects of the client's medication and the client's low motivation to make a personal investment in their progress hinders this participant's creativity.

Another participant echoed how the severity of clients' illnesses, which affected their ability to understand more abstract communications such as metaphors, combined with the client's limited motivation impeded her creativity. She stated,

Super ill people I find it really hard... I can do some really simple things with them for sure, like make a little collage, ... but if I want to do like something ... more abstract or more profound or get them to do ... even a strength box ... the motivation level here is so low.

These examples were not the only examples of how the clients' mental health concerns impeded the counsellor's creativity. Another participant mentioned that sometimes he felt his creativity was limited by the severity of the client's symptoms and he thought it best not to be too creative and avoid the potential for interfering with other medical professionals' treatment plans for the client.

One participant shared how a client's unwillingness to engage and consider alternate possibilities stymied creativity as well as frustrated him, which also hindered his creativity:

this particular woman was very set in the way things were...she had a particular way of viewing the world and wasn't open to exploring other possibilities. And the nature of why I was seeing her and what she was doing there contributed to

a feeling of frustration with the person. And that severely limited my ability to be creative.

The above example also illustrated how the client's fixed attitudes negatively affected the counsellor's creativity. It also illustrated how client factors could interact with personal factors to also impede counsellor creativity. Personal factors formed the next largest category to emerge from the data.

Personal factors.

After client factors, personal factors of the counsellor had the next largest hindering effect on their creativity. This category had a 63.6% participation rate with participants reporting 20 incidents. Personal factors included their emotional, cognitive and behavioural responses to people and situations in the past and the present.

One participant described how his personal factor and client factors interacted to hinder his creativity. His feelings of frustration and risk averseness would lead him to be less creative, utilizing basic techniques rather than attempting to be more creative or creative in a different way to engage the client.

Nothing will drive me crazier as a clinician than not being able to figure out how to engage the client ... because if I can't gauge a reaction from somebody, I ... don't want to descend into something that might feel like I'm experimenting ... So ... I revert to the basics ... I find that a limiting factor.... I get less creative. I think I fall back on just basic cognitive behavioural therapy, which is what I was initially trained in, ... like you run home to mama at that point.

The participant's frustration about his inability to fully engage the client combined with his apprehension about proceeding without a clear direction, inhibited his creativity as

he felt he needed to revert to a conventional approach rather than “experiment” and be creative in trying a different approach.

Another participant discussed how relational stress with significant others negatively impacted his creativity because it caused him to attempt to meet his needs rather than focusing on the client in a creative way:

There’s that kind of core stress that I feel. That I don’t think I’ve worked through enough ... that’s about belonging and being okay how I am, and having that unsettled will impact how I am with my clients. Which will stifle creativity because then I’m trying to feed me rather than take care of them.

A participant reported a related incident of how countertransference may have inhibited his creativity when clients do not seem to exhibit any kind of progress. He saw his feelings of inadequacy as possibly being projected into the therapeutic alliance, and as such it impeded his ability to be present and therefore creative with the client:

I feel that I don’t know what I’m doing...I feel inadequate and that just kind of feeds into [the client] not moving. So it kind of creates a loop. So maybe my judgments of her are judgments of me not being able to understand or help her move forward right? So, so what’s wrong with me that I can’t do this?

Insecurity, anxiety and fear was also cited by another participant but for different reasons. The participant felt concerned that she lacked life experiences that would “qualify” her to work with clients with such complex needs. Her worry that clients would not respect her, prompted her to ruminate. She gave an example of her thinking pattern that impedes her creativity:

clients who are 95% of the time older than me who most of the times have lived on the street and ... pretty different life experience.... I can still be quite intimidated by you know...I feel like they maybe don't take me seriously... "She's never had addiction problems. She's never had to sell her body for drugs. Like who the hell does she think she is?" These are the kinds of things I have playing in my mind.

Because the participant ruminates on her insecurities, she also finds that she is not able to be as present in her counselling sessions and as such is less able to be creative because her worries limit possibilities and opportunities for creativity.

Bureaucracy.

Bureaucratic aspects of the organizations in which participants were employed were viewed as impediments to their creativity. Bureaucracy had a participation rate of 63.6% with 16 incidents reported. For some participants, bureaucracy was represented by statistics, reporting requirements and the reporting systems themselves, and limited and restrictive job descriptions. For others, bureaucracy had to do with extensive approval processes for therapeutic interventions they might want to implement with their clients. One participant talked about paperwork that inhibited creativity because it required that she check boxes and nothing more, as well as voluminous paperwork for external Ministries. Another participant talked about how the bureaucratic separation between mental health and addictions services hindered her creativity. All of these incidents were reported as hindering events because they took time from other opportunities to be creative, or were often routine tasks that did not allow for variation or creativity, or the processes involved to implement were too time consuming and

frustrating that the participants chose not to bother being creative as it was perceived as not being worth the time and energy.

One participant spoke about trying to generate creative solutions for patients who smoked but had to adapt to a new no-smoking policy in the facility; the hoops she would have to jump through in order to implement a solution stopped her from attempting to implement the creative idea she co-generated with a colleague:

I was problem solving with [name] ... about how we get patients to come to these smoking groups, these withdrawal management groups, for example. And I would say, "we gotta think, we gotta be creative ..." Because we had just gone smoke free. And we talked about actually bringing those Nicorette things ... [but] something like that, you would have to go through so many hoops here to put it in place that you just wouldn't.

Another participant explained how the bureaucracy of working in partnership with two funders and the requirement of two reporting systems negatively impacted on her creativity because it was frustrating, and felt like an unnecessary duplication of work that took up time she could have used to be more creative on other tasks. She described the bureaucratic reporting system she had to work with:

the [employer] staff are not allowed to look at PARIS. And so we keep paper charts so that everyone, all the whole staff team can look...it's kind of silly because I have to [use] PARIS anyways ... but then only me, the social worker and the nurse can look at them. Like the two [employer] managers and all the [employer] staff ... can't even access, aren't even allowed to look at PARIS.

The silly nature of duplicating work because of access rules and restrictions limited her creativity.

Imposed models.

Imposed models also had a participation rate of 63.6% with seven participants reporting nine hindering incidents. Interestingly 100% of the participants who worked in forensic psychiatric settings reported at least one incident that fell within the imposed model category. Models ranged to prescribed theoretical orientations and approaches such as cognitive behaviour therapy or motivational interviewing, using stages of change to describe clients, having prescribed therapeutic goals or outcomes, and abstinence based models promoted by other stakeholders who held to different ideological tenets in contrast to the harm reduction frame work held by many of the participants and considered to be best practices in the literature.

One participant described how her work environment required her to work with clients with evidence-based models all of the time. She felt her creativity was hindered because of the technical requirements of the approaches as well as the inability to put her own stamp on the counselling process:

Here, it's like you've have to do evidence-based all the time, and you've got to be doing M.I., and you got to be rating your M.I., and you got to be counting how many times you've done your reflections versus your questions and it becomes like this whole technical game ... You got to do all your adherence scales, and it's so structured that you don't have room to add your own touch in it, because then you lose points on your adherence scale.

The client felt that reducing the therapeutic process to a numbers game, where her concentration was focused on the technique, rather than the client, impeded her ability to be herself in her sessions and therefore limited her creativity.

One participant summed up the underlying beliefs of colleagues and management that form the basis of the imposed model category:

I think there's such a divide in ideology here. You know, the trust doesn't -- ... doesn't stem from creativity, it stems from ideology around how patients change. So that's why the mistrust ... And so ultimately to have creativity you'd have to find a way to bridge the gaps in ideologies.

The participant worked in a forensic setting utilizing a medical model of treatment in which all interventions and programs are required to be evidence based. The participant elaborated to say that by remaining within evidence based processes, she was able to build a reputation for professionalism that her colleagues trusted, which helped her creativity. However, she also stated remaining within certain approved, evidence-based models limited her ability to be creative because she had fewer options available to use in her work with clients.

Another participant described how ideology and the abstinence model negatively impacted on his creativity from outside his workplace. He talked about how the general public, families and other advocates of abstinence models impeded his ability to be creative:

when you take an individual out of a family and you work with that individual, the world they exist in isn't being oriented to the same kind of transformative change process and that can be very much resistant. So it's harder for the client

to change when you know, health care is trying to engage them in what science says is, ... the harm reduction the work, the working paradigm, and they go home to this very, legalistic abstinence-based mentality because that's what the loved ones want.

In this instance, the participant reported that stakeholders working from an abstinence based framework impeded his creativity. His creativity was hindered in that he had to be aware of the environments to which the client would return were less likely to support creative solutions within a harm reduction framework and therefore his creativity was restricted as he had fewer options to collaborate with the client to generate achievable solutions to client challenges.

Unsupportive management.

Six participants, representing a participation rate of 54.5%, reported seven incidents of unsupportive management having a negative impact on their creativity. Unsupportive management items included not maintaining a suitable physical environment like the temperature of the facility, having to justify expenses along with budget limitations, being micromanaged and told what to do, conflict with a supervisor, and a lack of clinical supervision.

