Theses & Dissertations

Counseling & Human Services Theses and Dissertations

4-2017

Disenfranchised Grief and the Substance Abuse Counselor: A Heuristic Inquiry

Melissa Pettit

DISENFRANCHISED GRIEF AND THE SUBSTANCE ABUSE COUNSELOR:

A HEURISTIC INQUIRY

A

DISSERTATION

Presented to the Faculty of the Graduate School of

St. Mary's University in Partial Fulfillment

of the Requirements

for the Degree of

DOCTOR OF PHILOSOPHY

in

Counselor Education and Supervision

Melissa Pettit, M.Ed., LPC-S, LCDC

San Antonio, Texas

April 2017

ProQuest Number: 10600357

ProQuest 10600357

DISENFRANCHISED GRIEF IN THE SUBSTANCE ABUSE COUNSELOR:

A HEURISTIC INQUIRY

APPROVED:

_____

H. Ray Wooten, Ph.D., Dissertation Adviser

_____

Dana Comstock-Benzick, Ph.D.

_____

Jacqueline Parsons, Ph.D.

APPROVED:

_____

Megan Mustain Ph.D.
 Dean, Graduate Studies

_____

Date

DEDICATION

This dissertation and degree is dedicated to my loving, supportive, and hard-working

mother, Mary Jane Solansky.

Without your unconditional support, countless sacrifices,

and continuous encouragement, this educational dream

would have been left unfinished. Through the trials and tribulations,

as well as through the joyous and triumphant occasions,

You never faltered in your support of me.

I will never be able to express fully the gratitude I have.

Thank you.

ACKNOWLEDGMENT

time at Fort Hood and in the aftermath of the mass shooting as well as multiple other times along the way. You will never know how much you mean to me.

Dr. Parsons, you have been a continual positive influence and relentless cheerleader from the get-go. I am forever grateful for your joyful and beautiful spirit.

Dr. Ray Wooten, for your willingness to come full circle with me, and walking with me over the finish line with your authenticity, insight, and enthusiasm – you remain my favorite coach and one of my favorite people, ever.

To my fellow substance abuse counselors who shared their stories, this research was made possible by your willingness to share your experiences for the greater good of all substance abuse counselors. I thank you for your dedication, devotion, and love for your work with such a vulnerable population. As we have learned first-hand, someone will die today from this disease.

TABLE OF CONTENTS

LIST OF TABLES

ABSTRACT

DISENFRANCHISED GRIEF IN THE SUBSTANCE ABUSE COUNSELOR:

A HEURISTIC INQUIRY

Melissa Pettit, M.Ed. ABD

St. Mary's University, 2017

Dissertation Adviser: H. Ray Wooten, Ph.D.

Grief and loss are a part of the substance abuse counselor experience. The purpose of this study was to generate a heuristic inquiry on how substance abuse counselors' experience and manage disenfranchised grief in their work with the substance abuse population. A review of the literature indicated health care professionals experience disenfranchised grief. The experiences of disenfranchised grief were noted in relation to substance abuse counselors, who experience ongoing, client-related losses in the workplace. The researcher interviewed 10 Substance Abuse Counselors and asked the research questions, "How do you experience loss in your work as a substance abuse counselor?" and "How do you find and receive support for these losses?" Their responses generated loss-related themes and subthemes, including disenfranchised grief. The resultant themes generated recommendations for substance abuse counselors, and recommendations for ongoing research on this understudied population.

CHAPTER I

RATIONAL AND JUSTIFICATION FOR THE STUDY

People experience a range of losses each day, many of which go without recognition, validation and support. These unrecognized losses can include changes in jobs or health status, the death of an ex-spouse or partner, the death of a family pet, or the loss of a long-term goal or dream. In each case, there once was a bond or, as termed by Bowlby (1980), an attachment. Whatever the circumstances or relationship, losses should ideally be recognized and validated (Doka, 1984). Grief that is experienced without recognition or validation (sanctioned) is referred to as *disenfranchised grief* (Doka, 1984).

Disenfranchised grief is complicated in that marginalized losses do not have customary rituals, traditions, and processes that help to facilitate healing (Doka, 1984). Disenfranchised grief refers to losses in a mourner's relationships that are not socially recognized, and are often experienced in relational contexts in which "shame about one's feelings" plays a role based on "the imagined views of others" (Doka, 2002, p. 71). Researchers have found disenfranchised grief in multiple contexts. For example, when children lose a father on death row, their grief may be kept secret and, shared only with the immediate family, as they feel embarrassed or ashamed to express this loss in a public way such as at school or with friends (Beck & Jones, 2008). Other examples can include adolescents breaking up after a romantic relationship and being told that their intense reactions and feelings are not significant (Kaczmarek & Backlund, 1991); returning missionary workers re-entering society and being expected to react with only optimism and gratitude rather than the sadness that many experience and do not express (Selby et

al., 2009); or women relinquishing a child for adoption, who experience grief but fear the shame associated with their ambivalent feelings so instead show no feelings (Aloi, 2009).

Disenfranchised grief also occurs in family situations, such as the grief felt by ex-family members due to divorce (Smith, 2006), foster parents at the time they transition children out of their care (Edelstein, Burge, & Waterman, 2001), or when children go away to college and parents (and children) feel there is an expectation to transition smoothly away from the family (Doka, 2002). Researchers report disenfranchised grief resulting from perinatal loss (Lang et al., 2011) and DNA predictive testing (Sobel & Cowan, 2003), as there is a feeling of diminished grief and shaming of the loss associated with not being able to have children.

Children raised in dysfunctional families have experienced disenfranchised grief due to the unspoken losses they realize they experienced, once becoming an adult (Zupanick, 1994). In the health care field, this type of grief is extensively reported from nurses and doctors (Anderson & Gaugler, 2007), hospice medical personnel (Anderson, Ewen, & Miles, 2010), health-care chaplains (Helsel, 2008), and mental health providers (Zupanick, 1994).

From the literature review, a number of recurring themes emerged on disenfranchised grief: (a) reluctance or inability to acknowledge grief, (b) a lack of support, (c) a sense of isolation that the bereaved feel but cannot express, and (d) a lack of recognition or acceptance of a loss which the bereaved may experience as a deep sense of shame (Doka, 1989). In addition to these themes, there is the concept of psychogenic or *self-initiated disenfranchised grief*, where the source of the inhibition of the grief process is the perception that others do not support one's loss (Kauffman, 1989).

Whatever one is ashamed of in loss or grief is prone to be disenfranchised by one's own initiative. Self-initiated disenfranchised grief may merge into socially disenfranchised/ disenfranchised grief, or it may occur entirely on its own in an act of self-disenfranchising or as an implicit exposure (Doka, 2002).

Statement of the Problem

All of substance abuse counselors' work with their client's is based on the Alcoholics Anonymous (AA) tradition of someone else's recovery:

> Alcoholics Anonymous is a fellowship of men and women who share their experience, strength and hope with each other that they may solve their common problem and help others to recover from alcoholism. (AA World Services, 1983, p. 2)

A large number of substance abuse counselors come into the field due to their own experience around addiction, therefore experiencing the need for balance of therapeutic relationship and behavioral modifier. When client's get sober and become good members of the recovery community, substance abuse counselors feel partly responsible. In fact, "the term 'burnout' is worn like a badge because it means that the counselor is working hard and really cares. However, clients have become harder with more drug and alcohol combinations and the same clients are seen over and over again with greater regularity (White, 1998). They are called "frequent flyers," and when they die, we call them "sacrifice flies" while our own eyes stay dry and tired" (Culbreth, 2000, p. 66). Seeing more and more clients who can never obtain a stretch of functionality, appearing again and again with the background noise of hopelessness, some substance abuse counselors escape the disappointment and exhaustion by developing their own

conditions: disordered substance abuse, chronic illness or depression. Some leave and some stay and become more and more rigid with the unmet and unsupported expectations of their work.

Without an understanding of the losses experienced and the disenfranchisement of substance abuse counselors' grief, they may unknowingly and unwillingly contribute to the invalidation of their own feelings and experiences, as well as those of their substance abuse clients (O'Brien, 2011). This failure to identify and to claim grief exacerbates emotions of anger, loneliness and guilt, and impedes a healing process for these substance abuse counselors (White, 1998). These counselors may self-diagnose or be diagnosed with burnout, depression, anxiety or stress disorders (Emerson & Markos, 1996). Therefore, mental health professionals need to acquire a more in-depth knowledge and understanding of substance abuse counselor's grief to avoid pathologizing their reactions unnecessarily. In order to bring more awareness and clarity to substance abuse counselors' feelings of loss and grief after losses associated with client care, more research is warranted. The presented qualitative study helps to meet this need as well as to empower substance abuse counselors, validate their experiences, and break the silence surrounding an under-researched but frequently occurring phenomenon.

Research Questions

The researcher asked the following research questions: How do you experience loss in your work as a substance abuse counselor? How do you find and receive support for these losses?

Rationale or Justification of the Study

With no understanding of substance abuse counselors' disenfranchised grief in relation to work with clients who relapse, overdose, and sometimes die, they are unable to exercise proper self-care, which potentially leads to poor delivery of mental health services. Exploring these substance abuse counselors' experiences of disenfranchised grief, and how it impacts' them both personally and professionally, was needed to enhance both self-care and education. Substance abuse counselors benefit by having their losses understood and normalized. This information affects their self-care, performance, and ability to support one another through any difficulties pertinent to the counselor's own well-being. This information also assists in the understanding that feelings of depression, anger, guilt, stress, frustration, resentment, confusion, and hopelessness are signs that need to be addressed, while also being potential symptoms of disenfranchised grief (Spidell et al., 2011). The current research created the opportunity for substance abuse counselors to share their feelings regarding the issue of loss with others who understand the counselor's experience. Acknowledging the substance abuse counselors' disenfranchised grief will also provide a knowledge base for counselors about their own self-care, the care of their peers, and the disenfranchised grief experiences of their clients.

The results of this study illuminated substance abuse counselors' experiences of disenfranchised grief. This information was used to generate implications and recommendations to aid mental health professionals gaining insight into substance abuse counselors' experiences with disenfranchised grief in their work with clients struggling with addiction. The results of this study also indicated a need for education and advocacy in the area of grief and self-care for substance abuse counselors.

Theoretical Framework

The approach I adopted for this research was Heuristic Inquiry. Heuristic Inquiry uses personal narratives to understand the way people make sense of the world around them (Clandinin & Rosiek, 2006). These personal narratives convey important information about the memorable experiences people go through and reflect their understandings of those experiences. Heuristic Inquiry guides researchers in their interest not only in the content of the narratives, but also in the ways people interpret and integrate them in their personal lives (Frank, 2012). Substance abuse counselors' stories of their work-related losses carry valuable information about their views of grief, of self, their role as participants in another person's recovery from substance abuse, and the value they assign to their own recovery. Heuristic Inquiry offers researchers a framework for understanding how dominant cultural narratives about substance abuse and grief influence the individual narratives about the roles substance abuse counselors play in their clients' recovery.

The researcher aimed for a better understanding of the various stories of loss and grief in order to capture the multifaceted experiences of the substance abuse counselors. According to Heuristic Inquiry, one's world is built on one's assumptions and beliefs about the world which can be disrupted by any type of loss (Douglass & Moustakas, 1985). Therefore, a central task of grieving is to come to terms with disrupted assumptions about one's world in the service of revising held beliefs (Neimeyer & Jordan, 2002). Consequently, Heuristic Inquiry guides the researcher of disenfranchised grief and informs the understanding of substance abuse counselors' work-related losses,

the meanings of those losses and reconciliation with the lost expectations from those losses.

This study was based on Doka's (1989) theory of disenfranchised grief and loss. During the literature review, and listening to and reading over the stories of loss experienced by substance abuse counselors, the researcher found multiple similarities between the emotions described and the disenfranchised grief Doka presented in his work. The researcher used Doka's concept to bring more clarity to the process of the disenfranchised grief and the silence described by the substance abuse counselors who participated in this study.

Definitions

Abnormal or complicated grief.

Varieties of distinctive types of abnormal or complicated grief reactions, including those in which grief is concealed or its expression hindered. There are also marked individual differences in how intensely and how long people grieve (Bonanna & Kaltman, 2001).

Addiction.

A primary, chronic disease involving brain reward, motivation, memory, and related circuitry. It can lead to relapse, progressive development, and the potential for fatality if not treated. While the mental health field accepts pathological use of alcohol and, more recently, psychoactive substances as addictive diseases, developing brain science has set the stage for inclusion of process addictions, such as eating, sex, shopping, and gambling. In 2011, the American Society of Addiction Medicine (ASAM) (2011) embraced this broader definition of addiction to include those process addictions.

Ambiguous loss.

Loss for which there is no certain closure; this type of loss has an undefined beginning and an undetermined end (Boss, 1999, 2007). Examples include situations where the individual is physically present yet psychologically absent, as with Alzheimer's disease or brain injury. Conversely, those physically absent, but psychologically present to those who love and wait for them such as, prisoners of war, victims of natural disasters, and run-aways.

Attachment theory.

A psychological, neurophysiological and development drive to create and maintain a strong affectional bond with another (person, object, idea). These attachments come from the need for security and safety and have survival value. The greater the potential for loss, the more intense and more varied reactions to the loss may be (Bowlby, 1980).

Countertransference.

Unconscious reactions to a client that are determined by the counselors/therapist's own life history and unconscious content, including unconscious hostile and/or erotic feelings toward a patient that interfere with objectivity and limit the therapist's effectiveness (Sedgwick, 1994).

Disenfranchised grief.

Grief that is not socially acknowledged by society, by the health care culture, or by other individuals (Doka, 2002). This grief can apply to a wide range of situations: unrecognized losses, grievers and relationships, specific types of death, grief originated on a specific society's attitudes and values, grief that is not encountered therapeutically

but rather remains hidden, unrecognized or unhealed, or; grief frequently unnoticed and ignored (Papadatou, 2000). In some cases, it is the existence of the reaction that is disenfranchised; in other examples, it is the expression of the reaction that is disenfranchised (Corr, 1998).

Disenfranchised deaths.

Deaths whose nature disenfranchises emotions that otherwise might have been expected to follow in their aftermath. Society is repelled by or turns away from some types of deaths because their complexities are not well understood or because they are associated with a high degree of social stigma (Doka, 2002).

Disenfranchised grievers.

Disenfranchisement primarily concerns certain individuals to whom the socially-recognized status of griever is not attached; bereavement is not recognized or appreciated. There are different types of grievers; loss by death is but one category of loss and certain types of death are likely to be disenfranchised while other types are not (Doka, 2002).

Disenfranchised losses.

The focus of the disenfranchisement originates from a failure or unwillingness on the part of society to recognize that certain types of events do involve real losses. There exists a panorama of losses which may affect relationships involving human beings – some permanent, others temporary, some final, others reversible (Doka, 2002).

Disenfranchised relationships.

Relationships deemed by society (or a group) to be of insufficient or inappropriate foundation for grief. There are rich and varied types of relationships called "attachments" that serve to satisfy the basic needs of human beings (Doka, 2002).

Finite loss.

Loss which has a clear beginning and end and is developmentally accurate. This may or may not be a significant, life-changing event, but it is significant enough to cause an emotional reaction (Bruce & Schultz, 2001). An example might be the death of someone significant, but who was not necessarily emotionally close, such as a grandparent or teacher.

Kubler-Ross's Five Stages of Grief.

The Kübler-Ross model proposes a series of emotional stages experienced by survivors of an intimate's death, wherein the five stages are denial, anger, bargaining, depression and acceptance (Kübler-Ross, Kessler, & Shriver, 2014).

Loss.

"Produced by an event which is perceived to be negative by the individuals involved and results in long-term changes to one's social situations, relationships, or cognitions" (Miller & Omarzu, 1998, p. 12).

Nonfinite loss.

The loss of "what should have been," in terms of dreams and expectations of life events, based on one's personal and subjective thinking (Bruce & Schultz, 2001, p. 7). Examples include the birth of a child with permanent disabilities or not reaching one's anticipated potential or goals.

Psychogenic or self-initiated disenfranchised grief.

"The source of the inhibition of the grief process is the imagined view of others. . . therefore, prone to be disenfranchised on the self's own initiative" (Doka, 2002, p. 71).

Recovery.

Many substance abuse treatment models integrate the principles of 12-step programs, such as those popularized by Alcoholics Anonymous, in teaching clients how to live life on life's terms. To further guide counselors' efforts, the Substance Abuse and Mental Health Services Administration (SAMHSA) released a working definition of recovery in December 2011. The agency's definition spelled out four key elements of recovery: a physically and mentally healthy lifestyle, meaningful daily activities, a stable place to live, and a supportive social network (SAMHSA, 2015, para 12).

Relapse.

The recurrence of any disease that has gone into remission or recovery. (SAMHSA, 2015, para.11).

Self-disenfranchised grief.

"Self-delivers and receives on behalf of society a message such as 'Do not allow this grief to be real to you. This is not loss; it is not grief.' Self-enforces and abides by the order disallowing grief" (Doka, 2002, p.61). Taking into one's own hands the power to decide what is to be grieved.

Substance abuse counselor.

For the purpose of this study, LPCs, LCDCs and LMSWs are substance abuse counselors who guide people dealing with alcoholism or other types of addictions, such additions to intoxicants or painkillers. Counselors evaluate clients' mental and physical

health, addictive behaviors, and willingness for treatment and sobriety. On completing an evaluation, counselor's help their clients develop treatment and recovery plans, as well as identify behaviors that will impede the processes. Counselors also review and recommend treatment options to families and help them develop strategies to deal with a client's addiction, and their reactions to the addiction (Substance Abuse and Mental Health Administration [SAMHSA], 2015, para 63).

Transference.

An occurrence typified by unconscious transferal of feelings from one person to another "a reproduction of emotions relating to repressed experiences, especially of childhood . . . and the substitution of another person and for the original object of the repressed impulses" (Andersen & Berk, 1998, p. 112).

CHAPTER II

LITERATURE REVIEW

Grief is a natural reaction to loss (Bowlby, 1980). Optimally, following a loss, there is a social sanctioning of grief and a restoration in the absence of the loss by the bereaved (Romanoff, 1998; Stroebe & Schut, 1998). However, if circumstances surrounding a loss result in limited or constrained support from others, disenfranchised grief may be experienced (Deck & Foita, 1989; Romanoff, 1998).

Counselors, including substance abuse counselors, need to be adequately prepared to deal with disenfranchised grief in clients to assist them in recognizing the displacement of and resolution of their grief (Deutsch, 1985; McCrady, 1989; Reamer, 1992; Thoreson, Miller, & Krauskopf, 1989). Counselors should also to be able to identify and deal with the possibility of their own disenfranchised grief. Only with such identification can counselors establish their process of self-care (Emerson & Markos, 1996; Hays, Yeh, & Eisenberg, 2007).

Grief

Grief is a universal experience and at some point in their lives, most people are challenged with the death of a close friend or relative (Bonanno & Kaltman, 2001; Romanoff, 1998; Stroebe & Schut, 1998). Other types of losses are equally difficult and intense and prompt a grief reaction. What changes from loss to loss is the strength of the feeling that depends on the intensity or investment of the relationship (Romanoff, 1998; Stroebe & Schut, 1998).

Bowlby (1980) was among the first to study grief's similarity to what children experience after separating from their primary attachment source (Bowlby; Shapiro,

13

1994). It was during the study of the impact of separation that Bowlby formulated attachment theory, discovering that attachment is not only necessary for survival, but also a basis for life long feelings of security and emotional well- being. In addition to attachment theory, Bowlby also highlighted the role of cognitive theory in the grieving process (Bowlby; Bruce & Schultz, 2001). Individuals become attached to the inner working model of their perception of their world and their self in their world (Bowlby). When an individual's working model of the world or self is threatened by something environmental, the individual automatically begins searching behaviors that will assist to regain a sense of homeostasis or balance. This homeostasis or balance is regained once the individual is reunited with the attachment source, in this case, the internal working model (Bowlby). This is much of what happens during the process of grief. The loss of a person, object, or working model has forced the individual to begin searching for a way to make sense of who the individual is without the person or object or with a different model (Bruce & Schultz, 2001). By going through the stages of grief, the individual begins to detach from the lost attachment source (Bowlby). This grief process can affect the entire bio-psycho-social continuum of life and can have both immediate and lasting implications (Anderson & Gaugler, 2007).

Normal Grief

What is termed normal or common grief can be defined as "the emotional, psychological, and physical reaction to loss, most commonly encountered following the death of a significant other" (Anderson & Gaugler, 2007, p. 301). Grief is associated with "a wide range of emotions, including sadness, anger, guilt, and despair" (Kubler-Ross et al., 2014, p.16). Each individual "may experience a different set of specific emotions, but,

in general, these emotions diminish as time passes and with support from family and friends" (Ringold, Lynm, & Glass, 2005, p. 2686); hence, they are socially noticed and sanctioned. According to Demi and Miles (1987), the term *normal grief,*

> refers to a grief response that falls under a broad umbrella of predictability and is marked by a movement towards acceptance of the loss and a gradual alleviation of the symptoms, as well as the ability to continue to engage in basic daily activities. (p. 401)

Grieving Norms

All societies have norms that structure grieving (Romanoff, 1998; Stroebe & Schut, 1998). These norms include not only expected behaviors but also norms for feeling, thinking, and spiritual expression. When a loss occurs, these grieving rules direct not only who is to grieve but also how one is to feel and think in response to the loss (Murray, 2001). These rules govern the losses one grieves, how one is to grieve, who justifiably can grieve the loss, and how and to whom others reply with sympathy and support (Murray, 2001; Romanoff, 1998). More formal examples of these grieving rules can be seen in company policies and bereavement leave to certain individuals or in regulations and laws that define who has control of the deceased's body or funeral arrangements (Doka, 1989, 2002; Kauffman, 1989).

Cultural grieving norms exist as common practices, or informally expected behaviors, as well as laws (Doka, 1989; Kauffman, 1989). One example would be the public reaction to the death of one's spouse versus the reaction to someone with whom that person might have had an illicit affair (Doka, 2002). One would be publicly sanctioned, the other not (Doka, 1989, 2002).

Our society places most attention to relational grief responses on kin-based relationships and roles (Doka, 2002). There is scant information concerning non-kin-related losses. Also, society has set grieving rules that are in personnel policies of corporations and human resources. Some losses are recognized under a codified system, such as the death of an immediate family member, while others are not (such as the breakup of a relationship or the loss of a pet). Losses that are not recognized under a codified system are, therefore, defined as not socially significant or sanctified. Grief, in these cases, is not legitimized or foreseeable and, therefore, disenfranchised (Doka, 1989, 2002; Kauffman, 1989).

Many losses do not involve death, such as job loss, divorce, and separation from loved ones, or the loss of a goal, dream, desire, or the loss health (Corr, 1998; Doka, 1989; Kauffman, 1989). With these types of losses, resolution can be difficult, and these types of losses often present the griever with multiple challenges (Doka, 2002; Kauffman, 2002).

The American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders,* 5th ed. *(*[DSM-5] APA, 2013) "does not define bereavement as a disorder, but pre-existing conditions like major depression, or repercussions associated with the trauma of a death, such as acute stress or posttraumatic stress, can complicate bereavement" (p. 433). Normal symptoms of bereavement can mimic those of depression, but these symptoms typically pass within two months of the loss (Parkes, 1998). For those who may be vulnerable to depression, grief has the potential to precipitate a depressive episode, and for those who already experience depression, the bereavement process can be prolonged and worsened by the depression. "What distinguishes grief

from depression is that the feelings of grief are specifically related to the loss or death, and depression is characterized by a general sense of worthlessness, despair, and lack of joy" (Maercker et al., 2013, p. 1684).

Some cases of grief progress from what would be considered normal grief into a stressor that warrants a clinical diagnosis. These would be in extreme cases when other categories of psychopathology (such as depression) are evident (Boss, 2010; Enright & Marwit, 2002; Horowitz, Siegel, Holen, & Bonanno, 2003).

Complicated Grief

One of the earliest presentations of normal versus pathological or complicated grieving was proposed by Parkes (1965). Parkes distinguished normal or typical grief from three forms of atypical grief: *chronic grief* – defined as "an extended variant of typical grief…. pronounced symptoms and prolonged" (p. 14), *inhibited grief* – in which a bereaved person displays little evidence of overt grief; and *delayed grief* – when a typical or chronic grief reaction follows inhibited grief (Bonanno & Kaltman, 2001, p. 707).

Though most grieving individuals will not require special intervention (Boss, 1999; Hashim, Eng, Tohit, & Wahab, 2013; Stroebe & Schut, 1998), some need assistance with abnormal or complicated grief reactions. Abnormal of complicated grief reactions include those in which grief is concealed or hindered, powerful intrusive thoughts, episodes of difficult emotion, painful yearnings, feeling alone and empty, avoidance and isolation, abnormal sleep patterns, and loss of interest in activities once enjoyed (Horowitz et al., 2003; Moayedoddin & Markowitz, 2015). There are also

marked individual differences in how intensely and how long people grieve (Bonanna & Kaltman, 2001; Hashim et al., 2013).

The writers of the definitions of mental health conditions as found in the *DSM-5* (APA, 2013), previously focused primarily on the problem of over-diagnosis and omitted complicated grief because of insufficient evidence. However, the current *DSM-5* does include complicated grief as Prolonged Grief Disorder and the International Classification of Diseases 11th Revision (ICD-11, due in 2018) will include this disorder.

Nonfinite grief.

In some cases of loss, there is a slow and continuous manifestation over time, making it difficult or even impossible for an individual to go through the stages and process of grief (Bruce & Schultz, 2001). An example would be the loss and grief for parents experiencing the news that their young child will live a life with intellectual disabilities; while there is no threat to the child's immediate physical well-being, any expectation for normal development and ultimate self-sufficiency is lost (Bruce, 1994). The grieving parents are now stuck between the known and the dreaded, or what is known as non-finite grief.

Bruce and Schultz (2001) stipulated three conditions for a nonfinite loss: developmental expectations for the loved one cannot be met; the loss is continuous and follows a major event; and, the loss involves the loss of one's hopes and ideals. Disturbing and inescapable,

> nonfinite losses are continuous, invariably insidious, rarely recognized for what
> they are, and often preceded by a clearly distinguished negative life event or
> episode that for one reason or another retains a vivid physical or psychological

presence (e.g., diagnosis of congenital malformation, infertility, life-threatening

or degenerative illness, breakdown of a relationship, disappearance of a family

member in an impossible-to-reconcile circumstance such as torture or murder).

(Bruce & Schultz, 2001, p. 8).

Traumatic grief.

Traumatic losses, such as the death of a loved one by suicide, or other sudden and

violent means of death, are far outside of what we normally expect in life. Reactions are

the result of death and from traumatic distress (Jacobs, Mazure, & Prigerson, 2000). Due

to concurrent traumatic distress, the griever may experience numbness, disbelief, distrust,

anger, and a sense of futility about the future. The reactions of the survivors of these

deaths often include and go beyond normal grief reactions in severity and duration (Foa,

Stein, & McFarlane, 2006).

Loss of these types can "leave a sense of shock, disbelief, and numbness, . . .

leaving loved ones feeling lost, anxious, depressed, or physically unwell" (Shear &

Smith-Caroff, 2002, p. 1). Preoccupation with disturbing thoughts and images of the

death are frequent and may be followed by intense and disruptive emotions. In some

individuals, these reactions can become prolonged and debilitating, even pathological

(Prigerson, 2000; Prigerson & Jacobs, 2001), thereby increasing the importance of

distinguishing this type of grief from others so that those suffering would be able to

recognize and receive assistance for the trauma and the grief.

Ambiguous loss.

Frozen grief is one term used in defining ambiguous loss. Boss (1999) originally

described ambiguous loss as differing from ordinary loss in that there is no actual

verification of death or certainty that the person (loss) will return or come back the way the person had once been, as when families are separated by military deployment or after a brain injury. While loved ones hope to be reunited again, they also know that the individual will never be the same as before the stress of deployment or before the accident (Boss, 2007). In these circumstances, the loss creates a "frozen grief … making closure a myth" (Boss, 2007, p. 141).

There are two types of ambiguous loss situations: Type I is leaving without saying goodbye, and it occurs when there are physical absence and psychological presence, such as when a loved one is physically missing or gone (as in wartime, as described above). Type II is goodbye without leaving, when there is physical presence and psychological absence, as with a loved one who has Alzheimer's disease or other dementias - traumatic brain injury (TBI), autism, depression, addiction, or other chronic mental or physical illnesses that affect mind or memory (Boss, 2012).

Unlike death, an ambiguous loss has no official verification of loss and creates a complicated grief (no closure), but the complication is due to the type of loss: ambiguous, unclear, uncertain, and on-going. There is no possibility of resolution or closure (Boss, 1999).

Disenfranchised grief.

The concept of disenfranchised grief is found in more individualistic cultures, such as the United States and Britain, as opposed to more collective cultures of the Middle East and Africa, in which death and loss are marked communally, providing the opportunity for its members to express and experience grief (Doka, 1989, 2002). In more individualistic cultures, funeral rituals are no longer shared and communal, but rather

kept and practiced within the family. As a result, the right to express grief is limited to those in recognized kin roles. The grief of others is disenfranchised (Murray, 2001; Romanoff, 1998; Stroebe & Schut, 1998).

In a presentation on the comparison of the grief experiences of ex-spouses to those of hetero- and homosexual couples, Doka (1989) defined disenfranchised grief as that which is non-recognized or non-acknowledged by society, by a part of the culture in which the loss occurs, or by individuals within the culture. To understand how a type of grief could be non-recognized, Doka (2002) created a full systematic classification distinguishing four types of disenfranchised grief: (a) the relationship is not recognized, (b) the loss is not acknowledged, (c) the griever is excluded, and (d) the circumstances around a specific loss are deemed socially unacceptable. Therefore, disenfranchised grief is less likely to be confronted therapeutically because it remains hidden, unrecognized, unidentified, and, ultimately, unhealed (Corr, 1989; Kauffman, 1989; Papadatou, 2000).

Multiple studies in this area have highlighted the widespread presence of disenfranchised grief and looked at reasons for its being largely overlooked and ignored – mostly social (Corr, 1989; Kalich & Brabant, 2006; Papadatou, 1997). Since grief always occurs within a distinct social or cultural context, the concept of disenfranchised grief is recognized in various spoken and unspoken ways in communities that deny recognition of the loss or in having it legitimized. Disenfranchised losses are not defined as significant; the griever is excluded; there is little or no social recognition of one's sense of loss or need to mourn; circumstances of the death minimize reception of any social support; or, individual grieving styles do not fit the community's "rules for correct grieving" (Corr & Coolican, 2010, p. 170). In these situations, grieving individuals,

families, and groups are denied their grief (Doka, 1989, 2002). These very circumstances also tend to intensify the griever's emotional reactions to the loss – anger, guilt, and powerlessness (Kauffman, 2002).

    Self-disenfranchised grief. Also recognized in the literature is the concept of self-initiated disenfranchised grief. Kauffman (1989) described self-initiated disenfranchised grief as "not necessarily societal, but may arise from within oneself . . . the source is one's own lack of acknowledgment and recognition of it due to one's shame of his or her feelings" (p. 70). Guilt and shame are at the core of this form of disenfranchised grief (Attig, 2004; Kauffman, 2002). Doka (2002) expanded the idea that self is always intricately involved in disenfranchised grief and stated, "if it were not, grief could never truly be disenfranchised" (p. 72). Yet, it is essential to distinguish that any griever who *chooses* not to disclose aspects of his or her grief in the absence of shame, or *chooses* not to socially acknowledge his or her grief, is not experiencing disenfranchised grief. Moreover, those individuals willing to disclose their grief may have all or parts of their grief go overlooked by society or a particular group (Moules, 1998). This has been noted in several studies examining therapeutic *blind spots* that therapists have, placing themselves above their own, personal pain (Barnett, Baker, Elman, & Schoener, 2007; Callahan & Dittloff, 2007; Mahoney, 1997; McCrady, 1989).

    Doka (2002) described how disenfranchised grief, whether the loss of a close friend or domestic partner, the loss of a dearly loved pet, the loss of an aborted or miscarried child, or the multiple losses that have gone unacknowledged in a person's life, can contribute to any chronic or complicated grief (Holland, Neimeyer, Boelen, & Prigerson, 2009). Although there is overlap with the concept of complicated grief,

disenfranchised grief differs in that it stems from the often unspoken "grieving rules" (Kalsich & Brabant, 2006, p. 227) that a society holds. These unspoken rules make it more difficult for the person to adequately mourn the loss and reconstruct meaning afterward.

Similar to the grieving rules of "many societies that require the religious leaders of a community to be responsible for the grief of the community, mental health counselors often are held responsible for the grief of a specific mental health facility or community" (Helsel, 2008, p. 338). This burden can have a number of negative consequences, such as the counselor's experience as the last to grieve; or the community may imagine that grief is unnecessary for the counselor at all (Lenhardt, 1997b; Zimpfer, 1991). Counselors who are exposed to situations of frequent loss experienced by others often neglect to grieve and may respond to the loss without even knowing signs of their own grief (Barnett et al., 2007; O'Halloran & Linton, 2000). This form of neglecting the need to grieve can eventually crystallize into various forms of burnout in the life of the counselor and can lead to the avoidance of certain therapeutic as well as personal situations which might prompt undesired feelings, resolving into a form of frozen grief or grief swallowing (Boss, 1999; Grosch & Olsen, 1994; Lenhardt, 1997a; Rubington, 1984).

Although loss and accompanying grief have been issues of concern for health care providers in multiple settings, including mental health (Zimpfer, 1991; Zupanick, 1994), in past decades, studies have been done that reflect society's increasing concern for the experience of disenfranchised grief (Corr, 1998; Doka, 2002). Although previous researchers (Elman, 1997; O'Halloran & Linton, 2000; Wallace, Lee, & Lee, 2010)

examined interest in disenfranchised grief in various helping professions, that interest has not been extended to the study of disenfranchised grief in substance abuse counselors. Most professional understandings of stress and grief with substance abuse counselors refer to burnout or compassion fatigue, rather than grief explicitly (Barnett et al., 2007). This lack of understanding of substance abuse counselors' experiences of disenfranchised grief disrupts their ability to exercise significant self-care and effectively deliver mental health services to those suffering from addictions (Niemeier & Burnett, 2001).

   Disenfranchised grief in the substance abuse field. In health care, where loss is a daily event both for patients and for caregivers, disenfranchised grief is an understudied phenomenon (Papadatou, 2000). In the mental health care field, most professional considerations of stress and grief in the workplace typically refer to burnout or compassion fatigue, rather than grief explicitly.

   Spidell et al. (2011) examined health care chaplains' responses to grief, and found the recurring themes of "non-recognition of their losses by society, lack of support, isolation that the bereaved feel but cannot express, and social unacceptability of the situation in which the person being mourned had died (example, capital punishment)" p. 76). Spidell et al. highlighted the presence of disenfranchised grief in health care, where caregivers, including chaplains, experienced loss as a part of their profession. Spidell et al. noted that those they interviewed described feeling their grief as frequently overlooked and ignored.

   Similarly, substance abuse counselors, along with other mental health professionals, face the experience of their own loss as part of their profession (Neimeyer & Jordan, 2002). Rosenberg (2009) found that the disenfranchised grief of mental health

care professionals puts them at high risk for experiencing compassion fatigue and burnout. As early as 1978, Pines and Maslach found employees in the helping professions particularly vulnerable to the emotional and behavioral consequences of burnout and lower job satisfaction, which may be signs of a form of grief.

Recovery

The National Survey on Drug Use and Health (NSDUH) estimated that on average 20 million Americans aged 12 or older had used an illegal drug in the past 30 days (Center for Behavioral Health Statistics and Quality, 2015). This estimate represents 8% of the population aged 12 years or older. Alcohol is the most commonly used addictive substance in the United States, with one in every 12 adults (17.6 million people) suffering from alcohol abuse or dependence. Several million more people engage in risky, binge drinking patterns that could lead to alcohol problems (SAMHSA, 2015).

Additionally, it is estimated that more than half of all adults have alcoholism or problem drinking in their families, and more than 7 million children live in a household where at least one parent is dependent on or has abused alcohol (SAMHSA, 2015). Substance abuse and addiction affects all aspects of a person's life. Long-term substance use can cause serious health complications and can damage emotional stability, finances, and career, and impact one's family, friends, and community (SAMHSA, 2015).

Over 23 million (or 10%) of Americans, ages 18 and older, consider themselves in recovery from addiction to alcohol and other drugs (SAMHSA, 2015). Recovery is a complex and dynamic process encompassing all the positive benefits to physical, mental and social health that can occur when people with an addiction to alcohol or drugs, or their family members, get the help they need.

The Betty Ford Institute Consensus Panel (2008) defined recovery as being composed of three parts - sobriety, personal health, and citizenship:

> Sobriety refers to abstinence from alcohol and all other non-prescribed drugs; personal health refers to an enhanced quality of health; and citizenship refers to living with regard and respect for others. (p. 222)

According to White (2007), recovery is the experience through which individuals, families, and communities impacted by alcoholism and addiction use both internal and external resources to voluntarily resolve problems, heal wounds, and develop a healthy and happy way of life. Galanter (2007) described recovery from addiction as being in-sync with the spiritual framework supported by Alcoholics Anonymous. These aspects of recovery are based on the substance-using individuals' own evaluations and perspectives; however, there remains no complete consensus on the definition of recovery even among those who practice it (Laudet, 2007; Laudet, Morgen, & White, 2006).

The original model for self-help as a group is Alcoholics Anonymous (AA), founded in 1935 by a New York stockbroker named Bill W. (William Griffith Wilson) and a physician from Akron, Ohio, named Dr. Bob (Robert Holbrook Smith) (White, 1998). It is estimated that over 2 million people worldwide attend more than 115,000 groups in over 170 countries (SAMHSA, 2015). AA has come to be known as a "12-step program" because its program for sobriety involves 12 suggested steps for the recovery experience. Members of these groups are of all races and religions, and all that is necessary to join is a desire to stop drinking (or using drugs) and to admit that one has a problem. Meetings are free and there are no membership requirements or dues (AA, 2001). Finally, active involvement in AA has consistently shown to improve a person's

chances of long-term recovery (Fiorentine & Hillhouse, 2000; Longabaugh, Wirtz, Zweben, & Stout, 1998; Project MATCH Research Group, 1998).

Substance abuse counseling field.

As early as the 1940s and largely due to a shortage of professional counselors at the time, many recovered alcoholics were trained to enter the field of addiction treatment as paraprofessionals (Aiken, Losciuto, AnnAusetts, & Brown, 1984; McGovern & Armstrong, 1987). These senior alcoholic-patients-as-counselors worked with the new patients with the hopes that their personal experiences would help, unlike that of a non-alcoholic counselor.

This practice of using recovered alcoholics and addicts, simply based on their experience, as professional helpers in the field of recovery, created a great deal of controversy and debate in the early 1960s (Culbreth, 2000; White, 2000). However, the debate did not last long, as this took place during the period of what is known historically as "the paraprofessional movement," where the Joint Commission for Mental Health and Illness called for the inclusion of indigenous community volunteers as paid service providers (Brown, 1993; Pattison, 1973).

The belief grew that the recovered alcoholic could be trained to enter the field of addiction treatment as a paraprofessional (Doukas & Cullen, 2010), a belief fostered by the shortage of professional counselors and the hope of rehabilitation for the addict. Reports dating back to 1944 illustrate that paraprofessional counselors were hired as staff and lent credibility to drug and alcohol rehabilitation programs. Acting as role models, they made rehabilitation more acceptable to suspicious clients and acted as resource

persons for other non-addicted staff (Aiken et al., 1984; Ball, Graff, & Sheehan, 1974; White, 2000).

The use of recovered people as professional helpers has continued over the past decades with these significant helpers filling a void within a stigmatized arena that in its inception attracted only a small number of professionals (Aiken et al., 1984; White, 2000). Notably, many of those who work in the substance abuse field "come in through the side door of their own recovery" (Culbreth & Cooper, 2008, p. 68). Yet, the conditions under which recovered people pursued their service roles have changed significantly.

Today, to pursue the role of a recovered professional, individuals must typically bring at least two years of their own sobriety before entering the work field and must continue to access sobriety-based support groups to sustain their own recovery process (Laudet, 2007; Laudet et al., 2006). In addition, they now must receive considerable education and training before they begin counseling others, and they typically practice as a part of an interdisciplinary team with access to clinical supervision (McGovern & Armstrong, 1987; White, 2000). These individuals work in a variety of settings such as outpatient or inpatient facilities, hospitals, treatment centers, or human services. Some work in counseling sessions for one person, and some work in sessions for a group of people (McLellan, 2002; McLellan, Chalk, & Bartlett, 2007).

Today a variety of professionals work in the substance abuse field including Licensed Professional Counselors, Licensed Social Workers, and Licensed Chemical Dependency Counselors (Mulvey, Hubbard, & Hayashi, 2003). These professionals and paraprofessionals provide substance abuse counseling services using specific principles,

methods, and procedures of the chemical dependency field. This includes immediate assistance for people who are struggling with addictions to drugs or alcohol, as well as assisting addicts and alcoholics in understanding their addictions, recognizing the problems caused by their chemical dependency, and assisting them in beginning and managing a life without substance use (McLellan et al., 2007; White, 2000).

In a typical session, counselors assist those struggling with addiction with talking about, understanding, and coping with their problems. These counselors are responsible for assessments, treatment, case management, consultation, referral, and psychosocial evaluations (Barber et al., 2006). They also provide, as needed, therapeutic interventions including crisis counseling to individuals, groups, and families (Wallace et al., 2010).

Substance abuse counselor.

Substance abuse treatment is a distinctive area within the field of counseling, and perhaps the most prominent facet of this specialty is the issue of recovering versus non-recovering counselors who practice in this area (Culbreth, 2000; Doyle, 1997; White, 2000). Positive contributions to the addiction field by recovered counselors regarding clinical effectiveness, knowledge, and style in comparison to non-recovered counselors have been substantiated (Ball et al., 1974; Brown, Jackson, & Bass, 1973; Shipko & Stout, 2002).

In a comparison study between non-recovered and recovered counselors, Dalali, Charuvastra, and Schleisinger (1976) found that recovered counselors tended to be less flexible in their therapeutic approach by virtue of being resistant to new learning; whereas Humphreys, Noke, and Moos (1996) found them to be overcommitted to one treatment modality due to a personal loyalty to the 12-step approach of AA. Lawson,

Petosa, and Peterson (1982) found recovered counselors operated from a limited frame of reference because they viewed their clients in terms of being addicted or not, a view that might lead to over-diagnosis of addiction.

In contrast, Shipko and Stout (2002) studied the personality characteristics of counselors who described themselves as recovered from addiction and those who did not, and discovered that those with more education scored as more tender-minded while those with less education scored as more tough-minded. Shipko and Stout found that those who had more than 16 years of education and a college degree were more abstract in their thinking, while those with fewer than 16 years of education were more concrete. However, for the most part, the two groups were similar. Shipko and Stout looked particularly at empathy, the ability to be nonjudgmental, and flexibility and they found no statistically significant difference between the recovering and non-recovering counselors. Finally, their results showed that 93% of counselors who were recovered endorsed the disease model of alcoholism compared to 67% of the non-recovered counselors.

Client-Counselor Relationship

The crucial nature of the therapeutic alliance between counselor and client is not a new idea. Despite nineteenth century medical model assumptions, the clients' internal experiences affect the client-counselor relationship (White, 1998). Theorists from humanistic (Rogers, 2000), feminist (Brown, 2001), and existential (May, 1989) camps have emphasized the significance of the therapists' mental health (Hays et al., 2007). Even cognitive-behavioral theorists, who tend to emphasize technical factors in therapy, recognize the importance of the person of the therapist in treatment (Ellis, 2003). The potential for attachment and relationship seems to correlate with the degree that the

counselors are invited into the person or family's life, the deepening of connection over time through shared self-revelations, and a sense that the counselor's intervention has contributed to the spiritual and emotional well-being of the patient (Ritter et al., 2002; Simpson, Joe, Rowan-Szal, & Greener, 1997).

This relationship, or therapeutic alliance, refers to the actual trust between the counselor or therapist and the client (Bordin, 1979). This relationship is a critical and necessary component of treatment, often cited as the most important aspect of a client's substance abuse treatment and subsequent recovery (Ritter et al., 2002).

Meier, Barrowclough, and Donmall (2005) conducted a comprehensive review of studies on the effect of the therapeutic alliance on addiction treatment. This review evaluated the therapeutic relationship on retention, engagement, and treatment outcomes for substance abuse clients. The authors found that early engagement of clients in their drug treatment programs predicted positive long-term sobriety, and that it was the client-counselors' relationship that promoted that engagement. Additionally, certain counselor characteristics were found to be strong predictors of engagement in treatment – such as trustworthiness, relatability, and genuineness. Duff and Bedi (2010) also found a positive relationship between the frequency of these same identified counselor characteristics and the strength of the positive therapeutic relationship.

Therapeutic relationships occur within a secure set of boundaries on which both client and therapist rely (Pope, 1991). Therapeutic boundaries stand particularly relevant with chemically dependent clients and their families. The restructuring of boundaries is crucial due to the common boundary violations found within alcoholic and drug-addicted families (Coleman & Colgan, 1986). Preli, Protinsky, and Cross (1990) found alcoholic

families showed disturbed interactional boundaries and that nonalcoholic families did not show the same level of structural dysfunction.