One participant answered very quickly when asked what hindered her creativity. She quickly and firmly stated that "being micro managed or if my sessions were being taped and ... they were reviewed by a micromanager" inhibited her creativity. The micromanagement and possible interference would inhibit or eliminate her freedom to do her work, which in turn, hindered her creativity.

Another participant described working for a manager who did not trust him and would not allow any space for the participant to take the initiative or be creative. He stated,

managers look at their workers [in] two ways ... One way is your workers are not to be trusted, they have to be told what to do, they can't take initiative, et cetera, and that was the impression that I felt under her management ... I've left three jobs specifically because management and environment were uncaring of my comfort, my basic needs, like a normal room that has comfortable temperature, ... daylight, and also managing a caseload respectfully.

This participant felt that the uncaring nature of management as evidenced by their lack of concern for basic, environmental comforts as well as caseload concerns, so impeded his ability to function in his role and limited his creativity that he quit three jobs. His example illustrated that negative impact that unsupportive management can have on counsellor creativity as well as on their willingness to do that particular job all together.

Time pressure.

Time pressures were reported by 45.5% of the participants describing 10 incidents. Time pressures had to do with meeting the normal requests of others, working to deadlines on special projects such as reports to the federal government or inspections, not having time to prepare for sessions with clients, being booked two to three weeks in advance, and the need to work of the side of one's desk given there were too many additional tasks during the day beyond seeing clients.

One participant described time pressures generally and how they limited his

opportunities to be creative:

Time is always a limiting factor. The one thing about this role too is so many people want a piece of you. I could be two people and fill my time tomorrow.

Not having enough time to do everything I would like, that's a limiting factor.

This quote illustrates the feeling of many of the participants; there just were not enough hours in the day to be able to find space to be creative and therefore they felt limited in this regard.

Lack of resources.

Hindering incidents involving the lack of resources were reported by 45.5% of the participants describing eight incidents. Lack of resources referred to either a lack of funding or a lack of basic materials to create projects, reference resources such as DVDs and books, technological resources such as laptops that would have allowed for mobility in the community, and specific equipment that participants would have liked to have used in session, and finally human resources in the form of other health care professionals such as occupational and recreational therapists.

One participant has creative ideas about working with mental health concerns but is unable to do so because she lacks the equipment or funding to purchase the equipment. For example, she stated "I would like to be able to do some different things like there's [a] meter [I'd] like to buy ... this really neat mind meter, for helping with anxiety...I think I could train the kids with that".

A participant saw the benefit of creatively incorporating drumming into her group design but could not because she lacked funding to purchase the materials. She stated,

drumming is extremely therapeutic. And there's all of the spiritual stuff that would come out from the building of the drum. But they're about a hundred bucks. And ... unless I go out and fund raise ... I don't have the time to do that.

Colleagues.

Ten out of eleven participants identified collaboration and colleagues as being helpful for their creativity in practice. Given such a high participation rate and the impact of the influence of colleagues on helping creativity, the inverse, colleagues as a hindering factor was not unsurprising.

One participant specifically identified how systemic separation between mental health counselling and addiction/alcohol and drug counselling and the corresponding collegial attitudes and activities supporting the separation negatively impacted on her creativity as it deprived her opportunities to connect with her colleagues.

Everybody wants to dump their clients on us, but nobody wants to include us as part of their team. So we're not considered one of them. ... we never get invited to the team retreats, which is, planning, and ... team building and stuff like that. Never, ever included. But yet, you know, when clients come up, we're the first ones they want to just dump clients to.

The isolation and subsequent deprivation of opportunities to connect with colleagues negatively impacted the participant's creativity.

Another participant described how working collaboratively with interdisciplinary treatment teams working with different models of change, different priorities, and who may have a limited understanding of counselling or counselling approaches hindered her creativity:

you don't want to be too creative to the point where [the patients] get off on some ... tangent and you gotta deal with [the clients'] treatment teams ... when you're bringing in these ideas and they're like 'what are you doing?' ... makes you not even want to bother sometimes if you have to go through a treatment team just to do some fun intervention that you think will be beneficial because you have to spend the whole time explaining the therapeutic [objective] and it's just like, ugh. And usually they don't get it.

These two examples illustrate both ends of the spectrum of collegial influence. On one end isolation hindered creativity, on the other end, too much involvement from colleagues who lack knowledge of counselling or have different ideologies around patient care restricted participants' creativity.

Physical environment.

Five participants, representing a participation rate of 45.5%, reported five incidents of how their physical work environments hindered their creativity.

Participants cited incidents involving lack of personal office space; bare, unwelcoming treatment rooms; treatment rooms that were too hot and uncomfortable; having the office being located in an unsafe part of the city; and finally participants cited risk management elements that included the presence of security fencing and locked wards. All of these physical environment factors hindered the participants creativity because it either affected their ability to be present as in the case of rooms that were too hot, or the environment limited options such as not being able to go for a walk with the client because the neighbourhood was unsafe of they could not leave the grounds of the facility in the case of forensic settings.

Lack of special topics education and training.

A lack of training and education regarding special topics such as issues clients face or particular approaches to therapy had participation rate of 36.4% and seven incidents reported. Participants reported feeling that their creativity was hindered because they felt they lacked a solid grounding in the approach or the issue and were hesitant to try things out of concern of potentially causing harm to the patient. One participant reported that she did not think her basic Master's degree fully prepared her for the complexity of her role. Specific areas of training and education were identified. The lack of trauma training was identified by two participants as hindering their creativity. Training around eating disorders, as well as training in art therapy were identified. One participant talked about how, when she felt she lacked a solid grounding in an approach, her creativity was hindered:

A thing that gets in the way is I don't know a lot about like art therapy, so I'm hesitant to sort of get into stuff when I don't really know what I'm doing in that regard... I feel if I went and took an art therapy course, even just like a basic one to give me a foundation, I'd feel more comfortable. So I can do the stuff I know but to go into do an art type thing I would feel like ... it was ... outside my area of expertise. I don't like to do anything unless I understand what I'm doing. I don't want to do any harm to the client because I did something weird. You don't want to do it wrong... With mindfulness I feel like I can go in and battle any psychiatrist that asks me any questions about what the heck I'm doing because I know it so well. If I was to try something new in art and take a risk and try out something, I would feel like I would have a harder time with

that, because I don't know how to defend it, so I don't often take risks like that that might actually be okay, just because like I don't have a strong knowledge in it.

So this participant illustrated what the others felt about specific areas of training they felt they lacked. Because they did not feel they had a solid foundation in an issue or an approach, they did not feel they could ethically risk experimenting and potentially harming the client. As a result, their creativity was limited because they did not feel like they could try something new without the education and training to support the new approach.

4.3 Wish List Item Categories

In total, 43 wish list items were reported which were separated into twelve categories. All categories are reported.

Table 3. Wish List Items

Wish List Categories	Number of Incidents	% of Wish List Items	Number of Participants	% of Total Participants
1. More Special Topics Education and Training	7	16.3%	7	63.6%
2. More Resources	8	18.6%	6	54.5%
3. Alternative Therapies	9	20.9%	5	45.5%
4. Therapeutic Space	5	11.63%	4	36.4%
5. Integrated Co-Occurring Disorders Centre	4	9.3%	4	36.4%
6. Services Integration	5	11.6%	3	27.3%
7. Supportive Management	3	7.0%	2	18.2%
8. More Time	3	7.0%	2	18.2%
9. More Time with Creative People	2	4.7%	2	18.2%
10. Client Factors	2	4.7%	2	18.2%
11. More Autonomy	3	7.0%	1	9.1%
12. Preventative Work	1	2.3%	1	9.1%
TOTAL NUMBER OF WISH LIST ITEMS: 43				

More special topics education and training.

The largest wish list category represented the desire of 7 participants, representing a participation rate of 63.6%, reporting 7 incidents, for more special topics education in training. Participants reported seeing clients with complex needs and felt that knowing more about certain kinds of client experiences like trauma, bereavement, psychiatric symptoms, and personality disorders would help with their creativity. Participants also reported that they would like training in specific interventions and approaches, including Buddhist psychology, experiential approaches, DBT, existentialism, gestalt, families and systems to enhance their creativity and provide alternatives to talk therapy. For example one participant stated a desire for “training needs are prevalent ... we're seeing more and more kids with trauma, PTSD stuff”.

Another participant listed a number of different types of training she would like to engage in to aid her creativity. The participant stated “I feel like I need to know more about DBT...I want to do art therapy ... it would be great to get a bit more marriage and family stuff because I do ... some couples counselling and some family counselling”.

A participant described how family attitudes towards abstinence models, referenced above in the hindering factors section, sheds light on how, unintentionally at times, families can hinder counsellor creativity and impact the therapeutic process. In this light, obtaining training in a range of different approaches, including family counselling, could enhance counsellor training. Therefore it is no surprise that additional education and training tops the wish list category.

More resources.