Moreover, Nielsen (1988) proposed that by the very nature of the therapeutic alliance and the background of the client, substance abuse counselors may be particularly vulnerable to professional boundary violations as they are often recovering themselves and/ or are products of chemically dependent families. These counselors may, themselves, have poor boundary functioning which could lead to boundary violations.

Additionally, recovered substance abuse counselors, are often placed in situations, such as 12-step meetings and recovery groups, which could result in the possibility of dual relationships. Dual relationships violate boundaries and compromise the therapeutic relationship (Pope, 2000) and can place both the client and the substance abuse counselor at risk. Blurred boundaries or over-involvement with clients may be a symptom of impairment and can lead to ethical violations, as well as overt harm to clients (Emerson & Markos, 1996). The over-involvement may or may not be sexual in nature, but it is a clear sign that the counselor has not met his or her personal needs appropriately, instead becoming enmeshed with clients. Signs of this over-involvement and possible counselor impairment may include becoming obsessed with a client, withdrawing from other clients and family, wishing that the case would terminate or other forms of professional boundary issues (Herlihy, 1996; Sheffield, 1998; Witmer & Young, 1996).

Counselor Impairment

The American Counseling Association (ACA) defined *impairment* as "a significantly diminished capacity to perform professional functions" (ACA Code of Ethics, 2014, p.20). The American Medical Association (AMA) (as cited in Stadler,

Willing, Eberhage, & Ward, 1988) stated an impaired mental health professional as one who has "the inability to deliver competent patient care resulting from alcoholism, chemical dependency or mental illness, including burnout or the sense of emotional depletion which comes from stress" (p. 258). Kottler and Hazler (1996) estimated that "6,000 counselors currently practicing in the United States . . . have some type of mental or emotional impairment" (p. 96).

When anyone, including a substance abuse counselor, experiences a devastating personal loss or trauma, an emotional instability may result. A divorce, a death in the family, destruction or loss of home, illness of a loved one, or relationship difficulty all fall within the traumas that can result in emotional instability (Deutsch, 1985; McCrady, 1989; Reamer, 1992; Thoreson et al., 1989), causing professional and personal impairment. Swearingen (1990) found the prevalence of depression in mental health professionals to be 60% to 90%. The basis of this study was self-reports with the prevalence and definitions left to the respondents. Deutsch (1985) found that 57% of 264 of mental health professional participants described themselves as depressed at some point in their lives, with the definition of depression also left to the respondent's interpretation. Emerson and Markos (1996) also found the percentage of mental health counselors who experience depression at one time or another as high.

With burnout being the single most common personal consequence of working as a professional counselor, it is not a question of who will experience it, rather how long will it be before the professional counselor develops burnout (Grosch & Olsen, 1994; Kilburg, Kaslow, & VandenBos, 1988). Adams, Boscarino, and Figley (2006) measured burnout and compassion fatigue in social workers working with traumatized clients. Even

after other risk factors were controlled, these two dimensions were related to psychological distress and contributed to these professionals finding it increasingly difficult to meet the emotional needs of their clients. Additionally, Pines and Maslach (1978) described burn-out and counseling impairment as "physical and emotional exhaustion, involving the development of negative self-concept, negative job attitudes, and loss of concern and feeling for clients" (p. 235).

While burnout is only one type of impairment suffered by counselors, there are others, such as depersonalization, over-involvement with clients, and abuse of alcohol or other drugs (Meiselman, 1990; Stadler et al., 1988; Witmer & Young, 1996). For instance, if a counselor responds to the client in a derogatory way or negates the client as a person, and instead treats the client as an object, depersonalization is occurring (Jenkins & Baird, 2002). Vredenburgh, Carlozzi, and Stein (1999) found depersonalization in psychiatrists to be positively correlated with emotional exhaustion. These researchers also found mental health providers who worked in managed health care settings with large case numbers, such as treatment facilities, experienced higher rates of depersonalization and emotional exhaustion. This coincides with the significant problem many substance abuse treatment agencies under managed care face with counselor well-being and counselors' decision to leave jobs, and the high rate of counselor turn over in substance abuse centers (Knudsen, Ducharme, & Roman, 2006; Knudsen, Johnson, & Roman, 2003).

The AMA describes abuse of alcohol or other drugs as a significant indication of health care professional impairment (Sheffield, 1998; Stadler et al., 1988). Behaviors that accompany problematic alcohol consumption include high rates of smoking, recurrent

physical illness, a greater percentage of divorce and relationship problems, increased feelings of depression and anxiety, and changes in eating patterns (Good, Thoreson, & Shaughnessy, 1995; Witmer & Young, 1996).

There is an alarming rate of relapse to drinking or drug use among recovering counselors who are working in the field of substance abuse treatment (Lawson, Venart, Hazler, & Kottler, 2007). In a 2009 survey, nearly 38% of substance abuse counselors surveyed in the United States admitted to relapsing during some point in their careers (Jones, Sells, & Rehfuss, 2009).

It is quite common in the substance abuse treatment field, that those treating individuals struggling with addiction, have a history of chemical abuse or dependency and are currently working as a recovering professional (Klutschkowski & Troth, 1995; McGovern & Armstrong, 1987). This characteristic is unique to the substance abuse counselor profession in comparison to other human service disciplines, such as social workers or mental health professionals, where there is no prevalence of professionals in their fields who have received services as a patient and then go on to provide those same services as a professional. Researchers estimate that of all substance abuse counselors, 30% - 50% are recovered (McGovern & Armstrong, 1987; Shipko & Stout, 2002).

According to Tzankow (2010), national and state-based credentialing boards have long debated over the adequate number of years of sobriety required for a counselor in recovery to be eligible for licensure or certification (Mustaine, West, & Wyrick, 2003). Though no board mandates a specific number of years of sobriety, many agencies and treatment facilities require one to two years of actual recovery with counselors obligated to sustain their recovery (Doukas & Cullen, 2013; Doyle, 1997; Tzankow, 2010).

Additionally, though trained to deal with these same presenting problems in their clients, mental health professionals outside of the field of substance abuse recovery receive little or no training in how to deal with their own stress and anxiety (Kilburg et al., 1988). Licensing boards across the country operate with the directive and intent to protect the public, but unless members of the profession are sensitive to symptoms of impairment in themselves and their colleagues, and are aware and willing to treat early signs, impairment can be expected to escalate (Grosh & Olsen, 1994).

The list of impairment symptoms is long, and strong evidence suggests that no counselor, in any environment, is immune to impairment. In fact, Grosh and Olsen (1994) suggested that the average counselor has a professional lifespan of about 10 years before burnout or impairment is experienced. Some counselors may be so immersed in their roles as helper and healer that they have trouble seeing their own problems, making them their own worst enemies (Emerson & Markos, 1996).

Finally, in addition to the possibilities of burnout or impairment associated with being in the counseling field, substance abuse counselors may be more at risk due to their work with a particularly emotionally demanding population (Elman & Dowd, 1997; Knudsen, Ducharme, & Roman, 2008). The population that they work with include chemically-dependent individuals who often deny and minimize their problems – defenses that are inherent in the disease (Knauert & Davidson, 1979; Valle, 1979), often arriving into the substance abuse counselor's care due to family, work, or legal pressures, rather than their own conscious desire for restored health.

Future of Substance Abuse Counselors

Substance abuse and behavioral disorder counselors, including chemical dependency counselors, occupied an estimated 91,200 positions in 2014, according to the U.S. Department of Labor's Bureau of Labor Statistics (2015). Additionally, experts agree that in the coming century there will be a larger need for more well-trained addiction counselors to meet a higher than average job growth rate in response to higher numbers of people being treated for addictions (U.S. Census, 2014). Consequently, for mental health providers who come into contact with those who experience substance use, abuse, and addictions, the need for comprehensive training is important (Smith, Whitaker, & Weismuller, 2006) as addiction continues to be a growing epidemic in society.

Furthermore, with a projected 31% employment growth rate by 2022 (U.S. Census, 2014), substance abuse and behavioral disorder counselor jobs are growing at a faster rate than many other occupations. One essential reason for the growth is that the Affordable Care Act obligates insurance providers to cover treatment for mental health issues (Buck, 2011; Koh & Sebelius, 2010). Now that Americans are required to have insurance that will cover these services, experts predict there will be an increase in the number of people seeking mental health counseling (Buck, 2011; Mechanic, 2012). Another factor is a modification in how the justice system deals with drug offenders. Rather than jail time, many offenders are receiving treatment-oriented sentences (Mitchell, Wilson, Eggers, & MacKenzie, 2012).

Moreover, there is concern that there will be a substantial increase in the numbers of baby boomers in the U.S. who will be needing treatment for substance abuse problems.

Using data from the National Household Survey on Drug Abuse (SAMHSA, 2015), the number of adults over the age of 50 in need of substance abuse treatment is estimated to increase from 1.7 million from 2000 and 2001, to 4.4 million in 2020. The aging baby boom cohort alone is estimated to place increasing demands on the substance abuse treatment system in the next two decades (Han, Gfroerer, Colliver, & Penne, 2009).

The Bureau of Labor and Statistics projects that over the coming decade, 28,200 new counselor positions will be needed to meet the new demand ([NAADAC], The National Association of Alcohol and Drug Abuse Counselors, 2014). Ritchie, Lewis, and Elam (2003) also found that many substance abuse workers come late to the field as a career change in their 30s and that over half are between the ages of 40 and 55.

Counselors are no more able to transcend culture than anyone else, but their training, degrees, and experience are of greater value when they learn to recognize how they, too, share in the world's woundedness (White, 2000; Zerubavel & Wright, 2012). The mental health professional's role can lead others, as well as themselves, to believe that they are above personal pain (Callahan & Ditloff, 2007; O'Brien, 2011). The mental health professional needs to be cautious and not buy into this idea, thereby losing sight of the professional's own needs. As Barnett et al. (2007) stated,

> As individuals trained to attend to others' emotional states and difficulties, those of us (in the mental health profession) are at increased risk for overlooking or ignoring our own emotional needs and reactions. By virtue of our personal predispositions and professional training to be caregivers, many of us may have a professional blind spot and fail to focus on our own needs, issues, and concerns. (p. 605)

Not recognized or acknowledged, the loss of a patient/client, whether it be through death, relapse, suicide, incarceration, or even discharging from one's care, can have a profound effect on counselors in the form of disenfranchised or self-disenfranchised grief (Kauffman, 2002; Neimeyer & Jordan, 2002). While these effects may be lingering and show up in the forms of attitudes and sensitivities, a counselor's wounds can be a useful source of intervention with clients if they are explored and appropriately processed (O'Brien, 2011). Conversely, a counselor's personal undiscovered and unresolved grief can impede client progress with client's own issues, including grief (Hays et al., 2007).

How grief is experienced is critical for the resilience of the substance abuse counselors who come in contact with stories of experiences of loss and grief from their clients (Emerson & Markos, 1996), as these stories of loss may activate the substance abuse counselor's own unprocessed grief. Helsel (2008) posed this possible dilemma for those "in situations of loss who often neglect to or do not even know the signs of their own grief" (p. 338). Without recognition of grief triggers or the potential presence of disenfranchised grief, losses can transform into other emotions such as anger, anxiety, blame, helplessness, and guilt (Hays et al., 2007). These emotions can come on without warning and may be reactionary in nature (Bonanno, 2004; Bonanno & Kaltman, 2001). Reactions expressed as the result of chronic or delayed grief can lead to compassion fatigue or burnout (Adams et al., 2006; Corr, 1998.). In worst case scenarios, compassion fatigue can potentially fail to come to a satisfactory conclusion which may result in distressful physical, emotional, behavioral, cognitive and interpersonal effects (Adams et al., 2006; Figley, 2002; Kirk-Brown & Wallace, 2004; Salston & Figley, 2003). Although

these studies examined compassion fatigue or burnout in mental health care professionals, and other studies examined the relevance of substance abuse counselors' own recovery from substance abuse (Culbreth, 2000; Doukas & Cullen, 2010; Hecksher, 2007; Shipko & Stout, 2002; White, 2008), no research studies have been designed to study disenfranchised grief in substance abuse counselors.

Counselors must be cautious not to absorb the belief that they can handle all situations and be impervious to pain. Barnett et al. (2007) stated, "By virtue of their personal predispositions and professional training to be caregivers, many counselors have a professional blind spot and fail to focus on their own needs, issues, and concerns" (p. 605). Not doing so can lead to professional burnout and impairment.

Summary

In a survey study of disenfranchised grief in health care chaplains, Spidell et al. (2011) found recurring themes amongst the chaplains, which included non-recognition of the chaplain's sense of loss by society, lack of support, isolation that the chaplain felt but was unable to express, and cases of social unacceptability of the situation in which the person being grieved, had died. This study highlighted the widespread presence of disenfranchised grief in the helping professions, such as counseling. Previous studies on disenfranchised grief looked at other helping professions, such nurses and doctors who work amongst tangible loss on a daily basis (Anderson & Gaugler, 2006). There was no literature on the substance abuse counselors' experience with disenfranchised grief. Without an understanding of the losses experienced and the disenfranchisement of substance abuse counselors' grief, they may unknowingly and unwillingly contribute to the invalidation of their own feelings and experiences, as well as those of their substance

abuse clients (O'Brien, 2011). These counselors may self-diagnose or be diagnosed with

burnout, depression, anxiety or stress disorders (Emerson & Markos, 1996). Therefore, in

order to avoid pathologizing their reactions unnecessarily, mental health professionals

need more in-depth knowledge and understanding of grief. In order to bring more

awareness and clarity to substance abuse counselor's feelings of loss and grief after

losses associated with client care.

Heuristic Phenomenological methodology was utilized to glean an understanding

of substance abuse counselors' experience of disenfranchised grief in the work place.

CHAPTER III

METHODOLOGY

Many of the most significant and exciting life events and extraordinary
experiences – moments of clarity, illumination, and healing –
have been systematically excluded from conventional research.
Braud & Anderson, 1998, p. 3.

To explore the phenomena of recovering substance abuse counselors' experience with disenfranchised grief, Heuristic phenomenological method was used. Heuristic phenomenology permits and supports the researcher's investigation into lived experiences of people as they perceive it (Grbich, 2012), while encompassing intuitive and innovative approaches (Patton, 1999). The benefit of using this approach differs from almost every other science in that "heuristic phenomenology attempts to gain insight descriptions of the way we *experience* the world" [emphasis added] (Van Manen, 2015, p. 15).

Heuristic phenomenology helped to illuminate the understanding of disenfranchised grief for recovering substance abuse counselors, allowing for an understanding of each participant's experience. Listening to the stories of the substance abuse counselors' losses helped to create a safe space to uncover grief otherwise hidden. For this process, this researcher kept an open and unlimited stance so that themes could be revealed, free of personal and predetermined understanding of the phenomenon, thus creating more direct connections with their experiences.

This study aimed to illuminate the experience of substance abuse counselors' disenfranchised grief. This study sought increased clarity of the phenomenon of disenfranchisement from substance abuse counselors' experiences and how this

42

disenfranchisement could hinder their healing, self-care, self-actualization, their own recovery from addiction, and their clients' recovery.

By drawing forth increased clarity about the lived experiences of a recovering substance abuse counselors who have experienced loss and grief due to the nature of their work, this study permitted an exploration of a deeply human experience. Phenomenological methodology is rooted in "what it means to be human" and captures the manner in which meaning is shaped by "sociocultural and the historical traditions which have given meaning to our ways of being in the world" (Van Manen, 1984, p. 38). Use of this phenomenological research allowed for a broader understanding of what recovering substance abuse counselors may experience while grieving the various losses associated with their selected work field, and how this experience may shape their self-hood as a substance abuse counselor and a person in recovery.

Research Design

The research design utilized for this study was created in the tradition of the phenomenological theory of heuristic research. Heuristic research encourages connectedness and relatedness rather than researcher detachment. A process such as this is guided by the belief that "knowledge grows out of direct human experience and can be discovered and explicated initially through *self-inquiry"* [emphasis added] (Moustakas, 1990, p. 17). This design promotes a shared endeavor among the researcher and the participants in discovering knowledge about the phenomenon (Moustakas, 1990). The method recommends a personal calling to the topic of interest in what is defined as "a process of *internal search* through which one discovers the nature and meaning of experience and develops methods and procedures for further investigation and analysis"

[emphasis added] (Moustakas, 1990, p. 9). The *self of the researcher* exists throughout the development and, "while understanding the phenomenon with increasing depth, the *researcher also experiences growing self-awareness and self-knowledge*" [emphasis added] (p. 9).

Moreover, from the beginning, and throughout an investigation, heuristic research involves *self-search*, *self-dialogue*, and *self-discovery*,

the research question and the methodology flow out of inner awareness, meaning, and inspiration. When considering an issue, problem, or question, one must enter into it fully … challenge, confront, or even doubt one's own understanding of a human concern or issue; but when persistence in a disciplined and devoted way, ultimately knowledge of the phenomenon will deepen, and discovery will reveal connections with others. (Moustakas, 1990, p. 14)

In heuristic research, it is necessary that the investigator have had a direct, *personal encounter* [emphasis added] with the phenomenon being investigated.

The shared effort of researcher and participant speaks strongly to me due to my experience with the loss that the research explores. I have personal experience of loss and grief through my work as a substance abuse counselor, and I am in recovery.

The discovery of essential themes and experiences that are part of my research questions was possible only with another key heuristic dimension- the *tactic knowing*. "In heuristic research, the investigator must have had a direct, *personal encounter* with the phenomenon being investigated. There must have been actual auto-biographical connections" [emphasis added] (Moustakas, 1990, p. 14), which stands behind every heuristic discovery. The understanding that one knows more than one can describe with

words allows for the tactic knowledge of the parts and the whole of a phenomenon (Moustakas, 1990; Polanyi, 1966/1983). Tacit knowledge guided my inquiry throughout the process of self-inquiry and conducting interviews.

The link between the tacit dimension and the explicit knowledge is *intuition,* because it allows for understanding of the essential to the new discovery of inquiry, according to Moustakas (1990). This intuition directed my query in discerning the deeper meaning of the phenomenon in question by identifying traits, repetitions, and meanings within the experiences.

Additional significant heuristic methods I depended on during my research were those of *indwelling*, *focusing,* and *relying* on an internal frame of reference. Moustakas (1990) described indwelling as an essential process for heuristic inquiry as it acknowledges a conscious inward observation into the studied phenomenon. Indwelling is closely linked to focusing which is presented as "an inner attention, a staying with, a sustained process of systematically contacting the more central meaning of an experience" (Moustakas, 1990, p. 25). Focusing permits the researcher to eliminate clutter from findings and experiences and to gain awareness of his or her experience of the phenomenon (Moustakas, 1990).

Merging all processes and principles of heuristic research is the internal frame of reference which guides the understanding of the meaning and essences of the studied experience. Heuristic research prominently depends on the internal frame of reference of the participants and also of the researchers, who uses their own experiences and internal frames of reference to generate connectedness with participants and their distinctive stories. The methodology necessitates awareness about one's experience as a conduit to

self-reflection. This process develops personal growth and understanding along with the heuristic discovery of aspects of the illuminated phenomenon (Willis, 2004).

Procedures

Before the research process began, the Institutional Review Board (IRB) reviewed whether this study posed physical or mental harm to participants and determined the level of risk of such harm. St. Mary's University policy requires that any doctoral student who executes any study must first be trained and certified to submit research proposals to the University's IRB. Because this study posed minimum risk to participants, the researcher requested an expedited review by the IRB, which was approved (Appendix A).

Upon receipt of IRB approval, the researcher began recruitment via purposeful sampling. Purposeful sampling is notable for use in qualitative studies because it allows the researcher to invite only those who have had similar experiences to the study (Suri, 2011). According to Ritchie and Lewis (2003), the goals of purposeful sampling are

to ensure that all the key constituencies of relevance to the subject matter are covered . . . and, while paying attention to that within each of the key criteria, some diversity is included so that the impact of the phenomenon can be explored. (p. 79)

Participants

An invitation letter was posted to various mental health and substance abuse counselor's social media websites (Appendix B). These websites included the San Antonio Counseling Facebook page and the Licensed Dependency Counselors Network Facebook page. The invitation was distributed via a link to a Qualtrics demographic survey (Appendix C). Snowball sampling was also used so that qualified participants were invited to share information about the study with colleagues who they felt might be

eligible for inclusion. Snowball sampling is a form of intentional sampling that continues after initial participants are identified, and the participants can recommend others suitable to participate in the study (Creswell, 2012).

The Qualtrics demographic survey provided participants with informed consent information, as well as questions which served as a screening to identify qualified participants who met the criteria for inclusion in the study sample.

To qualify for inclusion in the study, the prospective participants had to meet the following criteria:

1. Read and agree to the conditions of the informed consent;

2. Be a licensed member of the mental health field: Licensed Chemical Dependency Counselors, Licensed Professional Counselors, and Licensed Social Workers, all of whom are fully qualified to work with the substance abuse population based on full-licensure (no interns);

3. Have at least two years of continuous sobriety, based on ethical recommendations gathered through the literature, (Dodge, Krantz, & Kenny, 2010);

4. Have two years or more work experience with the Substance Abuse population; and,

5. Self-identify with the examples given that described incidents of work-related disenfranchised grief.

The Informed Consent (Appendix C) form detailed an overview of the study, risks, and benefits of participating in the study, contact information, faculty advisor information, St. Mary's University Department of Counseling and Human Services

information, and Internal Review Board at St. Mary's University information. Qualified participants were contacted at provided contact information only. No prospective participants were considered members of a vulnerable population. No compensation was offered to participants in this study. Consistent with Holt and Tamminens' approach (2010), participants were selected based on their responses to the demographic survey with yielded answers describing their predetermined qualifications.

The researcher contacted 12 qualifying participants to answer any questions about the study, review expectations and set up a time and a date for the initial face-to-face interview. At the time of initial contacts, two of the 12 qualifying participants opted out of the study for personal reasons.

Once the researcher and participant agreed on the day and time of the initial meeting, the researcher discussed how confidentiality was to be kept and explained in detail how the interview was to be recorded.

Protection of Confidential Data

All interviews were recorded using a digital audio recording to ensure all the information from the interview was preserved for later analysis and transcription. The audio recording, notes and electronic copies of the transcriptions were maintained by the primary investigator at her residence behind two locks on an encrypted USB drive where each electronic file was also passcode protected. Once the study was completed, the audio recordings were destroyed, and paper copies of the transcription were destroyed. The electronic version of the transcriptions will be kept on the encrypted, passcode-protected USB drive for further analysis, research purposes, and publication.