Six participants, representing a participation rate of 54.5% reported eight incidents of wishing for more resources. Some participants wanted more material resources such as inspirational posters, comfortable sofas, yoga mats, and a kettle to help create a therapeutic environment that enhanced their creativity. Others wanted reference materials such as books, DVDs, and workbooks. Others wished for physical spaces such as their own office or an art studio to be able to creatively express themselves. Yet others wanted human resources such as more direct clinical supervision and more client access to Stand Up For Mental Health, an organization that teaches individuals with mental health issues to perform stand-up comedy. One participant stated that she would like more reference materials along with holistic materials such as “books, DVDs, work books in particular, ...videos... more of my holistic health stuff that I could incorporate” to enhance her creativity.

Alternative therapies.

Five participants representing 45.5% of the sample expressed a desire to bring more alternative therapies into their practice to enhance their creativity. Some of the examples that participants gave that would enhance their creativity included using more music, art therapy, theatre, dance, aroma therapy, companion animals, pet therapy, Bach flowers, yoga and mindfulness activities or resources. One participant stated,

something else where I can be creative is yoga. I think it helps me with helping my clients to relax. But I do yoga myself so ... it's like looking at whether there would be an opportunity to use yoga with a group of clients.

Other participants stated interest in learning about art therapy, eastern medicine practices and aromatherapy as alternative approaches they would like to be able to incorporate into their practices to enhance their creativity.

Therapeutic space.

Four participants, representing 36.4% of the sample, reported desires for more therapeutic spaces to aid their creativity. Therapeutic spaces included concrete elements as well as things like more confidentiality as a result of not having to extensively document sessions. For example, one participant wished for “a garden area outside where there's ... a pond with animals, where you can go and meditate, do relaxation in a serenity environment, a healing supportive environment”.

Another participant, working in forensics, wanted a safe place for clients where their every comment or behaviour was not observed and charted. The participant felt that the lack of confidentiality in the forensic environment severely hindered creativity, and creating a therapeutic space that allowed for the most basic of counselling practices, confidentiality, would enhance his creativity and the safety for clients.

Integrated co-occurring disorders centre.

Four participants, representing a participation rate of 36.4%, identified having an integrated centre for their co-occurring disorders clients. Generally, it was envisioned as a “one stop shop” where the diverse needs of these complex clients, whether it was housing, food, employment, education, physical health care, advanced psychological services, group and individual therapy, yoga and wellness could be met in one place.

One participant stated that she has this “vision of having [a] centre for youth concurrent disorders. My vision is this place where ... kids could get everything they need. They wouldn't have to shop around ...It would all be there. Housing, ... school, ... liaisons, health”.

Services integration.

Throughout a number of the interviews, several participants described incidents involving the segregation of services for clients with co-occurring disorders. In term of wish list items, three participants representing a participation rate of 27.3% desired greater service integration and therefore access to services for themselves and for clients as an item that would foster their creativity. Service integration was different from an integrated centre in the sense that the centre was conceived as a one-stop-shop; whereas, services integration was a systemic vision based on a desire to see greater collaboration and partnership within existing services and with the private sector such as restaurants that could provide food for clients.

For example one participant stated that she wished for,

greater access to services... you have to take care of your basic needs before you can move on. Food, shelter clothing. A lot of our clients are hungry. They can't afford to eat properly. They're eating ... Food Bank food ... Teach them the skills of how to cook, so then they can maintain that ... if they've got the resources, but at least they'll have the knowledge then, right? Get them involved in employment. Get them involved in bettering their whole life...Look at, how can I help improve the whole person and their whole quality of life

This wish list category addresses the complex needs of clients with co-occurring disorders. In these two incidents, the participant describes how often these clients do not have their basic needs met. Given that client factors were seen as hindering factors to counsellors' experiences of creativity, it is easy to see how clients may be unwilling or unable to respond in session, despite a counsellor's creativity, if they are concerned about food, shelter and clothing. If clients' basic needs were met, counsellors might have more space to be creative rather than either triaging basic needs or referring clients to other services.

Supportive management.

Supportive management appeared as a wish list item category with two participants representing 18.2% of the sample reporting three incidents. Since supportive management was identified by 63.6% of the participants as a helping factor and unsupportive management was identified by 45.5% of the sample as a hindering factor it logically follows that supportive management could appear, in some capacity, as a wish list item.

In this category, one participant wished for more administrative support, specifically to have someone complete statistics, reports and clerical work like filing so that she would be freed up for more creative and therapeutic work with the clients. The other participant wanted management to support her in her use of alternative therapies such as aromatherapy, Bach flowers and the use of companion animals or pet therapy. The additional clerical support as well as the support to use alternative therapies to enhance creativity required supportive management in order to be able to enact these participants' wishes.

More time.

Two participants representing 18.2% of the sample reported three incidents involving a desire for more time. It is included here to more fully describe the participants' experiences in their context and their practice, particularly since time pressure was identified as a hindering factor. The participants desired more time because there were so many things that they would like to do, but could not because there were not enough hours in the week.

More time with creative people.

As with several categories above, the desire for spend more time with creative people emerged as a wish list item category with two participants, representing 18.2% of the sample, reported two incidents. It is included here to more fully describe the participants' experiences in their context and their practice, particularly since collaboration with other creative colleagues appeared so often in the helping factors data. One participant described his wish to spend more time, "with people who are interested in this same thing, building the herd. ... Imagine a community of folks committed to being awake and helping each other wake up. It would be very cool". Access to, and time spent, with other creative people was desired because the chance to hear and exchange new ideas and to inspire each other would enhance their creativity.

Client factors.

Wishing for different characteristics amongst clients emerged as a category with two participants who reported two incidents. It is included because the wish list items corresponded to the client factors category reported by 63.6% of the sample as being

helpful. In addition, client factors were reported by 72.7% of the participants, forming the largest of the hindering categories.

One participant wished for clients who would be more willing to be more creative which would give her more options and opportunities for her own creativity. The other participant wished that clients would refrain from regularly gossiping and complaining about each other in a residential setting. The participant felt that if she spent less time addressing the complaints she would have more time and energy to be creative in session with the clients.

More autonomy.

One participant representing 9.1% of the sample cited 3 incidents involving autonomy as wish list items. Given that incidents involving autonomy as a helping factor were reported by 63.6% of the participants, it is not unreasonable to predict that autonomy would appear as a wish list item.

The participant who wished for more autonomy wished for autonomy both for herself and for her clients. For herself, she wished for more freedom to use her clinical judgment to select approaches and interventions she thought would be therapeutic for the client but that may fall outside the evidence-based canon. In addition, she wished that there were some freedom to try interventions and approaches and potentially fail. This individual worked in a forensic environment where risk management was always considered in treatment planning, and where experimentation with the potential for risk was suspect. She thought having more freedom to try different things, even if they may not work, would enhance her creativity.

Interestingly, this participant also wished for more autonomy for her clients in

terms of basic things like when, how and what to eat or when to sleep. She felt that if the clients were empowered to make their own choices, they would be less passive generally and might become more engaged in their therapeutic work, which would, in turn, enhance her creativity.

Preventative work.

Finally, wishing for the ability to do preventative work appeared during one interview. Generally speaking, based on the participant's comment, the mental health and addictions services in place are reactive, rather than proactive. As such, it was important to include this desire to do more preventative work as an opportunity, not just to bring more creativity into practice, but to have a potentially positive impact on clients' lives.

The participant described why a desire for the ability to do preventative work was so important to him.

[I would] love to do more prevention work. So much of what our system has become ... dealing with things after the fact.... People don't usually seek out services until they're already in dire straits of some kind.... Very few people come to services up front, and when they think they're heading down a path that might be, problematic, and further still, seek out services just for the sake of increasing their awareness of things.

This participant felt that the opportunity to be proactive and create preventative services, which are rare in the system in which he works, would enhance his creativity rather than generating reactive services only.

4.4 Contextual Findings

All participants were asked about their definition(s) for creativity and how they used it in practice and almost all of them gave specific examples of times when they were creative in their practice, working outside of the box as Lumadue et al. described.

Definitions of creativity.

All of the participants provided their own definitions of creativity. Themes emerged within their definitions including being “flexible and adaptable” as well as being open and accepting of the clients’ experiences. Some participants spoke of being in “flow”, while others talked of creativity involving experimentation, adding a personal touch and ultimately, creativity as an artful way of being.

The theme of openness was prominent in the data. For example, one participant stated, “creativity to me means openly meeting the person where they're at and looking; being open to a whole repertoire of possible ways of approaching. In any given situation”. Another participant described creativity as,

being open to experiencing what's happening right now and not predetermine it. Because I understand ... creativity would be seeing things that otherwise would not be generally seen. So if you can actually be present with the current situation, creativity is responding in a conscious, alert, dynamic way, rather than in a rote way.

Another participant defined creativity as something that is not done in a rote way. She spoke of creativity as being, “[outside] of any prescribed theories or specialty manuals... it’s being open to ... co-creating with the client”. For this participant, she saw clients playing an integral role in her creativity where the client

would meet with her in a therapeutic space to co-create solutions to the client's challenges. Her definition of creativity affirms the role of the client in counsellor creativity.

Another participant acknowledged the role of the client in the counsellor's creativity. The participant stated,

I define creativity not as -- a way of working with the client in a way that works for them that stimulates them to engage and to stay interested in whatever it is that is the target of the therapy. It could be the target behavior, it could be depends-- -- in my area it's usually the target behavior. So working with the client in a way that speaks to their perspective, their lens of learning.

These participants acknowledge the role of the client in the creative process of counselling, but creativity would not be possible, or at least more difficult within the framework of these definitions, if the counsellor was not open to the idea that the client brings some expertise or ability that the counsellor can draw upon to instill creativity into the therapeutic process. Therefore openness is a key feature of creativity, and this openness requires a certain comfort level with ambiguity in the moment.

Several participants related flexibility and openness to being in "flow"; flow also requires openness and comfort with ambiguity. One participant described creativity as flexibility, being in flow and allowing for technical eclecticism. Another stated simply, "creativity means ... spontaneous flow. It means letting happen what is rather than forcing something to be".

Other participants used the "thinking outside of the box" metaphor to define creativity. One stated, "I think creativity in some ways is more thinking outside the box

with maybe a different approach to people or how to deal with them.” Another participant elaborated, “

I would define creativity as thinking outside of the box in terms of sorting out new ways to work on issues that are suitable or make sense for specific people, because not everything works for everyone. And while there are definitely a lot of standard techniques that work really, really well, each client is different and requires a bit of improv in sorting out how to best help that person. So I guess I think of creativity as being adaptable.

So like openness, the theme of adaptability appeared fairly consistently in participants' definitions.

Yet another participant described creativity as thinking out of the box and being willing to take risks that something may or may not be effective. She said creativity is, thinking outside the box. But being creative, it's ... coming up with your own ideas or ways of doing things. So there's thinking outside the box, but it's still ...not just thinking, okay, what did that person do over there and bring it here. No, no, no, it's thinking, ... putting things together and coming up with something unique of your own. That may or may not work but at least it's being open to trying different things, different ideas or different ways of doing things.

So while participants saw thinking outside of the box, borrowing ideas from others, there was an element of putting one's own, unique stamp on the creative product to ensure something that works for each, unique client. Generating unique responses to

unique individuals requires experimentation and a willingness, an openness to the possibility of failure.

One participant alluded to risk taking and spoke concretely about the role of experimentation in creativity. She said,

[creativity] is about -- for me is about ...The art of life. ... I think about it ... [as] pushing the envelope, ... experimenting, trying something new, going places where you might not know, but you know ... that kind of stuff. ... And being happy doing it too ... you have to enjoy what you do.

In this instance, creativity, and the role experimentation plays in creativity, formed a joyful way of being. Creativity was seen as integral to the “art of life”. Another participant referenced creativity as an artful way of being. He stated, “creativity isn't just a concept, it has to be manifest, so it has to be some product, essentially... I think someone can [create] an artful life. But it would be manifested in relationships and certain ... elegant, aesthetic of living.” These two participants expand creativity beyond interventions and program designs to include the creativity in forming relationships. Certainly throughout the interviews, participants reported incidents where they used their creativity to engage clients and involve them in the therapeutic process. For some of them, their creativity manifested in the artful way they established and maintained their therapeutic alliances with clients.

There was one outlier in the group who defined creativity as “people who are artists”. This study was open to any concurrent disorders counsellor who was currently seeing clients. They did not have to identify as using creativity in their practice or as being creative themselves. Indeed this particular participant did not view herself as

creative at all. She talked about people she saw as creative in her personal life and at her place of work, but she did not see herself as creative. Yet as she talked about her work, the things she accomplished, and her visions for her future, there was no doubt in my mind that she was creative. She had created an entire series of groups that had not existed prior to her employment in her setting and had the ability to get her groups approved by conservative, ideological management. There were all kinds of examples of her creativity in the interview, and yet she did not view herself as creative because of her definition. At one point she said,

P: I always try to sneak at least a little bit of mindfulness in somewhere. ...

I: I think it's incredibly creative.

P: I never thought of it as being creative, I don't know why. Just because my whole definition I guess has been what it has been.

I: Well, how many ... other counsellors in forensic settings do you know who bring in principles from Buddhism and mindfulness in ...

P: None. Yeah.

I: So there's the novel piece that has a practical application.

P: Yeah and the patients like that and they respond really well.

During this interview, the participant reported that her definition of creativity was shifting and that it helped her to recognize her own creativity.

The definitions supplied by the participants shared several key features.

Common amongst the definitions were the ideas of flexibility, adaptability, openness, flow, willingness to acknowledge the client role in creativity, and a willingness to take

risks and experiment. Ultimately for some of the participants, some or all of these elements culminated in creative, artful ways of being.

Examples of creativity in action.

Almost all of the participants gave specific examples of how they implemented creativity to create an intervention or engage clients which are well represented in the Findings chapter. Many participants spoke of trying to find creative responses to meet the unique needs of unique individuals in order to respond effectively and further the therapeutic work. Often, creativity emerged as a result of an interplay of a number of different factors. For example, one participant explained how client feedback and collaboration with a colleague intersected to enhance his creativity:

So after awhile, ... you get such a good rapport with [clients] they get comfortable enough ... telling you group today that wasn't too good, or this really worked well....Just the way they react and respond to different ideas. When I first started going to the clubhouse ... I basically started with a very dry ... talk lecture ... group on whatever topic, or taking the dry, boring videos that were made... somewhere in the United States, and it just didn't work, people didn't like that stuff...I was able to get some of the youth counsellors at addictions to share some stuff with me ... and I figured okay, that's ... working with a mental health population....So we started doing more experiential stuff like games. One of the counsellors there had developed a PowerPoint presentation in the form of Jeopardy for addiction questions. That worked...that was a riot.

This participant found that looking at what wasn't working and using it as an

opportunity to be creative, drawing on client feedback and colleagues' experiences led to creative solutions.

Another interesting example came out of the interview with a participant who worked primarily in CBT and MI. She described how even though she worked with imposed models, she was still able to be creative. As others have said earlier, she drew upon the client as her source of inspiration and was open to adapting to the clients likes and strengths. She described working within a an imposed model but doing so creatively drawing upon client factors, resources and her training in CBT to adapt the model to meet the client where he was at:

if a client really loves art and we're doing CBT, we would do posters....one of my ways which I think I'm most creative with a client who had IQ [of] about 60. And ...his ability to learn was quite impaired. And verbally he had tremendous limitations. But he was a very visual, he loved art ... our connection between the two of us was really ... the model I was using for treatment. But within that, we were doing posters. Like how do I cope with cravings? We were drawing pictures, we were cutting out stuff from magazines and posting it on posters. And colourful markers ... so really, it's CBT, you're still doing cognitive and behavioral strategies, but you're doing it in a creative way that speaks to the client.

The above two comments illustrate how the individual factors interact to enhance counsellor creativity and effectiveness in working with clients with significant challenges and complex needs.

Is creativity important to the counselling process?

Although not part of the original questionnaire design, it became clear from the interviews that an assumption was being made, the assumption that creativity was important in counselling. Because this assumption is so significant, I began asking participants what their thoughts were. Seven out of nine participants who were asked if creativity was important responded in the affirmative.

One participant responded, that creativity was important, "because each client is a unique individual in a unique circumstance. Approaching without creativity negates this fact and invalidates them and the work". In another statement affirming creativity's importance in counselling, the theme of acknowledging clients uniqueness and the uniqueness of their situations continued:

creativity is important for counsellors because we must endeavor to meet the client where they are at as opposed to trying to fit the client into a preconceived modality akin to 'this pill for this ailment' [while respecting] ethics and evidence-based practices.

The above participant acknowledged the importance of being both creative while also attending to evidence-based practices and ethical behaviour.

Another participant commented about how creativity is essential in counselling while attending to core principles and protocols:

I understand creativity to be the opposite of rigidity or a predetermined approach to a person or problem. There are certainly fundamental principles that need to be applied to practice as well as specific protocols, but creativity involves openness to experiencing each client as new and unique and to enter

the relationship with fresh eyes. Creativity is therefore essential for good practice

Finally two participants explained the function and benefit of creativity. One stated,

Yes, I believe creativity helps me to help my client(s) with providing different options and ways of looking at how a client may be impacted by the events in their lives. It also provides different ways of looking at things with different clients, otherwise it would be very boring!

In this example, the participant indicated that creativity helped shift perspective and helped to generate alternate possibilities. Another participant related creativity with achieving outcomes. She said,

I think creativity is absolutely essential in my work with clients. I believe creativity helps the client to achieve their desired outcomes. I believe this because by being creative, the therapist is able to be flexible and responsive to the client rather than trying, or expecting, the client to fit into a particular approach. Achieving desired outcomes and the process of being creative also helps to make counselling enjoyable and rewarding for the therapist.

In this instance, creativity was seen as necessary for effective practice. And as with the participant comment above, creativity was seen as helping to keep the work fresh and enjoyable. As we read from some of the participants' definitions of creativity as being part of the art of life, it would seem that creativity combines both the evidence-based science and the art of being in counselling.

It should be noted that the two participants who did not respond to the question if counselling was important, both work in a strict imposed model where incorporating creativity, according to their interviews, into practice is problematic. The remaining two participants did not respond to any attempts at contact after the interview concluded.