Interviews

A crucial component of qualitative research is the actual interviewing of participants. Corbin and Strauss (2008) stated that "the most data dense interviews are those that are unstructured: that is, they are not dictated by any predetermined set of questions" (p. 27). For heuristic investigations, this extended interview "often takes the form of dialogues with oneself and one's research participants" (Moustakas, 1990, p. 46). While relying on an unprompted conversation based on the initial questions, the researcher was able to participate in a natural, unfolding dialogue with the participant. The participants were asked to give their experiences not guided by the clock, but following "their inner experiential clock" as described by Moustakas (1990, p. 46).

Upon their requests, eight participants were interviewed in their offices, and two were interviewed in their homes. Four of the ten participants were interviewed twice. The familiarity of the setting appeared to contribute to a safe space for participants to share openly and decreased the possibility of anxiety about the recording of our conversations or the content of the interviews. On average, the interviews lasted between one to two hours. The second interviews were generally under one hour.

These interviews began with the primary questions of interest:

1. How do you experience loss in your work as a substance abuse counselor?

2. How do you find and receive support for these losses?

Follow-up questions resulting from the dialogue, which were also found in the literature review included:

1. Have you ever felt that if you exercised your grief over a client's death, relapse, or other cause for seeking support, it would be an interference of your professional role?

2. Have you ever felt that circumstances around the death of a previous client, regardless of the cause (e.g., overdose, suicide) made your grief feel more or less legitimate?

3. Have you ever felt that you were not able to adequately express acknowledgment of the loss of a client?

4. To what degree do substance abuse counselors find their support effective in helping them to deal with their grief and their client's grief?

For interviewing purposes, "dialogue is the preferred interview approach in that it aims toward encouraging expression" (Moustakas, 1990, p. 47). Dialogue attempted to avoid direct questions and answers that only met the researcher's expectations and understanding of the topic and allowed for the natural exploration of the topic. Dialogue also allowed the participants to be partners in the study as opposed to being passive, studied subjects. Even though I began with preliminary questions of interest, I left the dialogue as unplanned and unmanaged as possible, thereby relying heavily on my intuition and self-awareness during the process.

Field Journal

A significant component of data collection for heuristic inquiry is researcher observation. Observations of one's internal thoughts, reactions, and dialogue, as well as the external dialogue of the participants, were worth noting and recording in a Field Journal. External participant observations allowed the researcher to note nonverbal cues and provided another level of noting what the interviewee was describing. Corbin and Strauss (2008) suggested the researcher maintain all written data and transcriptions in a Field Journal.

Corbin and Strauss (2008) also recommended the researcher maintain field notes, memos, and diagrams in the Field Journal to record ongoing observations, methodological decisions, conceptual coding and categorization, and reflective thinking. Following this same protocol, the researcher also hand-wrote notes in the same field journal on personal reflections for use during both the *immersion* and *indwelling* stages of the process. Notes and memos in the Field Journal were logged using pseudonyms only, and no identifying participant information was used in the Field Journal.

The process of recording, transcribing, analyzing the interviews, and maintaining notes and memos created an audit trail documenting the evolving dialogue between the researcher and the data. During this process, the researcher wrote memos, made notes of observation, personal reactions, and any questions in an effort to note researcher reactions and parallel experiences with the participants. These experiences of identification and involvement with the participants are the essence of heuristic phenomenological research.

The transcription software *Dragon Naturally Speaking 12 Premium* and the Phillips-Digital Pocket Memo 9600 were used to record and transcribe the audio recordings. The Phillips DPM 9600 is HIPAA-compliant, has encryption capabilities, and PIN access.

The researcher organized the interview transcripts and field notes using the MAXQDA software. This provided organization and assistance in finding themes and allowed for quick referencing. At that point, broader category codes began to appear linking concepts together. Using MAXQDA, the researcher was then able to examine how frequently each concept, sub concept and sub-sub concept was mentioned and thereby identify those concepts that seemed more significant to participants due to rate of

mention (number of incidents), while collecting less significant or less frequently mentioned concepts beneath these as subheadings and sub-subheadings. It is noteworthy that the three themes were found to encompass 14 subthemes, and the 14 subthemes contained 15 sub-subthemes that further defined and refined each of those concepts.

Analysis of Data

I followed the six phases of heuristic inquiry as described by Moustakas (1990):

1. **Initial engagement** was the period of turning inward to identify any tacit knowledge about the topic and its personal and social significance for me. I contemplated possible research questions to enhance the illumination of disenfranchised grief of substance abuse counselors. My initial understanding of the phenomenon developed and evolved into a more composed and comprehensive view of the different experiences shared with me later by the participants.

2. **Complete immersion** of the researcher in the phenomenon. I used journaling and self-reflection to inform my initial understanding of the topic, to contemplate any possible changes in this understanding and to develop my understanding of the phenomenon. This phase included my personal inquiry, a thorough engagement with the research literature, and constructing and conducting the first interviews with the participants. The literature review broadly explored the substance abuse field and grief. The extensive literature review allowed for an in-depth understanding of the topic of interest, as well as helped me to

narrow my research interest and to find the appropriate language to use when describing the phenomenon.

After the recording of the initial interviews with my participants, I engaged in an incessant study of the recordings, playing them numerous times as I transcribed them. After transcribing, I read through the transcripts multiple times without trying to identify any repeating themes. During this process, I was able to tune into the participants' meanings and experiences of the phenomenon.

3. **Incubation** of my ideas and understanding of the phenomenon took place for approximately seven months following the interviews, transcription, and reading of the interviews. During this period, I resisted any active focus on the questions and trusted the tacit incubation of ideas and meanings. As Moustakas (1990) stated, "Incubation is a process in which a seed has been planted; the seed undergoes silent nourishment, support, and care that produces a creative awareness of some dimension of a phenomenon or creative integration of its parts or qualities" (p. 29). This concept of incubation motivated me to dedicate my time to my family and make multiple trips to the coast for relaxation. During this period, I was able to return to my internal process and pay attention to ways my understanding of the topic had changed with time, experience, and space. I continued my personal journaling during that time to aid mental clarity and create a map for my journey.

4. The **illumination** phase was the period in which individual narratives
   for each interviewed participant were composed. These narratives
   were based on the first interviews while using the lens of substance
   abuse counselor loss and disenfranchised grief. During this analysis, I
   narrowed my focus from the text as a whole to single statements the
   participants had made during the interviews. With the assistance of a
   professional coding system (MAXQDA II), I was able to identify
   concepts which assisted in the further construction of the individual
   representation of the phenomenon by using the participant's language
   and examples from their experiences of the phenomenon. Identifiable
   concepts that otherwise may not have been realized through the
   process of open-coding were identified, allowing further discovery of
   new meaning about the topic found in the narratives. During this
   phase, coding was vital in the interpretive process of "moving from the
   data to the idea, and from the idea to all the data pertaining to that
   idea" (Richards & Morse, 2007, p. 137). I discovered various themes
   of loss and disenfranchised grief for the substance abuse counselors
   emerging from the data.

   I then emailed the narratives to the corresponding participants and
   asked them to read the narratives a few times and notice any new
   feelings and suggest any corrections that they wanted to make to the
   texts, as well as schedule subsequent interviews with willing
   participants. After the second interviews, new data were collected, and

participants were able to reflect on those final narratives. All data were reviewed, and tapes listened to numerous times to allow for further immersion with the data. None of the participants made any changes to their individual narratives after both rounds of interviews were completed.

5. In the **explication** phase, the exploration for new levels of meaning, different characteristics of the phenomenon, and comparison of themes of the individual narratives to describe the experience of loss and disenfranchised grief related to their work with the substance abuse population takes place. For this phase, the essential requirement is "to attend to one's own awareness, feelings, thoughts, beliefs, and judgments as a prelude to the understanding that is derived from conversations and dialogues with others" (Moustakas, 1990, p.31). This phase entailed comparing narratives to the original data from the interviews, then to each other's narratives, and looking to the coding for further conceptualization on bits of data related to other data. This process might ultimately assist in the exposition of mutual themes as a representation of the experience of disenfranchised grief for the substance abuse counselor.

6. Finally, for the **creative synthesis** phase of this research, "intuition, imagination, and personal knowledge of meanings and essences of the experience" were applied (Moustakas, 1990, p. 50). According to Moustakas (1990), for this phase, the researcher relies on tacit

knowledge and intuition to reveal the essences of the phenomenon and the common themes that were earlier depicted in a creative synthesis. This process typically takes a narrative form; however, it "may be expressed as a poem, story, drawing, painting, or by some other creative form" (Moustakas, 1990, p. 32). I struggled greatly with this phase. As Moustakas' warned, I was anxious to leave my inquiry findings underdeveloped due to lack of confidence in my creativity and my self-doubt as a writer. With an open mind, I trusted that the process of heuristic inquiry would eventually lead me to this final phase in its right shape and form. After a period of writing the findings of the study, I meditated and reflected on my personal experiences of disenfranchised grief and the experience of witnessing and immersing myself with the participants' lived experience of their grief. I then, slowly, pieced together a poem to represent my journey of disenfranchised grief in my work as a substance abuse counselor. My wish was to express and tribute a personal description of the studied phenomenon (see Chapter V, Creative Synthesis).

Discussion of the Rigor of Heuristic Research

In qualitative studies, the researcher aims to maintain trustworthiness of the findings rather than referring to the validity and reliability used in quantitative research to assess rigor. As Moustakas (1990) inferred, "Since heuristic inquiry utilizes qualitative methodology in arriving at themes and essences of experience, validity in heuristics is not a quantitative measurement to be determined by correlations or statistics (p. 32). There

are numerous measurements for evaluating the trustworthiness of a qualitative study, as suggested by Schwandt, Lincoln, and Guba (2007). For this study, credibility was measured by the meanings generated by the narrative depictions of the experiences of the participants. After creating the narratives by using the raw data from the first interviews, I sought to establish worthy credibility by using a member-checking method of returning to the participants with the depicted essences of phenomena and eliciting their assessments of the accurateness and understanding of the developed themes. The continual use of a Field Diary and memoing my thoughts and feelings that emerged throughout the study, helped to represent some of my predetermined ideas and preconceptions about the studied phenomenon.

Finally, dependability was used to analyze trustworthiness throughout this process. Dependability was sought and demonstrated through the transparency of the process of analyzing the interviews and creating individual narratives, the composite depiction of the phenomenon and the representative portrait of the participants. It was also established by using quotes from the interviews to portray the themes and to create the rich description of the phenomenon.

Limitations

Limitations of this study included a small sample size of 10 participants and recruitment strategy. Snowball recruitment strategy provided the researcher with comparable respondents in backgrounds, which is demonstrated in the demographic characteristics of the sample. Consequently, this research is limited in the scope of experiences of recovered substance abuse counselors who come from richly diverse ethnic, cultural, and socio-economic backgrounds. The small sample size, while limited

in generalizability, did allow for detailed, in-depth descriptions of the lived experiences of respondents.

Van Manen (2015) contended that, despite efforts to uphold objectivity, the phenomenological interpretation of one's own and others' experiences is at all times subjective and prompted by the researcher's preconceived knowledge and understanding about the topic. Thus, a different researcher might have a distinctively different interpretation of the themes discovered (Van Manen, 2015). In an attempt to manage this limitation, I sustained transparency throughout the data analysis, kept memos, and kept a personal reflective diary on the steps I took during the interpretations of the respondents' narratives.

Role of Researcher

Moustakas' work (1990) encompassed my experience with heuristic phenomenology research and methodology, as it embraced my experience with the phenomenon of disenfranchised grief as it relates to my work as a substance abuse counselor in this excerpt:

> The heuristic research process is not one that can be hurried or timed by the clock or calendar. It demands the total presence, honesty, maturity, and integrity of a researcher who not only strongly desires to know and understand but is willing to commit endless hours of sustained immersion and focused concentration on one central question, to risk opening of wounds and passionate concerns, and to undergo the personal transformation that exists as a possibility in every heuristic journey. (Moustakas, 1990, p. 14)

Fittingly, I had looming questions about my own work-related disenfranchised grief experiences long before I began this research. As Romanyshyn (2010) stated: "Research with soul in mind is *re-search*, a searching again, for something that has already made its claim upon us, something we have already known, however dimly, but have forgotten" [emphasis added] (p. 276). Tacit knowledge about this kind of grief already lay dormant inside me, and I strained to find words to describe it. I recognized that my inquiry had begun before I read the first scholarly article on this topic, and, in some way, I had gone through most of the phases that Moustakas (1990) described as heuristic research before discerning their existence and order. There was no schedule, planning, or controlling the steps; instead, there was a release of control and the discovery of what each stage brought.

The process of inquiry brought up suppressed memories and feelings for me regarding my experiences as a substance abuse counselor. I engaged in vivid reminiscence of my "failed" clients and those losses that surrounded that perception of failure with the ears of my sponsor and fellow substance abuse counselors. I struggled with an understanding of what went on during my time as a full - time substance abuse counselor and the emotional difficulties that at times overwhelmed me when I learned of a relapse, the destruction of a family or the death of a previous client. I realized that my feelings were not related to "burn out" or "pessimism," trauma, or depression. For the first time, I put words to the tacit knowledge about those losses and of my feelings for these clients whose care had been entrusted to me. I then eventually came to understand that the objective characteristics of the losses - relapse or death - did not matter as much

to me as did the subjective experience of loss of self-image as a recovering substance abuse counselor.

I have experienced (and continue to encounter) dismissive attitudes toward my stories of losses through my work as a substance abuse counselor. These attitudes encouraged me to look for other substance abuse counselors with similar experiences and struggles. The empathy and encouragement I received have inspired me to bring more awareness to this topic. My curiosity moved me to read, learning more, and questioning the literature that presently exists on disenfranchised grief in the mental health and substance abuse fields. My professional interest in helping and supporting other substance abuse counselors who need to give this phenomenon a name inspired me to pursue this doctoral dissertation research topic.

My progress has been slow and inconsistent due to my deep resistance to moving through some painful experiences and memories. My grief and writing have followed the same pattern - the more I read about disenfranchised grief and the losses associated with the substance abuse population and treatment field, the more I recognized my grief as it rose inside of me. Because of this process, I slowed down my project multiple times in an attempt to avoid emotional flooding. Fortunately, participating in a flow of conversation with my therapist, peers, and mentors, I was provided the external and internal validation of my losses and my grieving experience. This validation brought healing from my most vivid experiences of loss which are associated with my role as a substance abuse counselor. Reconciliation with these experiences, and the feelings connected with the losses gave me renewed desire and motivation to continue my inquiry into this phenomenon to give other substance abuse counselors a voice and bring confirmation and

healing to their experiences. Additionally, it helped me sustain a level of objectivity that made it possible to avoid imposing my narrative on the stories of the research participants. Finalizing the findings of this doctoral research brought bitter-sweet closure and peace coming from the challenging path of understanding and validation that I received through this heuristic inquiry.

CHAPTER IV

RESEARCH FINDINGS

Using heuristic methodology as described in Moustakas' work (1990), the purpose of this study was to examine and present the experience of the phenomenon of disenfranchised grief of substance abuse counselors. The researcher presented the studied phenomenon through individual and composite depictions. The individual depictions presented in this chapter are a shorter version of the original individual narratives created and approved by the participants. For the purposes of presenting the rich and extensive data succinctly, the researcher presents the main themes of the studied phenomena in these individual depictions.

Sample Description and Individual Depictions

Ten (*N*=10) adult participants (four male, six female) took part in the study. All 10 participants reside and work in a southern region of the U.S. Four participants were licensed professional counselors (LPCs), three were licensed chemical dependency counselors (LCDCs), and three were licensed master social workers (LMSWs). The ages of participants ranged from mid-30s to late 60s, with a mean age range of 40 to 50 years. All participants self-identified: seven as White American, three as Hispanic American, and two as African American. Table 1 displays this demographic information for interviewees corresponding to their assigned pseudonyms, followed by their individual biographies and depictions of the work-related disenfranchised grief.

Table 1

Participants' Demographics

Participant	Age	Gender	Ethnicity	License	Years in Field	Years Sober
Dana	53	F	Hispanic	LCDC	14	14
Frank	50	M	Hispanic	LPC-S	12	17
Les	68	F	White	LCDC	16	21
Letty	66	F	White	LCDC	18	25
Dade	62	M	White	LPC	12	16
Pam	47	F	Black	LPC	8	11
Greg	54	M	White	LMSW	23	28
Rebba	41	F	White	LCDC	10	14
Allen	34	M	White	LMSW	6	8
Whitney	56	F	White	LMSW	15	28

Participants

Dana: "There's a power there (AA)."

Dana is a 53-year-old female LCDC with 14 years of recovery and 14 years in the substance abuse field. A contractor with the Child Protective Services Substance Abuse Division, Dana was interviewed in person in the privacy of her own office. Dana described many years of working with the substance abuse population and their legal issues. Her losses have included deaths of clients, relapses, clients' losing custody of their children, as well as losing their personal freedom due to their addictions.

Dana recognized that often her hopes and expectations for her clients have created a lot of her grief. In the population she works with, "the relapse is unbelievable. Most are just trying to get their kids back and will try to manipulate the system. They usually get

caught and the child(ren) suffer the most." Dana described seeing the effects of her clients' addictions on their children as,

> Something I never get used to. Every time I experience it, it's just like the first. My counter transference is unbelievable, because I went through the system with my children too, because of my previous addiction. It's no accident I do what I do with the population I work with.

Dana said that she "automatically compartmentalize(s)" her grief when working with her clients; otherwise, they might see her as vulnerable and unprofessional. She described working next door to another counselor, who has become a friend, and with whom she can process some of her grief and frustrations. Dana also described her involvement with Alcoholics Anonymous (AA), a source of support for dealing with the pain of working with addiction:

> Being in a room full of people who not only can relate with the emotions that I might be feeling but also the things that my clients might be going through is very healing; there's a power there. The only expectations are for honesty and the desire to not "pick up" (use). If I can't get it out there, then I'll usually journal and meet with my sponsor to go over my part of my dilemma. It's worked for 14 years.

Knowing her signs of work-related grief has been a "process." When she was new in the field, Dana described her own self-harm by allowing herself to "do too much." Dana admitted to wanting to be recognized, and therefore volunteered for additional hours at a hospital where she had previously worked. When fatigued, she would justify her actions with the self-message of "if I don't do it, nobody will." Dana recognizes this

thinking now as a "character defect" and stated that she "still struggle(s) with saying no."

Her symptoms have also presented as feeling "stressed," "sad," and questioning her

clinical abilities and performance. Dana is cognizant of the fact that though she knows

intellectually and through academia what to look for in others for signs of emotional

needs, she often looks at her own thinking and behaviors only after she has become

"highly uncomfortable." Dana is of the opinion that most mental health professionals she

has met who work in the field of substance abuse do the same. She believes it is an issue

that needs far more attention and discussion among educators, supervisors, colleagues,

and peers: "We need to name it. We need more support and to support one another

more."

Frank: "No one gave us permission to talk about it."

Frank is a 50-year-old male LPC and supervisor with 12 years in the substance

abuse field and 17 years of sobriety. Frank has his own private practice during the week

and works as a substance abuse counselor at a treatment center on the weekends. He was

interviewed in-person in the privacy of his office. Frank was very familiar with feeling

restricted in expressing grief at his work place since being in the field. While "no one

said it out loud, losses are not discussed." The "unspoken rule" has always been

"business as usual," and the expectation to "put it aside" as part of one's professionalism.

The losses that Frank described included the deaths of clients, clients' relapsing, clients'

being incarcerated, clients' not being given the opportunity to complete treatment

(usually insurance related), and losses pertaining to the client's families.

In hindsight, however, the losses that have stayed with Frank the strongest were

those heard second - hand and when no details could be found: "Did you hear about so-

and-so who died, or relapsed and lost everything, or got incarcerated?" Frank described these exchanges as "news flashes" that were never accompanied by "we need to talk about this;" instead, it was heard, internalized, and back to business. There might be some follow-up talk about it between colleagues, but there had never been any discussion on grief surrounding the losses. In particular, the death of a 17-year-old male that Frank had worked with

> reminded me so much of myself at that age. I didn't hear about his overdose for about six months and then found out accidentally from one of his friends at an alumni function. It shook me. I was pissed that no one had said anything to the staff at the treatment center I was working at.

In his personal self-care, Frank has avenues to process his grief:

> It took me awhile to figure out that I had a safe and supportive place to share how I was feeling and that was in my own recovery. My sponsor and the regular AA meetings that I attend allow and give me permission to feel and discuss those feelings, both present and old. I've gathered insight and awareness of who I am and who I'm dealing with in my work. Because sometimes I forget where I came from and how vulnerable I am. This disease is wicked-sneaky. It's the only disease that tells you that you don't have it.

Frank described his professional training as such that boundaries are to be learned and used for the protection of both client and counselor. He said that he feels there are a great deal of assumptions of what professionalism looks like, and "grieving the loss of another human being you have made a connection with should be the expectation, not the exception. It's not brought up and it needs to be."

Les: "My humanity comes through when I allow someone to see me grieve."

Les, a 68-year-old female with 21 years of sobriety, has worked with the substance abuse population for 16 years. Les holds a master's degree in addiction studies and carries multiple certifications and licensures. Les specializes in various forms of addiction (not only chemical) and trauma in her work. Our interview was in-person in the privacy of her office. Les described her experience of grief over the years as being "a direct result of my love and affection for my clients." She explained,

> I love these people at a different level. And I show it through my actions and I believe grief is a very important part of life. I think we experience it in our bodies and in our minds and in our souls. Like we experience everything. It becomes an experience. And it either becomes an experience of trauma or it becomes an experience that we can sort of 'shake off' in a way and not have it stick.

Les described relapse as "partially dying; during a relapse, there is always the risk of seizures, brain damage, liver damage, or some other bodily damage." The physical damage happens along with the emotional damage of those who have invested in the person's well-being, such as family, treatment staff, doctors, counselors, an employer, etc. "No one is immune to the relapse—whether they know it or not." She added,

> All that potential damage is definitely a loss and a death that the person has to come back to and grieve, and deal with. I've seen the grief over a relapse paralyze people. It's very baffling and very sad to watch.

In regard to the expression of her grief being considered unprofessional or a sign of weakness, Les said, "In my experience of almost 20 years of doing this, anytime I have ever shown my expression of grief publicly, it has been appreciated. I am just very

careful that the timing is appropriate." Les feels strongly that being in recovery is very helpful for her in dealing with her grief: "I didn't know how to express much of anything, much less sadness and grief."

Les described being active in a recovery program:

Being able to go to a meeting or simply walking into a room where people are like-minded has made a significant difference for me and my perception and experience of my emotions, including grief. Being a part of a group where people know me and can simply look at me and know where I am, is a major support system, as opposed to walking into a room full of people, like my family, that don't get it and where I would not be so open to express what I'm feeling or thinking.