Participant response to the research process.

Finally, one thing I found interesting as the interview process progressed is that I assumed that the participants would very busy and they would be eager to move me in and out as quickly as possible. During the informed consent process, participants were advised that the interviews would last approximately ninety minutes. Many of the interviews went well beyond that time limit. Some interviews, combined with a follow up session, lasted as long as two and a half hours. Participants had lots to say about their creativity and what helped them to be creative and what impeded it.

Furthermore, some participants reported seeing a shift in how they viewed creativity and how they saw themselves as being creative. One participant reported

I'm thinking creativity -- it's very interesting....Because you use the word creativity a lot. And yet when you're asking me the questions it's more about in a context for me that puts it into finding out more about myself or my clients. And I'm just sitting here and thinking, but creativity is taking the word create and make something different with it. So I guess in that way I'm doing it and I have to try to help my clients do it.

The participant found the interview process interesting and indicated that he experienced a shift in awareness of creativity. The participant who originally defined

creativity as something only artists can do, also described experiencing a shift in her view of the nature of creativity. For some of these participants, the interview process appeared to be beneficial given the time they spent sharing their experiences and the shifts they described.

CHAPTER 5: DISCUSSION

Now that the findings of this study have been examined, we move to contextualizing the findings and exploring the implications. We return to the research question to guide the following examination of the fit of the findings to the literature, unique findings, and practical implications on the area of concurrent disorders counselling and counselling in general. Finally, the study's limitations will be discussed along with possible future research and concluding statements.

5.1 Research Question

This study investigated the research question: "how do counsellors working with clients with concurrent disorders experience creativity in their practice, and more specifically what helps and hinders them in their use of creativity?" A secondary question asked was "how do concurrent disorders counsellors define creativity?" Eleven concurrent disorders counsellors were interviewed and 298 incidents were reported. Incidents were grouped into helping, hindering and wish list categories to create a clear, logical and helpful framework to meaningfully explore and discuss the results. Through the research process, the incidents reported and the analysis of those incidents answers both questions.

5.2 Fit with the Literature

Several key themes emerged from the findings that should be viewed within the context of the literature. Although there are no known studies of factors that aid and hinder the creativity of concurrent disorders counsellors, there are two relevant studies that fit with the findings of this study: Mills' (2011) study on the helping and hindering factors affecting career practitioners' creativity and Amabile and Gryskiewicz's (1987)

study investigating the helping and impeding factors of research and development scientists' creativity. Some of the general literature on creativity in counselling applies as well.

Working within Imposed Models

Amabile and Gryskiewicz (1987) found that researcher's lack of freedom in deciding how to do one's work with the method dictated to them was the single most cited type of hindering factor for creativity in their study. Mills (2011) also found that career counsellors who had to work within a prescribed theoretical framework felt their creativity was hindered. Consequently, it is not surprising that Imposed Models emerged as a significant hindering factor in this study. Of the sample, 63.6% of the total participants and 100% of the participants working in forensics reported incidents that fell in the Imposed Models category. Even though the concurrent disorders counsellors working in forensics were adhering to prescribed theoretical orientations such as CBT or MI in their practices, they still managed to utilize creativity in their practice by introducing a creative approach like incorporating art into CBT work. One forensics-based participant described creativity, previously cited in Chapter 4, as the "medium to find what works". Participants in other settings, either residential or community, who spoke of what helped them be creative cited many more incidents where they had the autonomy to choose any intervention or work from any theoretical background provided there was some evidence for it. Autonomy as a helping factor was key in Amabile's studies; whereas, it was not as prevalent in Mills' study, which only provided one example of a lack of autonomy cited in the work environment category as a hindering factor.

Of note was the unwillingness of all but one participant to use the terms risk or risk-taking as being helpful to their creativity. During the interviews it was clear that participants were experimental, taking reasonable risks informed by research in their practice; however, almost all of them did not resonate with those terms. Several were very quick to deny that they took risks or experimented or said they did not want to descend into experimentation. As the interviewer, I almost felt we were playing a game of semantics, trying to describe risk-taking without the negative connotations. Amabile and Grysiewicz found that risk-orientation was a key factor in creativity. It is possible that risk and experimentation is associated with being irresponsible or potentially putting the client at risk for being harmed which would be unethical and therefore counsellors' shy away from the term. Further research into why counsellors do not often describe their creativity in terms of risk could be interesting.

Other Helping and Hindering Factors and Wish List Items

Personal factors emerged as both helping and hindering factors in this study. Amabile and Grysiewicz's study also found personal factors playing a role. They mention being unconventional as a factor. One person mentioned "not fitting into the norm" as being helpful. Being flexible, open, curious, and non-judgmental was often cited by participants in this study as it was in Amabile and Grysiewicz's. Curiosity also emerged as a helpful personal factor in Mills' study.

Amabile and Grysiewicz found that encouragement from management, constructive feedback, collaboration, resources, and shelter from pressure, enhanced researchers' creativity. These findings correspond to some of the findings in this study. Supportive management, which included sheltering participants either from other

managers or from external pressures such as outside stakeholders, was a significant category. Likewise, collaboration, feedback from clients and access to resources corresponded. On the hindering side, they found that lack of resources, incompetent or uncaring management, lack of collaboration, overly formal or complex procedures and political issues hindered creativity. Their findings correspond to unsupportive management, particularly in the case of the participant who talked about leaving three positions because of uncaring management. Unnecessarily complex reporting systems as part of the bureaucracy category somewhat relates to their findings, as does colleagues who were unsupportive.

One of the most interesting parallels was the political issues hindering creativity. One participant did discuss how some stakeholder's adherence to abstinence-based models and resistance to harm reduction hindered his creativity because it lacked opportunities. Resistance to harm reduction is rooted in ideology and it is clear from the federal government's litigation against 'Insite' that there is significant resistance to harm reduction at the highest level of government. Given that the sample size of this study was only eleven, it would be interesting to know if others felt that politically motivated activities hindered their creativity.

Mills found that clients aided career counsellors' creativity. Her findings corresponded to the role of client factors in this study, as well as the influence of clients on what works in therapy in general (Hubble et al., 2010). Therapists considered to be successful in practice, tend to draw upon client factors, using a strength-based approach (Bohart & Tallman, 2010). One participant of this study specifically noted that seeing clients' courage and resilience helped her be creative,

while another gave several examples of how clients' successes inspired her creativity. Yet another talked of how a client was ready to reduce his use of substances. All of the examples illustrate how clients' strengths played a role to inspire and enhance the counsellor's creativity. The clients who demonstrated progress and had some successes during the time they were in contact with the counsellor helped their counsellor's creativity. This factor corresponds to Amabile and Kramer's (2011) "progress principle".

Mills also found that colleagues, professional development, and personal activities/methods such as doodling helped career counsellors' creativity. These findings are somewhat related to the importance of colleagues, personal practices such as the use of diagrams and drawings, resources and the training categories in this study.

In her work environment category, Mills found that unsupportive supervisors, lack of colleague support, lack of resources, and limited access to professional development impeded career counsellors' creativity. These findings correspond with the findings of this study.

Three participants stated that they wished for greater integration of services. MHCC (2012, 2009) and other stakeholders have advocated for better integration and coordination of mental health and addictions services and programs, as well as improved collaboration services delivery. MHCC's assertions match with the desire of participants for more integration of services. One participant spoke at length about her frustration with the system and how colleagues would pass off clients with concurrent disorders. MHCC envisions a remodeled system in which individuals with complex

concurrent disorders will have their needs met within a holistic, coordinated manner so that they will not disappear in the gaps between services as they are passed between services. Given that collaboration was considered to be helpful for concurrent disorders counsellor's creativity, increasing opportunities for collaboration to enhance creativity could lead to creative solutions around improved integration and coordination.

Definitions and components of creativity.

Common themes between participants' definitions of creativity emerged in the data which corresponded to the definitions in the literature. Lumadue et al. (2005) wrote "creativity, as discussed within a mental health context, speaks in part to a therapist's willingness and ability to responsibly and creatively think outside the box, while fostering in their clients their own creative and innovative capacities to consider and work through issues and problems" (p.8). Several participants spoke of working outside of the box as being a defining feature of creativity.

Csikszentmihalyi concept of flow also resonated throughout their definitions. Participants defined creativity using words including flexible, adaptable, open, and flow.

Glover, Ronning & Reynolds' 1989 (as cited in Heppner et al.,1994) definition: creativity is a process that "involves the combination of information, often in unique and novel ways, that is ultimately used to elucidate or solve a client's problem by extending the client's experiential world in some way" (p. 78) was also echoed in some participants' definitions. One participant spoke of being outside of any prescribed theories, which speaks to behaving or generating novel, applied

approaches. Similarly, another spoke of drawing on other sources but putting her unique stamp on it. Many of the incidents cited by the participants also included examples of solutions to problems such as the creation of an effective safety plan for a suicidal client, the reduction of substances, and engagement of clients. Furthermore, the playfulness and the improvisation that participant described fit with several authors contentions that play and improvisation are integral to creativity and to the therapeutic process (Bohart, 1999; Panksepp, 2004; Rankin, 1999a; Winnicott, 1971)

In addition, several of the participants reported that they saw creativity as essential to being effective and helping clients achieve their goals. Their understanding of creativity as important or essential in counselling aligns with several researchers who state that creativity is essential (Carson & Becker, 2004; Gee et al., 2007; Hecker & Kottler, 2002)

5.3 Unique Findings

There is no known, published research investigating the experiences of concurrent disorders counsellors use of creativity in practice. There is one study exploring the experience of career practitioners experience of creativity (Mills, 2011) and while there were some similarities, many of the findings of this study are unique and will be discussed below.

Meditation and mindfulness.

Meditation and mindfulness as a helping factor was initially surprising, particularly since Mills (2011), did not find something similar. However, as previously mentioned in section 5.1, meditation and mindfulness is discussed in the addictions treatment literature, which given the systemic separation of co-occurring disorders into

mental health and addictions, participants would be familiar with. Given that participants associated meditation and mindfulness with acceptance and not being attached to rigid frameworks, it was important to isolate it and pull it from the personal and professional practice category. One participant described how colleagues often do not want to work with clients with co-occurring disorders

Personal therapy.

Three participants representing 27.2% of the sample shared that attending counselling sessions themselves benefited their creativity. Another participant, who did not cite therapy, shared how countertransference hindered both his creativity and impacted the relationship with the client. Of all of the findings, I think this is the most significant one and the registered psychologist who served as an expert to validate the categories agreed that it was an important finding. I wonder if the participation rate is actually higher than reported. There is stigma around seeking therapy and it is possible some counsellors may not want to discuss how creativity may be affected by doing personal therapy. There was one participant who mentioned his own recovery process and intimated that that it was helpful to his creativity but he did not specifically mention personal therapy nor did he cite an incident that could be used in the results of this study. It is possible however that participants did not disclose their own personal therapy because they did not see it as relevant to their creativity. Exploring a relationship between personal therapy and the creativity of counsellors could be an area for further research.

Imposed models.

Mills addressed some elements of restrictions in her similar study. However, the

field of co-occurring disorders has a distinct feature, risk management that is not a concern or not often a concern in traditional career counselling. Several participants spoke of the limitations of having to utilize evidence-based models within the medical model they worked in and for some, particularly in forensic psychiatry, risk management was a prominent consideration in how they had to approach clients, and therefore the counsellors in these settings were required to adhere to approaches considered to be evidence-based. The medical model does not generally apply in career counselling, and Mills' sample did not include any counsellors practicing in a forensic setting where risk management may have been an issue.

In addition, the imposition of other models, such as abstinence-based models, and the denial of the harm reduction models was referenced in three incidents by a participant who felt the beliefs of stakeholders, including three levels of government, police and families, impeded not only his creativity and his ability to implement potentially effective interventions, but also the opportunities for clients to meet their goals in achieving wellness. All of the participants worked in some kind of health care setting, and in a publicly funded health care system with multiple levels of government involved as well as other systems that interact like social work, policing, forensics to name a few, counsellors are not completely autonomous. It is a very distinct challenge that concurrent disorders counsellors face when some stakeholders reject and limit harm reduction approaches that afford opportunities and possibilities for creative solutions to clients problems.

More special topics education and training.

That participants would desire more education and training is not surprising.

What was unique about these findings was the type of training that participants wanted, because often counsellors refer clients with different needs to other practitioners, but the participants in this study wanted to enhance their creativity and options to be able to address clients' needs more holistically. Education and training involving trauma was mentioned by participants, illustrating the particular need for the client population being served. Some participants wanted dialectical behaviour therapy (DBT) training and discussed their work with clients diagnosed with borderline personality disorder. Art therapy was mentioned, and couples and families counselling was also specifically identified.

Burnout or lack thereof.

One unique, and surprising, finding was the lack of incidents referencing burnout. Although Mills found a participation rate of 15% for burnout in her study of career practitioners, only one participant in this study used the term burnout and this person was referring more to exhausting ideas and being in a state of low energy than a more clinical state of burnout. Concurrent disorders counsellors are susceptible to burnout because of the complex nature of the clients and the enduring nature of their concerns; however, none of the participants reported being in this state. The lack of mention of burnout may be due to the nature of this group, as counsellors experiencing burnout may not volunteer to participate in a study investigating creativity.

5.4 Practical Implications

As Mills noted in her study, many participants enjoyed the interview process as it helped them explore and clarify their own experiences and understanding of

creativity in counselling practice. One participant initially stated that she was not creative at all, and by the end of the interview she reported how she could see how she was creative and that her own definition of creativity as being done by artistic individuals was perhaps too narrow. Three participants specifically expressed curiosity in the results, wondering if their views were similar to others. It could be beneficial for concurrent disorders counsellors, and possibly all counsellors, to consider creativity in practice, and what helps and hinders and the impact of their creativity on their clients.

Another practical implication, borrowing from positive psychology, is that concurrent disorders counsellors may want to reflect further on the helping factors and consider how they can bring more of those features into their lives and their practices while also reflecting on the hindering factors and either limiting them or addressing them, perhaps creative ways, to minimize their effects.

Some of the participants felt their creativity was hindered by the low motivation for change, particularly amongst mandated clients. As mentioned in the literature review, some researchers and practitioners believe that there is no such thing as an unmotivated client (Bohart & Tallman, 2009); the issue is a misalignment between the client's motivation and the therapist's motivation. Working within an imposed model setting may be part of the issue. One participant working in forensic psychiatry described how having set, linear outcomes for his programs hindered his creativity. In this case the organization had approved predetermined outcomes without taking into consideration individual client's needs or goals, and did not provide autonomy to the therapist to adjust the treatment protocol to address the client's concern. So while clients may appear unmotivated, which is a hindering factor for the participant, it may

actually be an issue of imposed models and lack of counsellor autonomy that impacts motivation. Indeed one participant, who wished for more autonomy for clients tapped into this very issue. Therefore counsellors need to be aware that the models in which they work may be the cause of demotivation, and thus they need to advocate for more client and professional autonomy to be able to engage clients more effectively.

Furthermore, organizations that set treatment policies and standards may want to consider allowing their employees more freedom to use their clinical judgment in a creative, responsible and ethical manner. Risk management models certainly have their place in attempting to preserve safety for both clients and staff; however, by limiting counsellor creativity through restricting their autonomy they may be significantly impeding therapeutic processes, which increases costs and limits accessibility of services to other clients who need access to scarce resources.

Two participants in this study identified a desire to spend more time with creative people and 90.9% of the participants identified collaborating with colleagues as helping their creativity. Something that may aid Canadian counsellors in enhancing creativity in their practice is the formation of an organization like the Association for Creativity in Counselling, which is a subgroup of the American Counselling Association. The Canadian Counselling and Psychotherapy Association (CCPA) has the Creative Arts in Counselling Chapter. However, several participants in this study did not include the arts either in the definition of creativity or in their use of creativity in practice. As such, an organization that recognizes many forms of creativity could elevate the profile of creativity in practice, include more members, generate or support more research and discussion around creativity, and provide professional development

opportunities related to creativity. Taking it a step further, an international counselling organization with either a focus on creativity or a subgroup focusing on creativity could promote the same opportunities as something on the Canadian level but adding the significant benefit of international connections and expertise.

Furthermore, seven participants at a participation rate of 63.6% indicated that further training in special topics such as trauma and eating disorders, and approaches like dialectal behaviour therapy and art therapy to name a few would help them be creative. University training programs may want to consider incorporating explicit training in the underlying issues of clients, such as trauma, as well as some specific techniques to address concerns in the name of adding a few more tools to the counsellor toolbox. Of course not all topics or techniques can be offered in any training program; the cost and duration of such a proposal would render it impossible. Nevertheless, participants indicated that they would take techniques and add something to it themselves so some exposure to alternative approaches could be beneficial.

In addition, Carson & Becker (2004) had noted that creativity training is rare in counsellor training. Smith (2011) found that 96% of the sample of twenty-seven beginning counsellors reported that they may have been more likely to use creativity in their counselling practice if they had more training on creative techniques. Although not part of the formal interview process, seven participants in this study were asked if creativity was important in their practice, and 100% of them responded yes. One stated "Yes! [Creativity is important] because each client is a unique individual in a unique circumstance; approaching without creativity negates this fact and invalidates

them and the work". Another participant stated "Yes, [creativity is important] because every client is different and has different needs; creativity is the medium to find what works". Furthermore, another participant stated,

I understand creativity to be the opposite of rigidity or a predetermined approach to a person or problem. There are certainly fundamental principles that need to be applied to practice as well as specific protocols, but creativity involves openness to experiencing each client as new and unique and to enter the relationship with fresh eyes. Creativity is therefore essential for good practice.

However, university graduate programs do not typically reward risk taking and experimentation when it results in failure and given that poor marks can affect funding and continuation to further studies, there is a disincentive for counsellors in training to play, take risks and generally be creative in training programs. So if creativity is essential in working with clients with concurrent disorders, and beginning counsellors report they would be more likely to be creative, counselling training programs may wish to consider how they can encourage learners to take risks.