Outside of AA, a close net of friends, and her own intense therapy, Les does not seek out other local resources for her self-care. Les described feeling "unfortunate" in that her experience has been that the therapists in her community do not offer to help each other, stating "there is a real disconnect in this community when it comes to supporting one another." Instead, she attends meetings regularly for AA and another 12-step program. She said she knows her own work-related grief can manifest itself physically. Les described getting "bronchitis," or

something in my lungs that lets me know that I need to lie down and rest. Or I get really weak in that area. Because my lungs are where I take life in and, when it becomes difficult for me, that's my body's cue to rest and take better care of myself.

For Les, a large part of her self-care involves her boundaries. She called boundaries her "catcher's net," particularly when working with the substance abuse population, which comes in with "high levels of denial and bruised ego":

> Otherwise, you can really hurt yourself with grief or other emotions that can affect the therapeutic process. If they are angry, for instance; if they don't like what you say, don't like your opinion or your behavior, you have to have a pretty strong boundary to be able to work through that and that's one of the things I've developed through the years that I didn't have before.

Les said she believes that her being in recovery is helpful when attempting to work through denial with clients who have weak senses of self and their addictions. Because she had been through a lot of it herself, she believes that addiction is a disease in the brain that can manifest in all kinds of ways, and that it almost has to be experienced before one can really get it at a deep level. She can strongly recall that moment in her early recovery when she realized just how sick she had been before she made the commitment to get well:

> Everything seemed so 'normal,' you know. I've learned that abuse can be normalized. And so, it was really normalized in my family and in my relationships. So I had to get in quite a lot of pain to realize that my life was pretty dysfunctional. And when I realized that, I really worked hard in the program to be better, working the Steps.

At the conclusion of the interview, Les stated that she believes substance abuse counselors should be in recovery, stating,

I don't think you can intellectualize this or read about it and understand how

people feel and some of the things that happen to people when they have an

addiction. It's a very hard disease to comprehend. And, if you don't have it or

have experienced some part of it, I don't think it's very effective for other people.

In fact, that's in the research, I believe. That, 'It takes one to know one.'

Letty: "Loss is a big part of this field."

Interviewed in the privacy of her own office, Letty is a 66-year-old female LDCD

and clinical supervisor at a prominent treatment facility. With 25 years of sobriety, Letty

has worked in the substance abuse field for 18 years. Letty described having understood,

early in her career, that death and loss are a big part of working in the substance abuse

field. In her experiences of grief with work, she stated that early on, following the losses

of patients who would die or relapse, she would think to herself, "Why am I not feeling

more about this? Shouldn't I feel something about this?" Her conclusion about this form

of detachment was that as she came to understand the complexity of the disease of

addiction, her acceptance of people's (patients) choices and outcomes had grown.

However, she said that after many years in the field, and upon recollection of her own

experienced losses, "I am often surprised by my emotions; I never know what the

reaction will be or when it may come." Yet she described these feelings as "less intense;

not as much anger. You never know who it's going to be; you're baffled; there's just no

way to tell."

Letty claimed that she feels supported in her current role as a supervising

counselor at the treatment facility where she has worked for several years, mainly by her

supervisor, who is a LMSW and also in recovery. Even though she feels supported in her

role, she does recognize that other counselors may not feel the same, mostly because the

topics of the counselors' experiences of loss and grief are not discussed. Rather, all

therapeutic discussion is centered on the patients.

> It is present and we recognize it as grief, but I don't believe it's something that we
>
> as professionals go like, "Well, we really need to talk about this because it's
>
> happening every time we come to work." Every time we come to work. Because
>
> someone going against medical advice is a loss. Someone who's been
>
> administratively discharged is a loss. Someone has taken a new job and they are
>
> leaving our therapeutic team. I mean, although it doesn't (voice trails off). It may
>
> not have the impact as somebody actually dying as a result of the disease, but the
>
> potential (voice trails off). It's a loss.

Letty is cognizant and forthcoming about her own history of dealing with issues

of loss and countertransference in her work and how "my need for self-care never takes a

break. As a counselor who is in AA, whatever had not been addressed in my own

recovery will come up in work with a patient":

> If I don't deal with it, I will be projecting it on to others. There would be all kinds
>
> of countertransference going on. Being an effective counselor would become
>
> impossible. Being in recovery and a substance abuse counselor is a double-edged
>
> sword. While I am able to understand on an emotional and psychological level
>
> what the people that I am working with are going through, I am also vulnerable to
>
> using my work as my recovery work and that's just not an option. Too many
>
> people have tried it and they relapse. Untreated, people can get very sick working

with this population. It's an incredibly difficult population, mostly because of so much denial.

Other than feeling supported by her immediate supervisor, Letty described her being in recovery as "what has taught me to reach out for help in any aspects of my life—not just some, but all areas."

Letty said she does not always see her signs of work-related grief and needs her sponsor, supervisor and others who can see what she is unable to see. This support system can point out what they are hearing and how they are seeing her behaviors and her emotional state. Letty's recovery has taught her that she needs accountability or she can become "a loose cannon. The pathology we deal with every day, there has to be a way to assimilate that. Offload that. Process that. So that I can stay present to what's going on in my life and take care of myself." For Letty, the fellowship of AA is a form of support for not only her recovery, but the whole foundation of her life, "bring(ing) that into every aspect of my life, which includes my work life."

Letty stated that she feels "very strongly about the need for there to be support and help for counselors in the field of substance abuse." She added that she was in a place where she felt "supported and encouraged and nurtured as a counselor and a human being," but was "certain that did not happen for so many counselors." The high turnover rate in the counseling field is an indication that there are needs not being met for this workforce. Letty suggested opportunities for improving support, such as "peer advocacy." She also pointed out that,

> In this state (Texas), if a person is a chemical dependency counselor and they relapse, they basically lose their license. And that doesn't happen with anybody

else's license. It doesn't happen to nurses. It doesn't happen to doctors. It doesn't happen to lawyers. Anyone that's licensed. And I think that needs to be translated into the chemical dependency field as well so that these counselors won't fear getting the help they need.

Dade: "Let's have a moment of silence."

Dade is a 62-year-old male LMSW with 16 years of sobriety and 12 years of working in the substance abuse field. Working as a full-time weekend counselor for a treatment facility, Dade interviewed in-person in the privacy of his office. When asked about his experiences of loss associated with his current profession, Dade grimaced and stated, "substance abuse counselors certainly aren't exempt from experiencing loss like anyone else and going through the same grief process that everyone goes through. In fact, we experience and see a lot of loss with this population of clients." Losses for Dade included death, relapse and damage to patients' health, as well as the ripple effect on the family. Also included was loss of job and when colleague(s) leave. Dade described the intensity of the working relationships between client and counselor as well as between counselor and counselor as being much greater in this field than in other areas of mental health that he has worked in.

As far as a set forum for processing and support for work-related loss, Dade stated,

> [I] can't recall it ever happening; maybe some discussion between the counselors, but nothing formal or structured was offered or promoted. Most of what we learned of the losses was after the fact; there was little we were allowed to do as

far as reaching out to the family because of HIPPA rules. If they contact(ed) us, that was one thing. But we were not allowed to contact them.

Of significance to Dade was an instance when one of his previous patients had made it through treatment, had begun integrating into the community of recovery, living in a local half-way house, and becoming very active with recovery. Dade was leaving that half-way house one night after a meeting and found that patient in the parking lot, dead from a heart attack. While not relapse-related, the death was significant for Dade due to watching this young man work his way back to sanity and health, to finding him lifeless and alone in a parking lot, as described in the following:

> There was not one mention of this guy's death at the facility that I had worked with him at; but there was a lot of AA community support, because he was heavily involved in the local 12-step groups and a regular and dependable presence at the meetings. And so, you know, we had a memorial service that was well attended for him. Yeah. It wasn't any kind of official, you know, support. But that's where most of my support came from, nonetheless.

Dade described having seen what he called "healthy working environments," where the staff supported one another when losses or tragedy happened. He has also seen those environments where "it's just kind of ignored. You know, that's part of the job (long pause)… it comes with the territory. Not even a moment of silence."

While not certain that he could identify only those signs of work-related grief, Dade described knowing his unprocessed emotions, whether from grief or stress, have shown up in physical symptoms:

I get just exhausted. I mean, I just couldn't do anything. I was at a point in one job

that I had to where I got to the gate and I couldn't remember my code to get

inside. Thought, 'that's odd,' you know. Called in and got inside the facility.

Went up to my computer and couldn't remember how to get on the computer.

Thought I was having a stroke. I really began paying better attention to my self-

care after that. While it certainly did not come out of nowhere, I had really

ignored my fatigue—both mentally and emotionally. I restructured my self-care

after that; did more meetings, meditation and personal inventory.

Pam: "It was just supposed to be business as usual."

Pam, a 47-year-old, female, LCDC with a master's degree in addictions studies,

has 11 years of sobriety and has worked with the substance abuse population for

approximately eight years, interviewed in-person in the privacy of her office. Pam

described her substance abuse field counseling losses as "death of a patient, maybe loss

of a job, loss of friends." She associated the losses with the reality of becoming

"attached" to her patients and co-workers. She added, specifically, when patients leave

treatment,

even when it's a regular discharge, because I've helped to take care of them and

nurse them emotionally, as a caregiver . . . I miss them sometimes. Then there are

those that I don't want to leave, because I really believe they'll drink again or use

again.

Pam described her frustration and hurt at hearing about her patients' relapses or

deaths second hand. She said she feels as though a lot of work and time is invested

between counselor and patient, and for her there is a sadness and a feeling of guilt:

"Could I have done something different or better?" These thoughts have crossed her mind, yet she said that she "would not talk about them openly." When asked how she processes her feelings around these losses, she replied:

> I go to therapy. I've talked to one or two co-workers, friends, some family. Honestly, I just kind of work through it. You know. I understand that I have no control over anybody. And that's one of the biggest things that I have to remember. That, being a counselor, I can only do so much. Still, it's sad. It hurts.

Pam described one incident in particular, when a suicide occurred at the facility where she was working. She described the handling of the trauma and loss as "very matter of fact." While everyone, including herself, was offered the services of EAP counseling, most did not utilize the services. Pam stated that she continued to feel the following:

> anger, because of the way they didn't handled the situation. And that part, I had no control over. It made me feel less because I didn't have control over that. After that incident, I kept more to myself. I just kind of secluded in my office, working with clients, when I was there.

When asked about recognizing the signs of her own work-related grief, Pam described "wanting to isolate; getting angry real easily; less tolerant and much more judgmental of everyone (patients, colleagues, friends, family), not looking forward to work, crying easily, not sleeping well."

While Pam is in recovery herself, she described minimal use of the program, meetings, working the steps, etc. Instead, she utilizes her own therapist, is active in her

church and takes advantage of plenty of "personal downtime, including getting my nails done, hot baths, messages—things like that. 'Me' time."

Greg: "It just kind of hits you when it hits you."

Greg, a 53-year-old male, LMSW, and clinical supervisor for the in-patient substance abuse department in a large psychiatric hospital, interviewed in person in the privacy of his office. Greg described being affiliated with the substance field for approximately 23 years and being in recovery for 28 years. Recounting multiple experiences over his long career of loss around the area of addiction, both in his work and at a personal level, Greg felt that he has been fortunate in that he has had opportunities to discuss and process those losses. He described "very seldom feeling like it was not okay to say something about an incident to my co-workers. But I'm sure it's happened, depending on the situation."

His processing and acknowledgment has been with staff and with his recovery community. He stated, however, that with the increase of more focus on liability in the work environment, there has been a decrease in the support. In fact,

Particularly in hospitals, they do these things called RCAs (Root Cause Analysis), that are supposed to be like support, and non-accusatory, but can wind up being more of a witch hunt. After several suicides in a row, we got asked how we were doing and if we needed any other support or anything like that. But that was it.

It's different than it used to be, but I still feel like, overall, I will find the support that I need. I've been at the tail end of too many overdoses, suicides, accidental deaths and stuff like that. Most people that I've worked with want to believe, 'It's going to be okay and I really don't need any help.'

Crediting his educational and supervisory background, Greg said he believes that it might be his awareness of the "kinds of transference and countertransference stuff that goes on; sometimes it just hits you when it hits you," giving him the insight to know when he needs to give himself and any work-related symptoms of grief attention. Institutionally, however, he said he does not see it as being encouraged or getting the attention that it deserves before there is an issue with burn out or symptoms of unresolved feelings begin to show in other areas. Greg said he suspects that the hospital administration might have different ideas than clinical supervisors of how work-related losses should be handled.

Greg reported feeling that as a clinician who is also in recovery, there is "disarming" of his patients. However, whether in recovery themselves or not, he said he sees therapists "become incredibly judgmental, and incredibly impatient." When he starts to feel this way toward his patients and his work, Greg said he will spend more time at both AA and Al-Anon meetings and do more service work to "help me remember. I always want to keep my own recovery at the forefront of my reason for being in this field."

Rebba: "I would never tell a patient not to express their grief."

A 41-year-old female LCDC with 14 years of sobriety, Rebba has worked in the substance abuse treatment field for 11 years. Currently working at a treatment facility in the Texas hill country, Rebba was interviewed in-person and in the privacy of her office. Rebba described the most consciously felt losses from her work with the substance abuse population as having patients leave treatment in a good place, with hope, a plan and optimism, and then hearing within a short amount of time that they have "passed away."

Rebba said,

> If you were their counselor or case manager and had a lot of contact with them
> while they were in treatment, there is a real feeling of sadness and
> disappointment. At times I've even had some anger and some guilt, like I could
> have done more. I could have recommended that they have more time in care
> before they were back out there on their own.

In addition, Rebba described the "more subtle losses," like hearing that a patient or client has relapsed and the family reports their helplessness and grief over it. She said there is a sadness and feeling of loss at the knowledge that the patient is not living life to the fullest.

Rebba described at length the loss of personal relationships with fellow employees, explaining the loss as being due to the intensity of the relationships formed because of the depth of the work being shared. As Rebba stated, "these are not very superficial relationships; we tend to be more in-depth with everyone we're in contact with. Just due to what we do for a living. It seems to come naturally."

Rebba described working in environments where the response to losses she noted was to "blow it off" or "detach," stating:

> I think there are certain peers in this field that I can go to and express my sorrow
> with. But there's been other peers in this field that when I express sorrow when
> someone passes away, they're just like, 'I'm used to it. You'll get used to it.
> You'll get over it. It happens all the time.' And that's always been disheartening
> to me. And I think so unhealthy and such bullshit. It makes me question them as a
> therapeutic professional.

Rebba believes anytime someone dies that the Employees Assistance Program (EAP) should immediately be made available for grief counseling. And while she has seen this offered on several occasions, "it is not the norm." Instead, there were "unspoken rules" when it comes to what is considered professional (appropriate) and unprofessional (inappropriate) emotional investment with patients. Rebba described a paradox for her, in that she needs to be invested in order to relate to her patients, yet able to stay detached. In her opinion, this is an impossible task.

While Rebba said she does not feel like any work environment has purposefully tried to keep a patient's death from the personnel, she claimed she has never been formally notified that one of her patients had died. Instead, she recalled one instance where she happened to be in the administration office and was speaking with someone in the records department, when she looked down at a pile of charts and saw the word DECEASED written across the record of one of her previous patients. After discovering this, she would look and see several charts a week in the pile with DECEASED written across them, and no word of the death had been given to any of the therapeutic staff. Her reaction: "I felt betrayed and I felt like this person's death was disregarded. It really affected me and I knew that if I said anything, it would be seen as unprofessional. So I didn't."

Rebba described feeling her "signs of grief" during this time of her career. She recalled her productivity level falling, experiencing feelings of "burn out," and found herself staying "detached" from her patients, keeping her relationship with them "more superficial; more about the process than painful issues. I prompted less feelings from them and staying more cerebral, more cognitive, instead of a balance of the two."

Rebba described her need, at that point, to become more involved with her own recovery in the AA community. Attendance at more meetings, working closely and staying in close contact with her sponsor and seeking her own private counseling to deal with her signs of grief and burn out constituted her support system. Rebba described having maintained this self-care since her intense experience around contemplating leaving the substance abuse field.

She has also since moved to work within a facility where she has formed relationships with other counselors who are also in recovery and with whom she works closely and can talk to about how she is feeling. Rebba said that in the field of substance abuse counseling, there needs to be a thorough look at means and ways of providing professional support, perhaps even mandated through legislation for this professional field:

> Counselors need to be able to express their grief (pause) and not have this stigma. We should be able to openly grieve at any time. I would never tell one of my patients they couldn't express their feelings around grief. But it's funny how I would never do it to them but we do it to each other in the field, I think, all the time. It's a huge double-edged sword.

Allen: "I don't get to have bad days."

Allen, a 34-year-old male LMSW, with eight years of sobriety and six years in the substance abuse field, works at a well-known treatment center. Our interview took place in-person at a professional office that allowed for privacy. Allen described a diverse background working with substance abuse, initially in the juvenile justice system in Texas, as well as two substance abuse treatment centers.

Allen described losses for him in the field of addiction counseling as "the obvious—death, relapse," going on to describe "so many smaller losses, like hearing stories of loss from patients, daily; other smaller losses being the loss of clients who discharged, or left treatment for other reasons, after developing an intense therapeutic relationship. Also, counselors who've become friends, leave."

Allen described having "lost approximately 50 patients" to death in just six years of being in the substance abuse field. While working within the juvenile justice system, he described being "ostracized for asking for assistance," whether it was clinical or personal, such self-care was considered a "weakness or sign of incompetence." Allen described feeling that he had to,

> absolutely stand on your own a lot of the time. It really weighed on me; there was literally little recognition, much less support, for the counselors in regard to the losses that we encountered. Nothing was said. There was that *silent rule* [his emphasis] that it wasn't allowed.

Allen realized that if he were to have any longevity in the field, he needed a change. He sought out a working environment that he felt would promote self-care. In the substance abuse treatment center where he currently works, he said he is more active in expressions of grief, publicly and to his peers, as well as utilizing his own substance abuse recovery support system for his well-being—as an example for both patients and peers.

Allen recognized his own signs of grief, such as withdrawing from relationships, dark humor, decline in exercise and healthy diet, and less tolerance and patience. However, he went on to describe his regular attendance at AA, working with a sponsor,

service work with others and working the steps as the most important part of his healing. In fact, Allen acknowledged that because of the nature of the work with the recovery population, his self-care and his own personal recovery require more attention and more consistency. If he were to neglect himself, he said he feels he might, and has seen co-workers, "become emotionally sick and even relapsed." Allen said he knows this is a reality that cannot be ignored.

Whitney: "I don't want to look like I don't know how to manage my own emotions."

Whitney is a 56-year-old female LMSW who has been in the substance abuse field for 15 years and sober for 28 years. We conducted the interview in-person in the privacy of her personal office. Sharing some of her experiences around her grief in her profession, Whitney spoke specifically of "not feeling supported by administration," but also of "not feeling emotionally supported by some of the other counselors when I wanted to grieve."

> Some of the folks in this field are hard, tough. I don't know if that's because of all of the relapses and deaths we see, but just in general, substance abuse is kind of a tough field. I believe also that because most of us are also recovered, we know that either people make it or they don't. And after a while, we expect each other to realize that. The problem with that theory is that we can know it on an intellectual level, but if there is anything left unsettled in us, we are very vulnerable. Which is all of us at some point. We are human after all.

Whitney said being able to speak openly with colleagues is very important. But, ultimately, she has used her sponsor and her AA group as her primary source of support and sounding board. She expressed having experienced two substantial work-related

losses that she had a difficult time processing, due to feeling as though she should not have "gotten so invested." Whitney describes:

> I got much closer to this one patient than I intended and know that I should not have. My countertransference was off the scales. When I learned she died, I went into a real depression. I didn't say a word at work, but I was meeting with my sponsor, and going to my own therapist for a while. I realized that I had witnessed my own death if I had stayed on the path she was on. She was me about 20 years ago. Man, that was tough. I finally said something to my clinical supervisor about two years later. She asked why I didn't say something sooner. I was embarrassed and felt ashamed that I had crossed that professional line. Like I had so much power over it? Yeah, right. It happens to all of us, I'm guessing. I'm glad you're looking at this phenomenon. And now I know what to call it.

Emerging Themes and Subthemes

The researcher's objective in this study was to obtain knowledge regarding how substance abuse counselors experienced disenfranchised grief in their work in their work with those who are addicted. The researcher also sought to understand how they receive support for their grief. The primary research questions were, "How do you experience loss in your work as a substance abuse counselor?" and "How do you find and receive support for these losses?"

Commonly, the researcher would follow up initial responses with questions such as "How is your loss and grief acknowledged in your working environment?" or "What are your own signs of work-related grief?" or "How do you get the support you need after you've experienced loss?"

In analyzing the results through reading, coding and verification, the researcher identified three common themes, or presuppositions, 14 subthemes and 15 sub-subthemes across participants' stories. These themes, subthemes, and sub-subthemes were first identified and coded with a label for each concept, sub concept, and sub-sub concept. As each new concept emerged, it was compared and contrasted with previous concepts until no new themes appeared to be emerging. The responses from participants provided the researcher with a vast amount of knowledge regarding disenfranchised grief for these substance abuse counselors in the work place, and how this grief is experienced.

The themes outlined in Table 2 were derived from the data analysis. Supporting quotes from participants are used in the themes discussion section.

From the organization of the heading themes, subheadings and sub-subheadings emerging from the data, the researcher aimed to answer the research questions that were asked of all 10 participants: "How do you experience loss in your work as a substance

Grief in the workplace.

The first theme that emerged was the area of counselors' grief in the workplace. This overarching theme had two subsequent subthemes: patient-related grief and co-worker-related grief. Table 3 provides information regarding the frequency of themes, subthemes, and number of participant responses for this first question.

Table 2

Emergent Themes and Subthemes Defined by Substance Abuse Counselors

1. Grief in the Workplace
    - 1.1 Patient Related
        - 1.1.1 Death
        - 1.1.2 Relapse
        - 1.1.3 Discharge from treatment
    - 1.2 Co-worker Related
        - 1.2.1 Co-worker leaves
        - 1.2.2 Other
    - 1.3 "I didn't know it had a name" – i.e., Disenfranchised Grief
2. Reactions to Loss and Grief in the Workplace
    - 2.1 Sadness
    - 2.2 Acceptance
    - 2.3 Questioning
    - 2.4 Detachment/desensitization
    - 2.5 Evaluate boundaries
    - 2.6 Compartmentalize
    - 2.7 Self-disenfranchise
        - 2.7.1 Anger
        - 2.7.2 Questioning professionalism
        - 2.7.3 Shame
    - 2.8 Physical reactions
3. Self-care Practices for Substance Abuse Counselors Facing Disenfranchised Grief in the Workplace
    - 3.1 Support [from]
        - 3.1.1 Colleagues
        - 3.1.2 Professional counseling
        - 3.1.3 Sponsor
        - 3.1.4 Supervisor
    - 3.2 Decompress
        - 3.2.1 Take break from field
        - 3.2.2 Time away from work
        - 3.2.3 Pamper self
    - 3.3 Practice 12-step recovery

Participants were able to provide the researcher with descriptions of losses

experienced at their work places. Throughout the coding of the transcripts, the researcher

found that the participants had very similar experiences of patient-related grief.

Table 3

Frequency of Themes, Subthemes, and Number of Participants Responding to the
Question: How do you experience grief in the workplace (including disenfranchisement)?

		(Unit Segments)*
Themes	**Subthemes**	**Participant Responses**
Workplace Loss and Grief Described by Substance Abuse Counselors		10
1.	Patient-related	10
	1.1 Death	9
	1.2 Relapse	9
	1.3 Discharge from treatment	6
2.	Co-worker related	9
	2.1 Co-worker leaving	7
	2.2 Other	2
	2.3 "I didn't know it had a name," i.e., Disenfranchised grief	10

*Unit Segment depicts the frequency of the theme and how many participants responded.

Patient-related. Patient-related grief was the most widely discussed throughout

the interviews, with each of the 10 participants expressing these losses occurring in the

workplace, beginning with death. These patient-related deaths included overdose, suicide,

bad health (non-addiction related) and accidental death after periods of sobriety.

Death. As Allen said,

Whether that they died in a car accident or they died by overdose or whatever: To

me, all those losses are the same. Because, I mean, 90% of the time that happens,

it's substance related. I've had friends who died sober in accidents and things and

that grief isn't much different than my friends who have died from overdose, in

my personal life. And when it comes to clients, I've had clients who've died in

accidents. I've had clients who died at their own hand or, you know, other

situations. And I think, for me, the grief is the same. I think the situation

sometimes allows the healing process to begin a bit quicker. If it is an accident,

versus, you know, it's someone who relapses or, you know, commits suicide and

you think, well, that you know they still had a chance, they still had hope. Like,

you know, there was still hope for them. Not that they had hope, but there was

still hope for them to be successful. And they kind of removed that chance for

themselves. So, I think that sense of, I don't know what you'd call it. A sense of a

kind of waste. Like it's kind of wastefulness or what a waste, you know. That's in

addition to the grief or is a part of the grief. So, I think grief for me, I mean

honestly, is usually the same.

Moreover, Dana expressed similar experiences:

Clients dying? Yes. Because, when I worked in pharmacotherapy, it happened

more than once. These were clients that were heavily medicated and some of them

were still drug-seeking and so then there was always the risk of a harmful drug

interaction. And so that happened more than once in my experience as an LCDC.

And so, when you know them, there is a sense of loss.

Letty also shared her perspective:

Death is such a big part of chemical dependency recovery and chemical

dependency treatment. Of course, there are patients that we counsel that die. They

go back out and died. And relapse and die. And then there are people who

actually stay sober and clean and die. Clean. That's certainly a loss. It's work-

related loss for me, for sure.

Les described the experience of death with her patients in a multifaceted manner,

using the description of

brain damage, body damage, liver damage, some kind of organ damage. These are

each a type of a death. Ultimately, these can and do lead to death of the entire

body and individual. It's very sad to see, and I see all too often.

Greg shared his experience as follows:

People come in and out and we have many who don't make it for many reasons. .

. . I work at a partial hospital program now, so people come in and out. I mean,

we can have 12 admissions and 12 discharges in one day. We run a census close

to 60 or 70 people every day. In this field, people just don't make it. We've lost a

bunch.

While not as articulate about their experiences of the losses due to death in the

workplace, both Frank and Pam stated that they both had felt the deaths of patients as

significant work-related losses for them.

Rebba detailed a specific instance that she identified as a significant work-related

loss due to death:

Basically I had a patient who, he left treatment and I was called by the hospital

shortly after he left, probably a month after he was out of treatment. Working at

that treatment center, I had a lot of people come back on a regular basis. So, I saw

him a lot and he was doing pretty good and then I got a call from the hospital that

said that night before he went into a coma, eventually passing away. It really

affected me because he has listed me as his next of contact, over any of his

family.

Finally, Whitney described feeling the abundance of loss through death:

Well, the loss of life through relapse. The loss of life through drug-related or

alcohol-related accidents. A lot of loss. A lot.

Relapse. Nine of the 10 participants described the feeling of loss that they

experienced at finding out that a client had relapsed.

Les, Dana, Dade, Allen, and Letty all identified relapse as a loss, relating it as a

type of death and being a part of this field. "Patients die. They go back out and die no

matter how much we (counselor's) try to help them help themselves. So many relapse

and die. People don't understand that staying sober is the exception" stated Whitney.

Pam described herself as,

Sad and angry. Because I feel like I put all my best into them and they still didn't

listen, they didn't get it. So, it's sad because I just want them to call me so I can

help them. And they won't call.

Frank elaborate further on the disease and the person:

You hear a lot about them relapsing; or they suddenly are back in treatment after

doing well for a good period of time. It's sad and disappointing. But, that's the

disease. Cunning, baffling, and powerful.

Discharge from treatment. Six of the 10 participants could identify with the

discharge of the patient as a loss. Dana, Letty, Whitney, and Pam included losses as

treatment completion, leaving treatment against doctor's orders, and leaving treatment early due to insurance or financial issues.Allen describes the loss:

> I mean every month for us is a little loss for us because you have people you have spent time and energy for this entire month helping to get better and then they discharge and go back out into the world and some of them do well and some of them don't. I mean, even the change in the group and having that group leader leave is a little bit of loss. And then of course, you have the other small losses which happen on a day-to-day basis which are patients who are doing well that suddenly start having a lot of difficulties and things like that. That's a big part of it, too, that we tend to forget about sometimes.

> Frank further stated,

> The first thing that comes to mind is when you've worked with a patient really closely in treatment and they leave. . . . You know, even if they leave and you hear that, 5 years later, they're still sober. So, I kind of accept that in this field of substance abuse, that that's reality that comes and it happens. We get attached whether we intend to or not.

Co-worker-related grief.

While not discussed in as much depth and detail, losses pertaining to peers were described by seven of the 10 participants, with Rebba's statement embodying all of their remarks,

> Maybe, in a way, because I think, you know, generally treatment centers are somewhat of a smaller atmosphere. If we work with employees for a decent amount of time, you know. We spend a lot of time with them, and then they're

gone, you know, from our lives. Just the turnover. Maybe in some ways like that. . . . Because of our field and the nature of it, we do have a lot of personal relationships with the employees that we're around and we get really close to them and we're all geared toward being, you know, asking more in-depth questions. They're not very superficial relationships, I think, in this field. Well, I think just the nature of it, you know. We're just going more in depth with everyone we're in contact with. Just due to what we do for a living. And I think it becomes kind of the way that we operate. Even sometimes out in the world. I think addicts, some addicts, in general, have that anyway. They're not the type of people who do things like, "Oh, isn't it beautiful weather?" or you know, I do think they do just get more in-depth and ask more in-depth questions. You know, of themselves and others, in general, on a regular basis. So being in the field all the time, I think, you know, we cut through a lot of the small talk and we talk more about feelings and what we're experiencing and, you know, ways, solutions to it. Stuff like that. So, I think it just comes naturally. It comes more naturally in this field. And it makes us closer.

In addition Letty stated, "Like I said, colleagues leaving. People that I've worked with for a long time." "My coworkers… Loss of a friend, yeah. I think friendship. Think about it a lot. We get attached to one another," noted Pam. Finally, Allen added, "I mean all kinds. I mean coworkers, people who just move on to other positions, other jobs. That's a loss. It affects us whether we admit it or not. But we gotta keep moving on."

Experiences of disenfranchised grief in the workplace, i.e., "I didn't know it had a name."

States Les,

As far as the losses go, for sure, part of the profession is that it just goes on. It's because of our program that we just accept that that happened and we just move on. It really goes unspoken, you know. Yeah. I mean you might say, 'Did you hear about so-and-so who died or relapsed and lost everything or got incarcerated?' It's just like a news flash. There's never something that we take in, internalize and process and grieve over. I have never experienced that with another person in my work with this population. Not that I can recall. You know, just thinking about it now, I think that we weren't allowed to even talk about that. We weren't allowed … I mean. What my training was, is that I had to put that aside and make it not about me. *No one taught me that it had a name* [emphasis added]. We just don't talk about it. It was just a like a flat sheaf. So-and-so died, you know, and we continued with our work. I may be mistaken, but I feel that as a counselor I was taught to put those feelings aside and I had to move on to the next thing I had on my agenda at work. It was more or less expected as a part of that job. I really don't have an outlet on the job about those feelings and experiences.

Les reflected on some of her own reactions to the loss of a patient and the sense that it has to be private: "You know, like you wouldn't want to do it in pubic or when somebody else is around to let them know maybe you had a relationship with them. That might not seem professional and ethical."

Pam, describing a very specific and still sensitive reaction to her own experience of disenfranchised grief in one of her work places over the loss of a patient, stated,

My coworkers (pause). It was business as usual. And, for me, it was, we just lost somebody. I showed my true emotions and failed. And I got reprimanded for it. I wasn't supposed to cry. But, to me, that was a person. That it wasn't just a patient. He wasn't just a drug addict. Yeah. He was a person, you know, and I wasn't supposed to feel. It was just supposed to be business as usual. Which, for everybody else, all my other coworkers, it really was business as usual. They made sure the paperwork was in order. It wasn't business as usual for me though. Because it affected me, you know. And as if that were not enough, there was also an e-mail saying, enough talking about it in the e-mail. No more discussion in the e-mail. I was really fresh in counseling, so it kind of impacted me more.

Greg described the following on the issue of processing grief in the workplace:

Now very seldom does that ever happen. We might process it with most of the staff, but it's nothing like it used to be. One example is of a prior patient of mine. . . . He shot himself and they didn't want to even bring it up, you know. I don't know what they offered, a therapist or not. They were really kind of in a hurry just to get on with it. Yeah. Nowadays, I mean I think you get, like, support from other staff members all the way down. Now, they do these things, particularly in hospitals, called RCAs [Root Cause Analysis]. And depending upon who's running it, I mean they can be like witch hunts. They are supposed to be support. They're supposed to be non-accusatory. They're supposed to be to find out how we can prevent things like that from happening again. Now, I've never been in one that was bad. But I've known people who have been in ones that were pretty bad. The complete opposite of supportive.

The initial feeling that came up for Rebba was that of anger as she described a lack of support for the multiple losses. She stated,

Angry. Maybe a little bit of shame, you know, for not speaking my mind. But I have felt, you know, I have felt like it would not be received well. Angry more than anything. I don't think ever purposely trying to keep it from the staff. But, no. I've never, anywhere where I've worked, I've never had somebody come to me and like, sit me down and say, 'One of your patients, patient that you just worked with, has just passed away.' It's always secondhand. I mean, it's always secondhand. I've never had anyone come and say, 'Oh my God, I have some news for you.' And people who learn about it first, you know, it's either by word of mouth or they don't really, you know…. It's more word of mouth anymore. At SS, they would write it on their chart. They would pull their chart, because they would have to take their charts. And they would write "Deceased" across the chart and just put it at the bottom of the chart things. And you would just run across it. There was always, like every week, there was probably two, three, four charts down there. So, you would just walk in and you would just look, you know. No one ever, ever, ever said, 'Hey, you know. This is bad. We've got some bad news here for you, etc.' No. It's always been secondhand.

Dade stated,

It's just one of those things in treatment that are not safe to bring up. I've just never felt comfortable taking that chance and having someone give me crap about it. It might seem unprofessional. It's almost like a bunch of unspoken rules when it comes to, you know, the kind of losses we experience in this field and what to

do about it. No formal discussion on *support* [emphasis added] of even what we might experience.

Allen stated similar feelings:

I've felt that way more than once. I mean, you know, it just depends on the facility and who you're talking to, but yeah there have been times where I feel like if I expressed grief, sorrow over either one of those things… You know, it seems really callous but really kind of, you know, chastised for it.

Whitney stated,

So, I mean, it's just a weird deal. *I don't think we're supported* [emphasis added] with that type of collateral grief, you know, that we experience. Not fully supported, no. Or at all. And it was considered unprofessional, you know, that, you know, you were supposed to be a kind of robot. Like this unfeeling, unknowing. Like you just go do your job. Show up for your job and, you know, you don't need to have feelings about what you're doing. Just do it. Just do it. *I really had no idea this involved grief* [emphasis added].

Dana said,

You're not supposed to go to the funeral. You're not supposed to reach out. Offer condolences. You know, you've got to maintain that therapeutic distance… It's almost that you just ignore it to a certain extent. Or it's like, 'Oh, that's sad.' And then everybody just goes off alone and grieves. *I'd never even heard of a term for this. I thought it was just me* [emphasis added].

Finally, Letty concluded,

And, you know, they pretty much basically said, you know, 'Suck it up. It would

look unprofessional. It would look weak. Do your job.' Sometimes it's, like,

cumulative. But I've seen really some awful things happen. But something not

that big happening. I don't know. It just kind of hits you when it hits you, you

know. So, I'm not—I mean, I try to give myself permission that whatever

happens, happens. You know, if I'm kind of numb to it, then that's where I am. If

I'm really feeling it, then that's where I am. If I'm angry about it, then that's

where I am. If I'm kind of bargaining about it, then that's where I am. And I'm

going to go through the stages. You know. And not necessarily in the time frame

that I want. When it happens, it happens, you know.

Rebba added further explanation by stating,

Just, you know, the idea, like when someone does pass away and let's say people

are talking about it at lunch. And they're portraying… And to me it's like

counselors that have had way more time in the field. They're portraying, this is

how you're supposed to react to these situations, by saying, 'Well, that's what

happens when you don't do what we tell you to do.' You know, and all these

flippant comments. I don't know if that's their defense mechanism or whatever it

is, you know. But, at the same time, it's, you know, let's say if you were start

crying and say that, it's either dead silence, you know. *Like no one wants to*

acknowledge that you're experiencing that much pain [emphasis added] over it or

you're going to have toughen - up if you're going to stay in this field. You're

going to have to detach more. You can't let, you know, you can't let people get

that close to you, because this happens all the time. Etc., etc. And comments like that. Like frowned at for, you know, having any type of grief. And not in every situation but, yeah, I have felt that, or experienced that even. But even then, no one has ever even remotely suggested or said, 'Anytime somebody has passed away that, you know, we have EAP, we have grief counseling available to you, if you need it. *I thought I just didn't know how to deal with it professionally, like I was doing something wrong* [emphasis added].

Reactions to loss and grief in the workplace.

Reactions to work-related grief, disenfranchised and otherwise, varied with the participants. With everything from the more obvious, "sadness" to "detachment" and "physical symptoms," there were multiple indicators, which are shown in Table 4.

Table 4

Reactions to Disenfranchised Grief

Themes	Subthemes	(Unit Segments)* Participant Responses ($N = 10$)	
Reactions of Substance Abuse Counselors			
	Sadness		3
	Acceptance		2
	Questioning of personal reaction		3
	Detach/desensitize		7
	Evaluate boundaries		3
	Compartmentalization		4
	Self-disenfranchisement		3
	Anger	1	
	Question professionalism	1	
	Shame	1	
	Physical		4

*Unit Segment depicts the frequency of the theme and how many participants responded.

Sadness. What may seem like the most commonly experienced reaction, sadness, was noted by only three of the 10 participants with the following statements: "You know there was a level of sadness, but, it isn't anything that I wanted to share with my immediate colleagues; I was definitely at a place where … I was unable to express how I felt after hearing the news," described Dana; while Frank responded with feelings of "sadness; just a real shame; a real waste of a human life. Always sad for me." Similarly, Dade stated, "I always feel a sadness, a loss; sometimes followed by 'could I have done more?'"

Acceptance. Stating that his own experience of recovery and all the losses that he incurred allows him to accept the part of the disease of addiction that is loss, Frank noted,

> So, I kind of accept that in this field that's the reality that comes and it happens. And it's a part of being in recovery or trying to stay in recovery. So, I guess using my experience in my profession has probably helped me cope with that grief that I've experienced in the past and probably vice versa. I don't have to like it to accept it.

Dade noted a similar feeling, saying,

> I believe that after being in the field for so long, and being in recovery myself, I understand and can intellectualize the vastness of the disease, including loss and grief, but it's still a loss and some are more difficult to accept than others.

Questioning own feelings/reactions. Several participants noted their own awareness and concern about their reactions to certain losses in the work place, beginning with Frank:

I'll wonder about grief and other feelings that come up: is this because of something that happened in my personal life? Or, is it sadness that I'm feeling and thinking about toward this actual patient? I'm always on the lookout for transference or countertransference. Their stories are my story. It can get meshed.

Moreover, Letty similarly stated,

I question if my reaction is countertransference or just an inability to process through whatever reaction I am having. I understand that whatever is not addressed comes up and if I don't deal with it, I will be projecting it on to others.

Detachment/desensitization. Pam, Rebba, Frank, Letty, Allen, and Les used the term *detached.* Allen elaborated by saying,

In one situation, every time they would bring it [tragic death] up, it was like snatching a band aid off of a sore, and I would be like—I would actually get up and leave the room when they started discussing it. I would physically detach in order to go and mentally, emotionally detach.

Rebba described her experience with detachment as follows:

Well, I can stay detached. In fact, I can even remember being a new counselor and getting that message very loud and clear: 'You're going to have to detach more. You can't let, you know, you can't let people get that close to you, because this happens all the time, etc. etc.' Like for me, it's like I have a hard time counseling and not, you know, experiencing some sort of attachment. So, it comes in a form of keeping everything light, you know. We'll just keep it light and we won't have, you know, any intense moments and, etc. etc.

Why? We're just going more in depth with everyone we're in contact with in this field. Just due to what we do for a living. This shit is life and death! And I think it becomes kind of the way that we operate. Even sometimes out in the world. I think addicts, some addicts in general, have that anyway. They're not the type of people who do things like, 'Oh, isn't it beautiful weather?', or you know, I do think they do just get more in depth and ask more in depth questions. You know, of themselves and others, in general, on a regular basis. So being in the field all the time, I think, you know, we cut through a lot of the small talk and we talk more about feelings and what we're experiencing and, you know, ways, solutions to it. Stuff like that. So, I think it just comes naturally. It comes more neutrally in this field. And it makes us closer. I can feel myself shutting this down. Way down or all the way off. I'll see and feel myself purposefully not getting close to the clients. I'll keep everything really light.

Pam describes her experience in the following way: "Like this unfeeling, unknowing. Like you just go do your job. Show up for your job and, you know, you don't need to have feelings about what you're doing. Just do it. Just do it."

Whitney described the following:

I find myself getting irritated, you know, getting sarcastic, you know. I start judging, you know. Like somebody will be sharing in group and, you know, I'll be thinking to myself, 'You know, go to the God damn mall and buy yourself a fucking purse and shut the fuck up.' So, I mean, you know, I know something needs to be addressed. It's between that and just shutting down.

Finally, Greg described a "sort of emotional 'shut down.' I could tell, especially after the fact, that it had happened to me. I was detached to the situation. It's how I handled it at that time." The use of dark humor as a form of depersonalization and detachment is common, not only around loss and grief, but as a form of distancing from patients, stress, etc. Four of the 10 participants described use of dark humor, beginning with Greg: "We make fun of situations that most people would go, 'My God, that was so sick,' you know. Saying things to take the sting out of a situation is what it boils down to. We knew it."

Rebba spoke about the making of "flippant comments; things that might be said to a colleague about a patient or situation to minimize it. I have often said to myself, 'man, that's just sick. Did I really just say that out loud?'

Allen agreed, saying,

People tend to turn to black humor. It's a coping mechanism and probably a sign of some hardening to some of the difficult things we see, hear and experience, around so many sick people. It's almost like a contest sometimes; see who can be the most inappropriate and least compassionate. We know it. We're just careful who we do it in front of. Never in front of a new counselor. It's almost a rite of passage.

Evaluate boundaries. "Thank God, I have really good boundaries about this," stated Allen, while discussing various reactions to work-related loss:

I never confused my recovery with my work. I've always been told that. And that's the #1 ticket to burnout or a relapse. Not practicing healthy boundaries can really get someone in a world of hurt. I've seen this happen with what appeared to

be the most professional and healthy therapists. Using work-related recovery, as

their own, got them in a world of hurt. Also, skewing boundaries with the patients

can really land some problems. Emotionally and legally. I've see that as well.

Pam described another dynamic which comes as a result of boundary issues:

Over-identifying and relating too much. To connect you get attached, close. They

know if you care what happens to them or not. So, it's easy to go there with them.

Especially the younger ones; come in here looking or acting like my own

children. It's very difficult to keep that in check. But it's necessary and it's

possible.

Rebba stated the same, describing her experience with a previous patient with

whom she found herself becoming emotionally enmeshed: "I think there's an opposite

end of that spectrum to where you get, you know, involved in a patient's life and it's

equally as sick."

Les described her understanding of the possibility of enmeshment, stating, "I

really focus on boundaries; I call them my 'catcher's mitt.'"

Compartmentalization. Allen was notably familiar with this reaction in his

statement,

In my experience, addiction counselors seem to be, especially the people with

longevity, seem to be more able to compartmentalize loss than people who are not

in the substance abuse field. I think that's primarily because we see so many just

small losses and the fact that so few of our patients getting long-term sobriety and

also the patients that pass away over the years. I mean, I've probably lost well

over 50 patients in just the 6 years that I've been in this field. So, I think that we

learn to compartmentalize it better to be able to deal with that.

Greg had another term for it:

For the most part, I can keep it separate. I'll *tuck it away* until I can do some work

around it, either with my sponsor or colleagues. But I usually have to wait on that.

I can't just react to it right away. Even if I wanted to. Which I usually don't. I

wait until I am in a safe place.

Moreover, Rebba said, "It's almost that you just ignore it to a certain extent. Or

it's like, 'Oh, that's sad.' And then everybody just goes off alone and grieves."

Describing how she disconnects, Whitney stated,

Like, I'll binge watch TV. I want to turn everything completely off. Don't want to

go anywhere or have any contact with people, AA or anyone with problems or

issues. I'm done. I'll do that until the next work day where I'll have this internal

dialogue with myself, *suck it up,* and go back to work.

Self-disenfranchisement. *Anger.* Rebba stated,

Anger, maybe a little bit of shame, you know, for not speaking my mind. But I

have felt, you know, I have felt like it would not be received well. I've felt that

way more than once. I mean, you know, it just depends on the facility and who

you're talking to, but yeah there have been times where I feel like if I expressed

grief, sorrow over either one of those things—You know, it seems really callous

but really kind of, you know, chastised for it.

Question professionalism. Pam described the following, after hearing about a

young former patient's death:

I openly cried in staffing that morning and I believe I was supported by my peers

and that nobody in there made me feel like shit for being that attached, you know,

to a patient. And, in others were thinking about me. Did I seem unprofessional or

too attached? Maybe they thought I was weak?