Finally with stakeholders such as MHCC calling for a revolution in how individuals with concurrent disorders are cared for through the creation of a holistic, coordinated system, the creativity of the professionals engaged in treatment and service provision will need to be engaged. If such a system is to become a reality, the creativity of counsellors will need to be enhanced and nurtured and therefore the findings of this study will be significant.

5.5 Personal Observations

The political nature of working in concurrent disorders and how counselor creativity may be subsequently impacted emerged in the data. Participants talked about small “p” politics of working within interdisciplinary teams with differing ideologies of care as well as large “P” politics such as the resistance to harm reduction approaches by various stakeholders. It became apparent that the field was highly politicized and that counsellors had to carefully navigate various stakeholders, not just in their use of creativity, but in their work in general.

During the participant cross-checking stage, three participants either withdrew or significantly qualified incidents, both hindering and helpful. In all three cases, it was apparent that these changes had political implications either within their specific work places or within the systems that they work that involved multiple provincial government ministries, policing organizations, multiple level of governments and the general public. Supportive management in the face of political machinations did help clients to be more creative and effective in their work. However, bureaucracy, a common feature of politicized environments, was an impediment to creativity and counsellor effectiveness.

It would be a utopian vision to be able to work with clients in a depoliticized environment; however, I draw specific attention to the political nature of the work because the political is present in work related to addictions and with mental health. In meeting with one of my experts, he identified how blame is often assigned to individuals who use substances. Their use of substances is sometimes described as a moral failing for which they are at fault. Often this attitude is associated with the moral

mode of addictions. Morality and politics often co-exist with both positive and negative impacts on the issues to which they are applied.

Furthermore, the participants' aversion to using the term "risk" or "experimentation" in terms of developing their creativity seemed related to the political. Ethical practice excludes irresponsible risks; however, even the use of empathy can involve risking the possibility that the counsellor may be inaccurate or wrong. Also, not all interventions work for all clients all the time, therefore risk seems to be an inherent feature of the counselling process. Nevertheless, most participants whose incidents related to risk orientation avoided the term. In addition to working in a field with a code of ethics and responsibilities where professional peer censure is possible, risk management is a central feature in health care and forensic psychiatry. Both of these systems are heavily politicized. The idea of taking any kind of risk or describing practices using language associated with risk in environments where risk is to be avoided at best and managed at worst seemed like a risk in itself even in a study where their identities would be protected. Further investigation to illuminate the role politics in affecting the counselling of clients with concurrent disorders could be helpful.

Finally, the personal therapy category emerged as helpful to three participants' creativity. However, two more participants cited their own recovery processes as being helpful to their creativity. These two participants were not included in the personal therapy category because they did not explicitly identify therapy as helpful, and it is possible to recover from substance use without attending counselling. However, often there is stigma attached to seeking personal counselling that may involve mental

health or substance use, or even relational issues. Also, seeking counselling can be used against individuals to discredit them. It is possible that personal therapy played a bigger role in counsellors' creativity; however, there may be reasons that participants chose not to share their experiences of therapy that did not emerge in the interviews, and ECIT does not allow for the investigator to pursue those possibilities.

5.6 Limitations

All studies have limitations, so it is important to recognize the limitations of this study. Utilizing a snowball sampling approach may have impacted the findings in terms of who volunteered to participate in the study. The sample was narrowed by someone deciding that they knew someone who was creative, and then narrowed further by participants making specific referrals to others whom they believed to be interested in the topic and creative. It is possible that the participants of this study have similar experiences of creativity because they have common backgrounds and work environments. The participants responses may have been different had it been more of a random sample, but such is the nature of recruitment.

It is possible that there may be some demographic limitations as well. The design of the study allowed for participants of all cultural backgrounds; however, all participants appeared to be Caucasian, and no visible minorities agreed to participate. The lack of visible minority participants may have been due to the nature of the snowball sampling technique. Perhaps some feature of the concurrent disorders specialty or the very nature of the career decision making process in choosing counselling as a profession may influence the participant rate of non-visible minorities in the field. Furthermore, information about participants' cultural backgrounds was not

collected, but may have played a role in their responses. Although all participants appeared to be “white”, Alessandria (2002) rightly argues that there are many cultural variations within Caucasian individuals of European descent. Generally, culture was not explicitly identified by participants as an influential factor on their creativity. However, humour, playfulness and communication styles emerged as helpful personal factors, and these factors can be influenced by culture so it is possible that culture played a role. So in addition to a lack of greater cultural diversity amongst participants, the ECIT protocol may have been a limitation for, as a researcher, I was not able to deviate from the structure in order to explore the potential underlying influence of culture on creativity in counselling.

Related to demographic information, although this study was open to individuals with doctoral training, all of the participants had Masters degrees, leaving out an entire group of professionals who work with clients with concurrent disorders. Again, snowball sampling may have been a factor in this regard. It is also possible that while psychologists and counselling psychologists engage in therapy and counselling, they may not identify themselves as counsellors and therefore self-selected out of the study.

Another limitation of the ECIT approach involved the personal therapy category. Given that two participants reported that their recovery from substance use helped their creativity, but did not explicitly cite therapy as being helpful, they were not included in this category. It is possible that they engaged in therapy and it may be possible that it was helpful to their creativity, however, the limitations of the research method precluded me from seeking that information out without it emerging in the incidents.

When mindfulness/meditation emerged as a helping category with a significant participation rate, I wondered if the location where the study was conducted played a role. Currently on the west coast of North America, yoga and mindfulness practices have entered mainstream culture and I wondered if its role in the culture impacted the results of this study. On the other hand, mindfulness and meditation does appear in the addictions and concurrent disorders literature (Brewer, Bowen et al., 2010; Brewer, Sinha et al., 2009; Groves & Farmer, 1994; Marlatt, 2002; Witkiewitz, Marlatt, & Walker, 2005). Having said that, Marlatt was a major proponent of mindfulness informed treatment, and he was based at the University of Washington in Washington State, a west coast institution. Researchers also tend to collaborate, such as Marlatt and Brewer, with like-minded individuals or how else would anything get done?

The study was open to any concurrent disorders counsellor currently counselling clients with co-occurring disorders regardless of the length of their professional experience. There was a small range of settings with one residential, three forensic and seven community health based. A larger sample with a more diverse range of work settings may affect the findings.

Finally, the very nature of the topic and its place in counselling may have been a limitation. There is limited discussion in the literature about training new counsellors and creativity. Also, creativity itself is a complicated process, comprised of different factors, and ultimately an ill-defined concept that can be challenging to measure. It became apparent from some of the interviews that the participants, even when they were being creative, were not sitting around thinking about their work being creative. One participant, at the end of the interview, said that having

consciously discussed creativity, he could see now that he was quite creative. As a researcher investigating creativity and immersed in the literature and the practice of it, it was apparent to me all along that this participant was creative but it was not so for this person. Another participant thought she was not creative at all, based on a fairly narrow definition of what she perceived it to be. By the end of the interview, she stated that her sense of creativity had shifted and that she could see how she was creative. These examples illustrated that the participants' view of creativity and the factors that relate to it, are affected by their subjective interpretations and meaning assignments to their experiences and the features that seem most prominent to them at the time. Further discussions and elaborations on the topic may again shift their contributions to the research, and this is the nature of research embedded in constructivism.

5.7 Future Research

Given the lack of research on creativity and counselling in the co-occurring disorders field, there is a continued need for further investigation. This study focused on how participants defined creativity, what helps them to be creative, what hinders them and what they would wish for to enhance their creativity. It excluded a whole range of other interesting questions that could benefit the field.

For example, further research could investigate the impact of counsellor creativity on clients. Some participants reported that they thought their openness to possibilities and using creativity stimulated the creativity in their clients. Although I did ask several participants if they thought creativity was important and why it is important, a systematic investigation of the importance of creativity in counselling could be beneficial.

In addition, this study investigated the factors that help and hinder the creativity of concurrent disorders counsellors. Mills (2011) explored the factors impacting career counsellors and there were similarities and differences in our respective results. Further research could explore the factors of other counselling specialties. A meta-analysis could then be conducted to try and understand what factors affect counsellors at a meta level. Additionally each one of the categories that emerged in this study, or in Mills' study, could be explored individually to yield a deeper understanding of how they impact counsellor creativity.

Specifically looking at the finding that meditation and mindfulness played a role in creativity, it would be interesting to replicate the study with a sample somewhere other than the west coast of North America to tease out whether the popularity of meditation, mindfulness and yoga as a feature of the west coast affected the findings of this study.

Demographic information regarding the participants' cultural background was not collected, and all participants appeared to be Caucasian. Further research involving visible minorities as well as specifically exploring the role of culture amongst all counsellors' and their creativity could be beneficial.

With Smith's (2011) finding that lack of training in creativity and creative practices and this study's finding that participants desired more education and training to enhance their creativity, further research could be directed toward the possibility of developing curricula that promotes some of the helping factors required for creativity within education and training programs.