Shame. Frank described his feelings as,

I would find myself, later on, wishing I had said something to at least

acknowledge the loss and my own feelings. I tend to always delay with that. I'd

wished I had said something then and there.

Physical reactions. Four of the 10 participants had self-described physical

manifestations as reactions to grief and loss in the workplace. Allen described his

reactions as the following:

I was much more stressed out. I was much more unhappy. I was much more

unhealthy, in general. I mean, everything from, like, my eating habits to exercise

was unhealthy in that environment because I was just—My stress levels were so

high all the time without being able to have, like, that experience of being able to

vent with other people or share with other people in that environment.

I get very, very worn out very, very easily. I can—For me personally, like

I had trouble concentrating. I kept, like, going back to ruminating on whatever the

issue was and I found myself doing it, like over and over again. So that's usually

when I would be like "You know, I've already gone for much longer than I

probably would. I've got to work on and process some of this loss and tragedy

that I see every day."

Whitney's reactions were similar:

You know, I get irritated and tired. You know, it will be like not sleepy-tired but

like, 'Oh my God, I don't know if I can take one more step,' you know. And go

home and the thought of cleaning the house or answering the phone or doing

anything—You know, I find myself withdrawing and isolating. And that's

dangerous when that happens, because then I'm not reaching out and I'm not

asking for help. You know, here I am trying to help others learn to ask for help

and sometimes, when I most need it, I don't ask, because I withdraw.

Pam described her symptoms: "I feel absolutely, physically fatigued. Not wanting

to get out of bed fatigued. But I get up anyway."

Finally, Les stated,

It always goes straight to my lungs—respiratory issues. This is where I hold my

unexpressed or recognized feelings. I've actually been ordered to bed rest twice in

my career for this exact thing. I pay very close attention to how I am breathing.

I've seen what it can do to my body, as well as my state of mind.

To find relief from these feelings, whether unexpressed or unrecognized,

participants explored self-care practices to relieve their discomforts as shown in the

subthemes in Table 5.

Self-care practices.

Support. All 10 participants described seeking and receiving self-care through

the support of others. This support was found in the following areas:

Colleagues. Rebba stated,

Honestly, I get the support I need from counselors who are also in recovery. But,

by that, I mean actively going to meetings and working with others within that,

outside of this. Two very completely different things. There's been a couple of

times if it hadn't been for other counselors who are also in recovery talking me

through it and being supportive to me—one time, I mean I would have not have

stayed in this field, 100% would not have."

Table 5

Frequency of Themes, Subthemes, and Number of Participants Responding to the Question: What is your self-care practice for work-related losses/grief?

Themes	Subthemes	(Unit Segments)* Participant Responses
Self-care practices of substance abuse counselors who experience disenfranchised grief in the workplace: Support from		10
	Colleagues	5
	Professional counseling	6
	Sponsor	2
	Supervisor	1
Decompression		
	Take break from field	1
	More time off	2
	Pamper self	2
Recovery		
	12-Steps	8

*Unit Segment depicts the frequency of the theme and how many participants responded.

Frank concurred with Rebba regarding one particularly difficult loss that was

incurred at work by a patient's relapse while in treatment: "I did consult a friend who was

a colleague about it because I was afraid I might have transference about continuing to be

engaged with this client. Definitely, my number-one coping skill is processing with other people."

Describing the steps he took after a former client committed suicide, Greg said,

I talked about that with people at work. And then I talked about it, without mentioning names, with some of the guys in my clinic. However, mentioning that while we might process it with most of the staff, but it's nothing like it used to be.

Les described,

I allow someone to see my grief. Usually a colleague. You know, like you wouldn't want to do it in public or when somebody else is around to let them know maybe you had a relationship with them. But I will certainly share my grief with someone. I know that I have to seek out help on my own. I need another person who can be there for me.

Dade expressed similar experiences with,

I can always talk to someone I either currently work with, or call someone that I've grown close to from my past work places. Ordinarily, whomever I talk to has experienced it and been through it and can give me support, a listening ear and some sympathy. You know, sometimes it's just part of that grieving process. It's—If I need to grieve it on my own without someone around me, in a non-work environment, that's okay too. I'm absolutely for both methods. Whichever is gonna work for the situation. It's different a lot of the time.

Pam identified with the support of colleagues: "I talk to my co-workers."

Professional counseling. Five out of 10 participants described the use of professional counseling, starting with Dana: "I actually see a counselor; if I'm going to

advocate the use of professional help, I'm certainly going to use it. I'm way beyond

thinking I am immune," whereas Letty briefly described the use of EPA for assistance

when there was the possibility of secondary trauma, following a death at the treatment

facility she was employed with. Pam stated, "I go to therapy. It's one of my tools for

taking care of myself." Allen explained that he "either find support groups in my friends

who are counselors or, you know, licensed professionals that I don't work with. I can get

together with one of them and sit down and talk."

Finally, Frank describes the following:

I've been doing this for a long time. I used to rely strictly on my colleagues or

recovery. Then there came a time where it needed to be someone who I could feel

confident would be completely objective. I knew I was needing a completely

fresh perspective. Not necessarily someone who could relate, but who could help

me take some layers off of my grief. Best thing I ever did. It made it easier for me

to feel those feelings again, more immediately, rather than stuffing.

Sponsor. Two out of the 10, Letty and Greg, identified with the use of a sponsor

to talk with about their work-related grief or losses. Letty said, "That's why I need people

to talk. That's why I needed a sponsor." Greg stated,

I always have a sponsor; someone that I'm talking with who can keep me in check

and have me checking myself for any underlying shit. It really works for me…

Well, a lot of times, most of the people that I've worked with want to believe,

'It's going to be okay. I really don't need any help.' But, you know, I've seen—I

know when things like that happen, I have to do a check-in. So, I think a lot of it's

sort of kind of when people have been in the field for a while. We either get lazy

or we get arrogant about our personal care.

Supervisor. Of the 10 participants, Letty was the exception when she stated, "I

can take any kind of issue around to my direct supervisor."

Decompression. Beginning with Dana, four of the 10 participants spoke in terms

of how they engage in self-care through decompression.

Take break from field. Dana described an intense experience where there was a

significant loss for her with a patient, so painful that "I took a physical and mental break

from the field so that I could work through that. I did a lot of exercising, meditating,

meetings, step work. I did an emotional detox."

Take time off. Letty described her work schedule where she intentionally worked

fewer, longer-hour days in order to "have time to decompress and debrief and take care of

myself to come back in and do it all over again."

Pamper self. Pam explained, "I have a lot of *me time*. I go to the spa and have

myself pampered on a regular basis. It really takes whatever I may be holding in my body

and rids it."

Finally, Allen described the importance of exercise for relieving stress, as well as

taking plenty of time to have fun while away from work. "Work-personal life balance is

key."

AA: 12-step recovery. While all participants indicated being in recovery as part

of their qualifying for the study, only eight described using the recovery program of

Alcoholics Anonymous.

Frank was specific in his description of use:

12 steps that I've used. I mean, that's the guide for living for me today. And it's a—yeah. It's beneficial, you know. Working the steps and attending meetings. It's where I go to get free of anything that's bothering me. Sometimes I won't even know it's been bothering me until I work some steps on it. Like in this case, with grief.

Dade said,

It doesn't even matter what the issue is, grief, anger, whatever; if I do some step work around it, and then sit down with my sponsor, I will be able to identify it. Then I will find a solution. Or, if I share about it, or better yet, listen for it at a meeting, it comes to the surface. Once that happens, I'm dealing with it.

Rebba added:

So, I think I get a huge part of my support from that and then even just in AA in general and not people even necessarily in this field. I think people in this field who are in AA understand a little bit better. But I obviously get support from the fellowship as well. Umm, but I mean, it's a close-knit deal. And, uh, I think that, umm, without that piece of it, yeah, I might not still be in this field.

Moreover, Greg described,

a real need to stay close to the program [AA], work with my sponsor, sponsee's and do the work around the steps. I'm all about taking measures outside the program when it's necessary, but for me, for the most part, if I keep my program and my own personal recovery as my main priority, I'm going to be able to identify and then take action on my own stuff. Stuff that comes down the pike and gets all over me due to the nature of my work and of this field. Being able to

identify with the losses is a double-edged sword. It works for me, as a professional, as long as I keep my shit in order. Otherwise, the identification can become unhealthy. I've been around long enough to get that. And I've learned that, mostly, from being in recovery.

Letty further described the experience of attending AA, being involved with recovery and its effect on her in the following way:

I seriously don't think I would still be functioning at the level I function at, professionally, without my recovery. AA and the 12 steps are a way of life. Not just a 'now and then' luxury. It's literally the filter by which I live my life through. Everything from the Steps to the Traditions. It's a guide to living; and in that guide is a very solid and consistent way to handle feelings, problems, people, and that includes my work. It's truly a gift.

Les, Whitney, and Dana, while not as elaborate in their discussion on the importance of and their use of AA and recovery, indicated that meetings were, as Whitney stated, "an important part of my life." Les indicated that "three meetings a week is what I have determined to be what keeps me in a good place"; Dana stated use of the "three meetings a week" rule for her "well-being."

Journaling.

The researcher also kept a reflective journal during the individual interviews. The written journal entries allowed the researcher to identify her thoughts, biases, and decisions regarding disenfranchised grief. The journal further allowed the researcher to more adequately understand the phenomenon of disenfranchised grief in substance abuse counselors as discussed through the participants' own words and experiences. The

researcher has taken excerpts from the personal, reflexive journal to provide insight

regarding how the researcher was able to acknowledge her personal thoughts, biases, and

assumptions so that they could be minimized when coding the results of the study.

   Personal reflections prior to participant interviews. The researcher was able to

acknowledge and recognize that disenfranchised grief had been a part of her experience

as a Licensed Professional Counselor and Licensed Chemical Dependency Counselor

working in the substance abuse field. Although the researcher was aware that grief and

loss are an integral part of the health care field, and in particular the substance abuse

field, due to the nature of the disease of addiction, the researcher was not aware of the

stressors that the experience of disenfranchised grief could produce. While fully aware

that grief is present in work as a substance abuse counselor, the researcher was not aware

that as a result one's wellness can be mildly or severely altered. Moreover, the

implementation of strategies to maintain mental, emotional, and physical sobriety do not

always happen as quickly or as successfully as the researcher would like.

   Moreover, the personal and professional performance as a substance abuse

counselor, as well as the researcher's own sobriety, has fluctuated over the years and is

something that will constantly have to be worked at, maintaining and creating the time

and space for it. For instance, throughout this dissertation journey, the researcher was

able to acknowledge that her own responses to emotional stress, including work-related

disenfranchised grief, had restraints and were often not met with healthy responses and

reactions. The researcher was able to identify that although having the personal belief in

the acknowledgment and need for care of the substance abuse counselor and the impact

of work-related disenfranchised grief, the researcher did not impose this value onto the participants that were interviewed, as they may have a different perspective from hers.

Therefore, it was hypothesized that substance abuse counselors experience work-related disenfranchised grief. The reasoning behind this hypothesis is based on the researcher's personal experience both as a substance abuse counselor who has experienced work-related disenfranchised grief, as well as disenfranchised grief in her personal life.

Personal reflections during participant interviews. During some interviews, the researcher noticed that some feelings were elicited prior to, during, or after the interviews. Here are some examples of those thought process:

Memo: Interviewed participant Dana today (09/25/2014). This was my first interview to conduct, and I was extremely nervous and excited. My main concern was to ask questions without eliciting anticipated responses. The interview ended up being very short and was conducted too quickly. After discussing my anxiety and interview method with my dissertation chair, she recommended that I expect to conduct follow up interviews on participants who were not as prone to go into discussion. She also offered guidance for the actual interview process by giving examples of probing for clarification and additional information, without compromising the purity of the interview. The follow-up interview was conducted on October 15, 2014, and I felt grateful and excited that this participant was so willing to continue participation in my study and provide me with additional feedback. I felt slightly anxious to admit that I had rushed the previous interview, but the participant was able to make the experience one that was both meaningful and enlightening for both of us.

Memo: Interviewed participant Les today (09/30/2014). This interview was calm and inspiring. I was in awe of the dedication that this participant had towards being present for her clients while being mindful of the need for boundaries in order to take care of herself. I felt truly inspired and feel like I learned a great deal from this interview, as I listened to her personal experiences of disenfranchised grief both professionally and personally. I felt honored and privileged to listen as she talked of the loss of her own son due to the disease of addiction, and how she was able to take part of that experience and delve into taking better care of herself. I was interested in hearing about how she learned to become a better friend to herself and to take full responsibility for her own recovery, especially her boundaries and self-care regarding her work with recovering addicts and any other area of her life that needed attention. This interview sparked me to consider my own self-care and boundaries around my work with addicts, as well as with my own children.

Memo: Interviewed participant Pam today (10/07/2014). I found myself resonating with this participant when she described some work-related disenfranchised grief regarding co-workers who she had established close working and personal relationships with leaving. I felt a sense of compassion, as I experienced the very same feelings when leaving work at the last substance abuse program I worked at, after having become very close to several of my co-workers. They remain like family today.

Memo: Interviewed participant Rebba today (10/18/2014). I was fascinated and enlightened by this participant's responses. Not only was she articulate and descriptive with every detail about her experiences of disenfranchised grief in the workplace, she was able to describe her understanding of this phenomenon in a way that made it much more

real to me. Her understanding of the nature of addiction and those who work in the field really pulled some loose pieces together for me. Wow! I was super excited about this topic when we finished the interview.

Memo: Interviewed participant Allen today, also (10/18/2014). This, too, was a very heartfelt and insightful interview. The participant covered so much information in such a brief period of time due to his ability to articulate his experiences so thoroughly and without any prompting. He easily made his way through all the dynamics that I had hoped to hear about without my needing to direct or redirect him. I felt like he was telling my story and my experience.

This process of journaling in the reflexive diary allowed the researcher experience both the immersion and indwelling stages of the heuristic process. To further understand all data collected, the researcher will share a discussion of the results obtained throughout this study.

CHAPTER V

SUMMARY, IMPLICATIONS, AND RECOMMENDATIONS

This chapter summarizes the findings of the researcher's heuristic inquiry into the lived experiences of ten substance abuse counselors' work-related disenfranchised grief, implications of those findings, and recommendations for future research.

The purpose of the heuristic inquiry was to gain insight and knowledge regarding how substance abuse counselors experienced disenfranchised grief in their work with those struggling with addiction as well as how they addressed that grief. Through their discussion, all of the substance abuse counselors interviewed, generated themes. These themes were then compared with those of the other participants to discover the commonalities throughout their shared experiences.

The findings from this study portray the unique experiences of grief and loss of the participants in their richness and variations. The participants were at different points in their professional careers in the substance abuse treatment field, as well as personal recovery from substance abuse, which allowed for broader and more diverse descriptions of the grief and the processes. Despite the differences, the participants presented similar experiences of loss and grief related to their work in the substance abuse treatment field, and shared experiences of work environment and self-disenfranchisement of their loss and grief.

Summary

The Rationale for the Study in the first chapter explained the researcher's objective for the study as an inquiry into how substance abuse counselors experienced disenfranchised in their work with those who are struggling with addiction. An

understanding of substance abuse counselors' disenfranchised grief in relation to work with clients was necessary to enhance both self-care and education. Having these losses understood and normalized would benefit these substance abuse counselors, as well as make it understandable for them in their work with clients who may experience their own disenfranchised grief.

The Literature Review in the second chapter explicated a variety of grief experiences, including normal grief (Kubler-Ross et al., 2014) and various forms of complicated grief (Boss, 1999; Hashim et al., 2013; Stroebe & Schut, 1998), including disenfranchised grief (Doka, 2002). In addition, the experience of substance abuse, recovery (SAMHSA, 2015), and the substance abuse counselor (Culbreth, 2000; Doyle, 1997; White, 2000) was examined to further define the population chosen for this research.

The third chapter, Methodology, discussed the research techniques used in this qualitative inquiry, which was conducted as a heuristic phenomenology. This method provided the framework through which the researcher could best understand substance abuse counselors' experience of loss and grief and how it impacted their work with their substance abuse clients. Stories were shared and perspectives were captured, while the researcher simultaneously discovered more about herself and gained insight into her personal experience of disenfranchised grief as a substance abuse counselor.

Criteria used to determine adequate sample size for qualitative research was based on saturation of themes which was achieved with ten participants. Use of MAXQDA, a computer-based software program, was valuable in storing, organizing, and codifying information for further analysis.

The fourth chapter, Research Findings, provided a brief description of each participant including their stories of loss and grief as a substance abuse counselor.

In analyzing the results through reading, coding, and verification, results of these data revealed three overarching themes: work-related grief in the workplace as defined by the substance abuse counselors, reactions to grief in the workplace as defined by substance abuse counselors, and self-care practices of substance abuse counselors who experience disenfranchised grief in the workplace. Fourteen subthemes emerged that were subsequently assigned to one of the overarching themes that they represented. For the defined work-related grief, participants expressed patient-related and co-worker-related themes, with patient-related subthemes of death, relapse, and patient discharge from treatment. Reactions to work-related grief included sadness, acceptance, questioning, detachment and desensitization (including the use of dark humor), self-evaluation of boundaries, compartmentalization, self-disenfranchisement (anger, questioning professionalism, and shame), and physical symptoms. Finally, self-care practices subthemes were support (colleagues, professional counseling, sponsor, and supervisor), decompression (break from field, time off from work, and pamper self), and practicing the 12 step recovery program.

All participants interviewed were able to identify that, although disenfranchised grief is present in their work, they do have strategies that help them to identify and to manage the grief. The study results revealed the need for substance abuse counselors to create change in the area of grief and loss recognition in the substance abuse treatment environment, to educate those who are new in this field or are training to work in this field, and, lastly, to evoke change in the literature.

Implications.

The theoretical implications from this study include the presence of disenfranchised grief in this population before they even began training or work as substance abuse counselors. It was clear in the study that substance abuse counselors did not discuss their feelings of grief, publicly or socially, due to deeply ingrained cultural norms about how a substance abuse counselor should feel and handle a work-related loss. They described feeling embarrassed, ashamed, and guilty for having such feelings and preferred to be silent rather than risk being perceived as unprofessional or incapable. Consequently, the naming, destigmatizing, and promotion for awareness of this grief experience needs to be initiated and validated. More information is needed and it would be helpful and beneficial for substance abuse counselor educators, as well as treatment facilities who employ these counselors, to offer training and awareness through classes, presentations, and continuing education. Such curricula can prepare substance abuse counselors to characterize their experiences of disenfranchised grief and address it.

Recommendations for Future Research

Gaining an in-depth understanding of this study's participants' experiences of work-related disenfranchised grief posed new questions as a researcher and as a substance abuse counselor.

Considering the impact of work-related disenfranchised grief on the substance abuse counselor, it would seem appropriate for future studies to focus on the effects on those substance abuse counselors who had ultimately been allowed to sanction their grief through public acknowledgment or rituals versus those who had not, and how it impacts

the effectiveness of their counseling efficacy and understanding of this grief in their clients.

In addition, the potential for expanding this research and adding to the current state of knowledge is abounding with possibilities, beginning with a comparison study of the impact of disenfranchised grief on those substance abuse counselors who are not in recovery compared to the population from this study.

Finally, widening the sample base to include substance abuse counselors from other parts of the United States and other brands of treatment centers for substance abuse would enhance the quality of the sample and study. Investigating gender differences around disenfranchised grief in the substance abuse work place would provide yet another discourse and study. There is no discernable end to where this research may lead.

Researcher's Final Perspective

What can we, as a culture, learn from these participants? We recognize that grief is highly individual and individuals grieve in their own way. The way one grieves mirrors one's inner experience of loss. When one is experiencing grief on the inside and feels unsupported or unsanctioned to express this grief on the outside, disenfranchisement happens. Whether it be an individual's perceptions of the right to sanction a loss or the perception that the grief is not appropriate to acknowledge in the workplace, organizations have a responsibility to include providing support for their staff as many hospice care organizations do. Staff, and particularly therapists or counselors, including substance abuse counselors working in a substance abuse facility, need to be encouraged to engage in their own rituals as a way of validating and supporting their losses.

During and after this investigation, this researcher experienced an array of emotions ranging from sadness and frustration to elation and relief. Some were complex and difficult to report. These difficulties were especially true when exploring the complex relationships between substance abuse counselors and their clients, as well as counselor-to-counselor relationships. In this study I have shared the professional as well as recovery-laden background of all the participants, which resulted in intense reflection of my own experiences as a counselor and as a woman in recovery and how those two concepts impact each other.

Exploring this singular concept in an area (addiction) that can seem so complex, this researcher was reminded of the vulnerability not only of our clientele but also of ourselves. Experiences in this addiction culture are laden with pain, and were at times a difficult process for me as researcher, as well as the participants, to delve into. However, even though this research can be technically and emotionally cumbersome, the importance of future research in this area should not go unmentioned. As researcher, I found that with greater understanding of these participants' lives came a more educated respect for the area of work in the substance abuse counseling field and what it means to be a substance abuse counselor.

CREATIVE SYNTHESIS

Finally, I present a creative synthesis of my own understanding of and emotional response to the studied phenomenon of disenfranchised grief as a substance abuse counselor. From reflection upon the range of reactions, feelings, and dynamics I experienced while conducting this study, I created two poems. Below I present one of the

poems as illustrative of my own subjective journey alongside these generous, open, and

articulate participants/co-researchers.

<u>This Is How I See It</u>

This is how it seems to me,
Life's pretty much like therapy.

Lots of expense,
With little guarantee.

With many couches,
Places for me to lay my head.

But always expensive,
With little guarantee.

Looking for that courage,
That I seldom thought I had.

Being given a solution,
With little guarantee.

Going through the emotions,
Not knowing what they mean.

Might have stayed there forever,
With little guarantee.

Stuck on that couch,
Frozen in my own grief.

Until I touched the Ultimate,
Until I found a guarantee.

Out of myself,
And out of my grief.

Out of the dark,
With FULL guarantee.

Making light out of dark,
Laughing all the way.

REFERENCES

Adams, R. E., Boscarino, J. A., & Figley, C. R. (2006). Compassion fatigue and psychological distress among social workers: a validation study. *American Journal of Orthopsychiatry*, *76*(1), 103.

Aiken, L. S., Losciuto, L. A., AnnAusetts, M., & Brown, B. S. (1984). Paraprofessional versus professional drug counselors: Diverse routes to the same role. *International Journal of the Addictions*, *19*(2), 153-173.

Alcoholics Anonymous. (2001). *Alcoholics Anonymous* (4th ed.). New York, NY: AA World Services.

Alcoholics Anonymous World Services, Inc. (1983). *Questions and answers on sponsorship.* New York, NY: AA World Services.