Finally, it is important to note that creativity in counselling does not happen in a

vacuum. It comes to be in the dynamic relationship between counsellor and client where client and counsellor factors interact to enhance or impede the possibility for creativity in counselling. Further research could explore the nature of this relationship and the role creativity plays in it. Or, research into clients and their creativity could be investigated.

It seems that there are gaps between research, training and what actually occurs in counselling practice. Because creativity is ill-defined and difficult to measure, it is not very well understood in terms of counselling practice. Further research into creativity in counselling could serve to narrow the gaps mentioned above, and more fully illuminate how creativity, counsellors and counselling helps clients change. Essentially, research examining creativity in practice could help further establish its role in evidence-based practice.

5.8 Conclusion

The participants in this study shared many amazing examples of where the factors that helped them to be creative resulted in their use of creativity with their clients to achieve a result. Sometimes the result was engagement, sometimes it was developing the therapeutic relationship, and sometimes it was reduction in substance use. Given the increasing demands on the health care system, the role of third party payers, the demands for greater accountability from stakeholders, the limited resources available to support the system, and the complex nature of the concerns of clients with concurrent disorders, innovation and creativity in how we support these clients to live meaningful, productive lives seems paramount.

As we have seen in the review of the literature, a number of counselling and psychotherapy experts advocate for creativity in counselling practice, yet despite the repeated calls for creativity, there is limited research on creativity in the practice of counselling clients with concurrent disorders and its impact or on its impact on the counsellor themselves. The majority of the participants in this study indicated that creativity was either important or essential to their practice as concurrent disorders counsellors. This study shed light on the factors that help concurrent disorders counsellors to be creative as well as what hinders them. It also revealed what they would wish for to be more creative and help them in their practice. The study also revealed that concurrent disorders counsellors use their creativity responsibly, taking into account best practices, to care for and promote the welfare of their clients. Ultimately, the participants affirmed the need for creativity in counselling clients with complex needs. In the words of one participant, creativity is important to the counselling process "because every client is different and has different needs; creativity is the medium to find what works". If counsellors' intend to be helpful to their clients, then creativity in practice must be encouraged and supported not only by counsellors but by the organizations in which they work.

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APPENDICES

Appendix A: Interview Protocol

Participant #: _____ Date: _____

Interview Start Time: _____

1. Contextual Component

Preamble: As we have discussed earlier, I am researching the ways in which concurrent disorders counsellors utilize creativity in their practice. This is the first of two interviews, and its purpose is to collect information about your experience using creativity when working with your clients.

a. As a way of getting started, perhaps you could tell me a little bit about your experience as a concurrent disorders counsellor?

b. You volunteered to participate in this study because you identified yourself as using creativity in your practice. What does “creativity” mean to you?

2a. What has helped you in using creativity in your work?

(Probes: What was the incident/factor? How did it impact you? Can you give me a specific example? How did the incident/factor help you?)

2b. Helpful Factor & What it Means to Participant

(What do you mean by ..?)

2.c Importance

(How did it help? Tell me what it was about ____ that you find so helpful.)

Example (What led up to it? Incident. Outcome of incident.)

3a. Are there things that have impeded you in being creative creativity? (Alternate question: What kinds of things have happened that made it more challenging for you to use creativity?)

3b. Hindering Factor & What it Means to Participant

(What do you mean by ..?)

3c. Importance

(How did it hinder? Tell me what it was about _____ that you find unhelpful.)

Example (What led up to it? Incident. Outcome of incident.)

4. Summarize what has been discussed up to this point with the participant as a transition to the next question:

5a. We've talked about what helps you use creativity (name them), and some things that have made it more challenging for you to use creativity (name them). Are there other things that would help you?

(Alternate question: I wonder what else might have been or might be helpful to you that you haven't had access to?)

5b. Wish List Item & What it Means to Participant
(What do you mean by _____?)

5c. Importance (How would it help? Tell me what it is about _____ that you would find helpful.)

Example (In what circumstances might this be helpful?)

Appendix B. Demographic Questionnaire

- i. Occupation: _____
- ii. Number of years in this occupation: _____
- iii. Setting in which participant works: _____
- iv. Length of time in current job/employer: _____
- v. Industry in which the person works: _____
- vi. Number of years in this industry: _____
- vii. Theoretical orientation(s) applied in setting: _____
- viii. Participant's preferred theoretical orientation: _____
- ix. Age _____
- x. Sex _____
- xi. Income level (household) _____
- xii. Country of birth_____. If not Canada, length of time in Canada _____
- xiii. Primary language spoken _____
- xiv. Marital status _____
- xv. Family status/parental status _____
- xvi. Education level _____
- xvii. Additional training relevant to practice _____

Interview End Time: _____ Length of interview: _____

Interviewer's Name: _____

Appendix C: Informed Consent Form

Informed Consent Form

“Counsellors’ Experiences of Using Creativity in Counselling Clients with Concurrent Disorders: What Helps And Hinders”

Principal Investigator: Dr. Norman E. Amundson, Professor
The University of British Columbia
Department of Education & Counselling Psychology, and Special Education
604-822-6757

Co-Investigator: Barbara A. Smith, M.A. Student
The University of British Columbia
Department of Education & Counselling Psychology, and Special Education
604-xxx-xxxx

This research is being conducted during the course of study for Barbara A. Smith (under the supervision of Dr. Norman Amundson) related to the completion of a Master’s of Art (M.A.) degree in Counselling Psychology at The University of British Columbia (UBC). The results of this study will be reported in a graduate thesis to be stored in the UBC library and presented at conferences. It may also be published in journal articles and books.

Purpose

You are being invited to take part in this research study because of you have identified yourself as using creativity in your practice counselling clients with concurrent disorders. The purpose of this study is to help us learn more about how concurrent disorders counsellors’ define and experience creativity in practice as well as what helps them to be creative, what hinders them, and if there are any things they wish they had to help them be creative.

Procedures

If you say “yes” to participating in this study, we will interview you for 90 minutes. During this time, we will ask you about your experiences as a Concurrent Disorders Counsellor and how you define creativity. Then we will ask you about what helps you be creative along with some examples. Then we will ask you what hinders you in being creative and some examples. We will ask you if you have any “wish list” items that may impact on your creativity. Finally, we will give you a brief demographic questionnaire to complete.

A second, brief interview will be scheduled at a time and location convenient for you to review the information from the first interview. You will be able to add, delete or change any information at this time in order to ensure the information accurately reflects your experiences. Telephone, email or Skype contact in the second interview is possible if these methods of contact are more convenient for you.

The interviews will be voice recorded in order to ensure accuracy of the information. The recording will be transcribed and given a code number to ensure confidentiality. Upon completion of the final report of the study, these audiofiles will be erased.

Results

The results of this study will be reported in a graduate thesis and presented at conferences. It may also be published in journal articles and books.

Potential Risks of the Study

We do not think there is anything in this study that could harm you or be bad for you. Some of the questions we ask may seem sensitive or personal. Please let the researcher know if you have any concerns. You do not have to answer any question if you do not want to.

Potential Benefits of the Study

While this study does not intend to be therapeutic, you may be helped by having an opportunity to candidly discuss what helps and hinders you to be creative in your practice. In the future, others might benefit from what we learn in this study.

Confidentiality

Your confidentiality will be respected. Information that discloses your identity will not be released without your consent unless required by law. Upon signing the informed consent form, your responses will be assigned a code to ensure the maintenance of confidentiality and privacy. You will not be identified by the use of names or initials in any reports of the completed study. All research will be kept in a locked filing cabinet in a locked office, and all computer data files will be password protected. All audio recordings will be destroyed upon completion of the report of this study.

Limits to Confidentiality

Your identity will be kept confidential. However, there are some exceptions to confidentiality:

1. If you tell the researcher you are going to harm yourself or someone else, the researcher is required by law to do anything that she can do to reasonably prevent this from happening,
2. The researcher is required by law to report suspected or potential child abuse/neglect to the Ministry of Children and Family Development or the police.
3. If a vulnerable adult is abused/neglected, a report may be filed with the appropriate governmental agency, and

4. A subpoena by a court of law requires disclosure from the researcher or submission of research records.

Payment

We will not pay you for the time you take to be in this study.

Contact for Information About the Study

If you have any questions or concerns about what we are asking you, or you would like more information about the study, please contact either the co-investigator Barbara A. Smith at 604-271-7491 or the principle investigator Dr. Norman E. Amundson at 604-822-6757.

Contact for Concerns About the Rights of Research Subjects

If you have any concerns about your rights as a research subject and/or your experiences while participating in this study, you may contact the Research Subject Information Line in the UBC Office of Research Services at 604-822-8598 or if long distance, email RSIL@ors.ubc.ca or call toll free 1-877-822-8598.

Consent

Taking part in this study is entirely up to you. You have the right to refuse to participate in this study. If you decide to take part, you may choose to pull out of the study at any time without giving a reason and without any negative impact on your employment.

Your signature below indicates that you have received a copy of this consent form for your own records.

Your signature indicates that you consent to participate in this study.

Participant Signature

Date

Print Name of the Participant signing above

Thank you for your willingness to participate in this study.