Aloi, J. A. (2009). Nursing the disenfranchised: Women who have relinquished an infant for adoption. *Journal of Psychiatric and Mental Health Nursing, 16*(1), 27-31. doi:10.111/j.1365.2850.2008.01324.x.

American Counseling Association (2014). *ACA Code of Ethics*. Alexandria, VA: Author Retrieved from www.counseling.org/knowledg-center/ethics

American Psychiatric Association (APA). 2013. *Diagnostic and statistical manual of mental disorders* (5th ed.). Washington, DC: Author.

American Society of Addiction Medicine (ASAM). (2011). *Public policy statement: Definition of addiction*. Retrieved from www.asam.org/research-treatment /definition-of-addiction

Andersen, S. M., & Berk, M. (1998). The social-cognitive model of transference: Experiencing past relationships in the present. *Current Directions in Psychological Science, 7*(4), 109-115.

Anderson, K., Ewen, H., & Miles, E. (2010). The grief support in healthcare scale. Development and testing. *Nursing Research, 59*(6), 372-379. doi:10.1097/NNR.0b013e3181fca9de

Anderson, K., & Gaugler, J. (2007). The grief experiences of Certified Nursing Assistants: Personal growth and complicated grief. *Omega-Journal of Death and Dying, 54*(4), 301-318. doi:10.2190/T14N-W223-7612-0224

Attig, T. (2004). Disenfranchised grief revisited: Discounting hope and love. *OMEGA-Journal of Death and Dying*, *49*(3), 197-215.

Ball, J., Graff, H., & Sheehan, J. (1974). The heroin addicts' view of methadone maintenance. *Journal of Addiction, 69*(1), 89-95.

Barber, J. P., Gallop, R., Crits-Christoph, P., Frank, A., Thase, M. E., Weiss, R. D., & Beth Connolly Gibbons, M. (2006). The role of therapist adherence, therapist competence, and alliance in predicting outcome of individual drug counseling: Results from the National Institute Drug Abuse Collaborative Cocaine Treatment Study. *Psychotherapy Research, 16*(02), 229-240.

Barnett, J., Baker, N., Elman, N., & Schoener, G. (2007). In pursuit of wellness: The self-care imperative. *Professional Psychology: Research and Practice, 38,* 603-612.

Beck, E., & Jones, S. (2008). Children of the condemned: Grieving the loss of a father to death row. *OMEGA, 56*(2), 191-215.

Betty Ford Institute Consensus Panel. (2008). What is recovery? Revisiting the Betty Ford Institute Consensus Panel definition. *International Journal of Mental Health Addiction, 33*, 221-228. Retrieved from www.springerlink.com/content /119974/?p =55aa4dc755134a94af46d51a39170 528andpi=0

Bonanno, G. A. (2004). Loss, trauma, and human resilience: Have we underestimated the human capacity to thrive after extremely aversive events? *American Psychologist*, *59*(1), 20.

Bonanno, G., & Kaltman, S. (2001). The varieties of grief experience. *Clinical Psychology Review, 21*(5), 705-734.

Bordin, E. S. (1979). The generalizability of the psychoanalytic concept of the working alliance. *Psychotherapy: Theory, Research & Practice, 16*(3), 252–60.

Boss, P. (1999). *Ambiguous loss: Learning to live with unresolved grief*. Cambridge, MA: Harvard University Press.

Boss, P. (2007). Ambiguous loss theory: Challenges for scholars and practitioners. *Family Relations, 56,* 105-111.

Boss, P. (2010). The trauma and complicated grief of ambiguous loss. *Pastoral Psychology, 5,* 137-145.

Boss, P. (2012). The myth of closure. *Family Process*, *51*(4), 437-537.

Bowlby, J. (1980). Attachment and loss: Vol. 3. *Loss, sadness, and depression*. New York, NY: Basic Books.

Braud, W., & Anderson, R. (1998). *Transpersonal research methods for the social sciences: Honoring human experience*. Thousand Oaks, CA: Sage Publications.

Brown, B. S. (1993). Observations on the recent history of drug user counseling. *International Journal of the Addictions*, *28*(12), 1243-1255.

Brown, B., Jackson, C., & Bass, U. (1973). Methadone and abstinent clients in group counseling sessions. *The International Journal of the Addictions, 8*(2), 309-316.

Brown, L. S. (2001). Feelings in context: Countertransference and the real world in feminist therapy. *Journal of Clinical Psychology, 57*, 1005-1012.

Bruce, E. J. (1994). *A longitudinal investigation of loss and grief for mothers and fathers of children with intellectual disability.* LaTrobe University, Melbourne, Victoria, Australia.

Bruce, E. J., & Schultz, C.L. (2001). *Nonfinite loss and grief: A psychoeducational approach.* Baltimore, MD: Paul H. Brookes Publishing. The New York State Office of Alcoholism and Substance Abuse Services (OASAS) and The Partnership at Drugfree.org conducted among 2,526 adults, ages 18 and older, living in the United States.

Buck, J. A. (2011). The looming expansion and transformation of public substance abuse treatment under the Affordable Care Act. *Health Affairs*, *30*(8), 1402-1410.

Callahan, J. L., & Ditloff, M. (2007). Through a glass darkly: Reflections on therapist transformations. *Professional Psychology: Research and Practice, 38,* 547-553.

Center for Behavioral Health Statistics and Quality. (2015). *Behavioral health trends in the United States: Results from the 2014 National Survey on drug use and health* (HHS Publication No. SMA 15-4927, NSDUH Series H-50). Retrieved from http://www.samhsa.gov/ data/

Clandinin, D. J., & Rosiek, J. (2006). Mapping a landscape of narrative inquiry: Borderline spaces and tensions. In D. J. Clandinin (Ed.), *Handbook of narrative inquiry: Mapping a methodology* (pp. 35-75). Thousand Oaks, CA: Sage.

Coleman, E., & Colgan, P. (1986). Boundary inadequacy in drug dependent families. *Journal of Psychoactive Drugs*, *18*(1), 21-30.

Corr, C. A. (1998). Enhancing the concept of disenfranchised grief. *OMEGA, 38*(1), 1-20.

Corr, C. A., & Coolican, M. B. (2010). Understanding bereavement, grief, and mourning: implications for donation and transplant professionals. *Progress in Transplantation*, *20*(2), 169-177.

Creswell, J. (2012). *Qualitative inquiry and research design: Choosing among five approaches* (3rd ed). Los Angeles, CA: Sage.

Culbreth, J. (2000). Substance abuse counselors with and without a personal history of chemical dependency. *Alcoholism Treatment Quarterly, 18*(2), 67-82.

Culbreth, J. R., & Cooper, J. B. (2008). Factors impacting the development of substance abuse counseling supervisors. *Journal of Addictions & Offender Counseling*, *29*(1), 22-35.

Dalali, I., Charuvastra,V., & Schlesinger, J. (1976). Training of paraprofessionals–Some caveats. *Journal of Drug Education, 6*(2), 105-112.

Deck, E. S., & Foita, J. R. (1989). The friend griever. In K. J. Doka (Ed.), *Disenfranchised grief: Recognizing hidden sorrow* (pp. 77-89). Lexington, MA: Lexington Books.

Demi, A. S., & Miles, M. S. (1987). Parameters of normal grief: A Delphi study. *Death Studies*, *11*(6), 397-412.

Deutsch, C. J. (1985). A survey of therapists' personal problems and treatment. *Professional Psychology: Research and Practice, 16*(2), 305-515.

Dodge, K., Krantz, B., & Kenny, P. J. (2010). How can we begin to measure recovery? *Substance Abuse Treatment, Prevention, and Policy*, *5*(1), 1.

Doka, K. J. (1984). *Bereft and bereaved: Grief in non-traditional relationships.* Paper presented at a symposium of the Foundation of Thanatology, New York, NY.

Doka, K. (Ed.). (1989). *Disenfranchised grief: Recognizing hidden sorrow*. Lexington, MA: Lexington Books.

Doka, K. (2002). *Disenfranchised grief: New directions, challenges and strategies for practice.* Champaign, IL: Research Press.

Douglass, B. G., & Moustakas, C. (1985). Heuristic inquiry the internal search to know. *Journal of Humanistic Psychology*, *25*(3), 39-55.

Doukas, N., & Cullen, J. (2010). Recovered addicts working in the addiction field: Pitfalls to substance abuse relapse. *Drugs, Education, Prevention and Policy, 17*(3), 216-231.

Doukas, N., & Cullen, J. (2013). Addiction counselors in recovery: Perceived barriers in the workplace. *Journal of Addiction Research & Therapy*, *2011*.

Doyle, K. (1997). Substance abuse counselors in recovery: Implications for the ethical issue of dual relationships. *Journal of Counseling & Development*, *75*(6), 428-432.

Duff, C. T., & Bedi, R. P. (2010). Counsellor behaviors that predict therapeutic alliance: From the client's perspective. *Counselling Psychology Quarterly, 23*(1), 91-110.

Edelstein, S., Burge, D., & Waterman, J. (2001). Helping foster parents cope with separation, loss and grief. *Child Welfare League of America, 53*(1)*,* 5-25.

Ellis, A. (2003). How to deal with your most difficult client-You. *Journal of Rational-Emotive and Cognitive-Behavior Therapy, 21*, 203-213.

Elman, B. (1997). Correlates of burnout in inpatient substance abuse treatment therapists. *Journal of Addictions & Offender Counseling, 17*(2)*,* 56-66.

Elman, B. D., & Dowd, E. T. (1997). Correlates of burnout in inpatient substance abuse treatment therapists. *Journal of Addictions & Offender Counseling*, *17*(2), 56-65.

Emerson, S., & Markos, P. (1996). Signs and symptoms of the impaired counselor. *The Journal of Humanistic Education and Development, 34*(3), 108-117. doi:1001:10.1002/j.2164-4683.1996.tb00335.x

Enright, B., & Marwit, S. (2002). Diagnosing complicated grief: A closer look. *Journal of Clinical Psychology, 58*(7), 747-757. doi:10.1002/jclp.2002

Figley, C. (2002). Compassion fatigue: Psychotherapists' chronic lack of self-care. *Journal of Clinical Psychology, 58*(11), 1433-1441. doi: 10.1002/jclp.10090

Fiorentine, R., & Hillhouse, M. P. (2000). Drug treatment and 12-step program participation: The additive effects of integrated recovery activities. *Journal of Substance Abuse Treatment, 18*, 65-74.

Foa, E. B., Stein, D. J., & McFarlane, A. C. (2006). Symptomatology and psychopathology of mental health problems after disaster. *Journal of Clinical Psychiatry*, *67*(Suppl 2), 15-25.

Frank, A. W. (2012). Practicing dialogical narrative analysis. *Varieties of Narrative Analysis*, 33-52.

Galanter, M. (2007). Spirituality and recovery in 12-step programs: An empirical model. *Journal of Substance Abuse Treatment, 33,* 265–272. doi:10.1016/j.jsat.2007.04.016

Gibson, C. (1998). Semi-structured and unstructured interviewing: A comparison of methodologies in research with patients following discharge from an acute psychiatric hospital. *Journal of Psychiatric and Mental Health Nursing, 5*(6), 469-477.

Good, G. E., Thoreson, R. W., & Shaughnessy, P. (1995). Substance use, confrontation of impaired colleagues, and psychological functioning among counseling psychologists: A national survey. *The Counseling Psychologist, 23*(4), 703-721.

Grbich, C. (2012). *Qualitative data analysis: An introduction*. Thousand Oaks, CA: Sage.

Griffiths, M. (2005) The biopsychosocial approach to addiction. *Psyke & Logos, 26*(1), 18.

Grosh, W. N., & Olsen, D. C. (1994). *When helping starts to hurt: A new look at burnout among psychotherapists.* New York, NY: Norton.

Han, B., Gfroerer, J. C., Colliver, J. D., & Penne, M. A. (2009). Substance use disorder among older adults in the United States in 2020. *Addiction, 104*(1), 88-96.

Hashim, S. M., Eng, T. C., Tohit, N., & Wahab, S. (2013). Bereavement in the elderly: The role of primary care. *Mental health in family medicine, 10*(3), 159.

Hays, J. A., Yeh, Y. J., & Eisenberg, A. (2007). Good grief and not-so-good grief: Countertransference in bereavement therapy. *Journal of Clinical Psychology, 63*(4), 345-355.

Hecksher, D. (2007). Former substance abuse users working as counselors. A dual

    relationship. *Substance Use & Misuse, 42*, 1253-1268.

Helsel, P. (2008). In memoriam: The disenfranchised grief of chaplains and the recovery

    of memory. *The Journal of Pastoral Care & Counseling*, *62*(4)*,* 337-342.

Herlihy, B. (1996). When a colleague is impaired: The individual counselor's response.

    The Journal of Humanistic Education and Development, *34*(3), 118-127.

Holland, J. M., Neimeyer, R. A., Boelen, P. A., & Prigerson, H. G. (2009). The

    underlying structure of grief: A taximetrics investigation of prolonged and normal

    reactions to loss. *Journal of Psychopathology and Behavioral Assessment*, *31*(3),

    190-201.

Holt, N. L., & Tamminen, K. A. (2010). Moving forward with grounded theory in sport

    and exercise psychology. *Psychology of Sport and \Exercise*, *11*(6), 419-422.

Horowitz, M., Seigel, B., Holan, A., & Bonanno, G. (2003). Diagnostic criteria for

    complicated grief disorder. *American Journal of Psychiatry, 154*, 904-910.

Humphreys, K., Noke, J., & Moos, R. (1996). Recovering substance abuse staff

    members' beliefs about addiction. *Journal of Substance Abuse Treatment, 13*(1),

    75-78.

Jacobs, C., Mazure, H., & Prigerson, S. (2000). Diagnostic criteria for traumatic grief.

    Death Studies, *24*(3), 185-199.

Jacobs, S. (1999). *Traumatic grief: Diagnosis, treatment, and prevention*. Philadelphia,

    PA: Taylor & Francis.

Jenkins, S. R., & Baird, S. (2002). Secondary traumatic stress and vicarious trauma: A

    validational study. *Journal of Traumatic Stress*, *15*(5), 423-432.

Jones, T., Sells, J., & Rehfuss, M. (2009). How wounded the healers? The prevalence of relapse among addiction counselors in recovery from alcohol and other drugs. *Alcoholism Treatment Quarterly, 17,* 389-408.

Kaczmarek, M., & Backlund, B. (1991). Disenfranchised grief: The loss of an adolescent romantic relationship. *Adolescence, 26*(102), 253-260.

Kalisch, D., & Brabant, S. (2006). A continued look at Doka's grieving rules: Deviance and anomie as clinical tools. *OMEGA, 53*(3), 227-241. doi:10.2190/FVTR-T8EV-3TQ6-QAJC

Kauffman, J. (1989). Intrapsychic dimensions of disenfranchised grief. In K. J. Doka (Ed.), *Disenfranchised grief: Recognizing hidden sorrow* (pp. 331-378). Lexington, MA: Lexington Books.

Kauffman, J. (2002). The psychology of disenfranchised grief: Liberation, shame, and self-disenfranchisement. In Kenneth J. Doka (Ed.), *Disenfranchised grief: New directions, challenges, and strategies for practice* (pp. 61-77). Champaign, IL: Research Press.

Kilburg, R., Kaslow, F., & VandenBos, G. (1988). Professionals in distress. *Hospital and Community Psychiatry, 39*(7), 723-725.

Kirk-Brown, A., & Wallace, D. (2004). Predicting burnout and job satisfaction in work place counselors: The influence of role stressors, job challenges, and organizational knowledge. *Journal of Employment Counseling, 41*(1), 29-37. doi:10.1002/J.2161-1920.2004.TB00875.X

Klutschkowski, F., & Troth, W. A. (1995). Components for a substance abuse counselor education curriculum: A Delphi study. *Journal of Addictions & Offender Counseling*, *15*(2), 34-41.

Knauert, A., & Davidson, S. (1979). Maintaining the sanity of alcoholism counselors. *Family and Community Health*, *2,* 65-70.

Knudsen, H. K., Ducharme, L. J., & Roman, P. M. (2006). Counselor emotional exhaustion and turnover intention in therapeutic communities. *Journal of Substance Abuse Treatment*, *31*(2), 173-180.

Knudsen, H. K., Ducharme, L. J., & Roman, P. M. (2008). Clinical supervision, emotional exhaustion, and turnover intention: A study of substance abuse treatment counselors in the Clinical Trials Network of the National Institute on Drug Abuse. *Journal of substance abuse treatment*,*35*(4), 387-395.

Knudsen, H. K., Johnson, J. A., & Roman, P. M. (2003). Retaining counseling staff at substance abuse treatment centers: Effects of management practices. *Journal of Substance Abuse Treatment*, *24*(2), 129-135.

Koh, H. K., & Sebelius, K. G. (2010). Promoting prevention through the Affordable Care Act. *New England Journal of Medicine*, *363*(14), 1296-1299.

Kottler, J., & Hazier, R. J. (1996). Impaired counselors: The dark side brought into light. *The Journal of Humanistic Education and Development*, *34*(3), 98-107.

Kübler-Ross, E., Kessler, D., & Shriver, M. (2014). *On grief and grieving: Finding the meaning of grief through the five stages of loss*. New York, NY: Simon and Schuster.

Lang, A., Fleiszer, A., Duhamel, F., Sword, W., Gilbert, K., & Corsini-Munt, S. (2011). Perinatal loss and parental grief: The challenge of ambiguity and disenfranchised grief. *OMEGA, 63*(2), 183-196.

Laudet, A. (2007). What does recovery mean to you? Lessons from the recovery experience for research and practice. *Journal of Substance Abuse Treatment, 33,* 243−256.

Laudet, A., Morgen, K., & White, W. (2006). The role of social supports, spirituality, religiousness, life meaning and affiliation with 12-step fellowships in quality of life satisfaction among individuals in recovery from alcohol and drug use. *Alcoholism Treatment Quarterly, 24,* 33−73.

Lawson, G., Petosa, R., & Peterson, J. (1982). Diagnosis of alcoholism by recovering alcoholics and by non-alcoholics. *Journal of Studies on Alcohol, 43*(7), 834-838.

Lawson, G., Venart, E., Hazler, R. J., & Kottler, J. A. (2007). Toward a culture of counselor wellness. *The Journal of Humanistic Counseling, 46*(1), 5.

Lenhardt, A. (1997a). Disenfranchised grief/hidden sorrow: Implications for the school counselor. *School Counselor, 44*(4), 264-271.

Lenhardt, A. (1997b). Grieving disenfranchised losses: Background strategies for counselors. *Journal of Humanistic Education & Development, 35*(4), 208-216.

Longabaugh,, R., Wirtz, P. W., Zweban, A., & Stout, R. L. (1998). Network support for drinking, Alcoholics Anonymous and long-term matching effects. *Addiction, 93*(9), 1313-1333.

Maercker, A., Brewin, C. R., Bryant, R. A., Cloitre, M., Reed, G. M., van Ommeren, M.,

... Rousseau, C. (2013). Proposals for mental disorders specifically associated

with stress in the International Classification of Diseases-11. *The Lancet*,

381(9878), 1683-1685.

Mahoney, M. J. (1997). Psychotherapists' personal problems and self-care patterns.

Professional Psychology: Research and Practice, *28*(1), 14.

May, R. (1939/1989). *The art of counseling.* New York, NY: Garnder.

McCrady, B. (1989). The distressed or impaired professional: From retribution to

rehabilitation. *Journal of Drug Issues, 19*(3), 337-349.

McGovern, T., & Armstrong, D. (1987). Comparison of recovering and non-alcoholic

counselors: A survey. *Alcoholism Treatment Quarterly, 4*(1), 43-60.

McLellan, A. T. (2002). Questioning the effectiveness of addiction treatments. In W. R.

Miller and Constance M. Weisner (Eds.), *Changing substance abuse through*

health and social systems (pp. 29-45). New York, NY: Springer US.

McLellan, A. T., Chalk, M., & Bartlett, J. (2007). Outcomes, performance, and quality—

What's the difference? *Journal of Substance Abuse Treatment*, *32*(4), 331-340.

Mechanic, D. (2012). Seizing opportunities under the Affordable Care Act for

transforming the mental and behavioral health system. *Health Affairs*, *31*(2), 376-

382.

Meier, P. S., Barrowclough, C., & Donmall, M. C. (2005). The role of the therapeutic

alliance in the treatment of substance misuse: a critical review of the literature.

Addiction, *100*(3), 304-316.

Meiselman, K .C. (1990). *Resolving the trauma of incest.* San Francisco, CA: Jossey-

    Bass.

Miller, E., & Omarzu, J.(1998). New directions in loss research. In J. Harvey (Ed.),

    Perspectives on loss: A sourcebook (pp. 228 - 344). London, UK: Taylor &

    Francis.

Mitchell, O., Wilson, D. B., Eggers, A., & MacKenzie, D. L. (2012). Assessing the

    effectiveness of drug courts on recidivism: A meta-analytic review of traditional

    and non-traditional drug courts. *Journal of Criminal Justice*, *40*(1), 60-71.

Moayedoddin, B., & Markowitz, J. C. (2015). Abnormal grief: should we consider a

    more patient-centered approach?. *American Journal of Psychotherapy*, *69*(4),

    361-378.

Moules, N. (1998). Legitimizing grief: Challenging beliefs that constrain. *Journal of*

    Family Nursing, 4(2), 142-166. doi:10.1177/107484079800400203

Moustakas, C. (1990). *Heuristic research: Design, methodology, and applications*.

    Newbury Park, CA: Sage Publications.

Moustakas, C. (1994). *Phenomenological research methods.* Thousand Oaks, CA: Sage.

Murray, J. A. (2001). Loss as a universal concept: A review of the literature to identify

    common aspects of loss in diverse situations. *Journal of Loss & Trauma*, *6*(3),

    219-241.

Mustaine, B. L., West, P. L., & Wyrick, B. K. (2003). Substance abuse counselor

    certification requirements: Is it time for a change? *Journal of Addictions &*

    Offender Counseling, *23*(2), 99-107.

Mulvey, K. P., Hubbard, S., & Hayashi, S. (2003). A national study of the substance abuse treatment workforce. *Journal of Substance Abuse Treatment*, *24*(1), 51-57.

National Association of Alcohol and Drug Abuse Counselors (NAADAC). (2014, Web log message). Mission and Vision Statements adopted 1998. Retrieved from http://naadac.org/vision-a-mission

Nielsen, L. A. (1988). Substance abuse, shame and professional boundaries and ethics: Disentangling the issues. *Alcoholism Treatment Quarterly*, *4*(2), 109-137.

Niemeier, J., & Burnett, D. (2001). No such thing as 'uncomplicated bereavement' for patients in rehabilitation. *Disability and Rehabilitation, 23*(15), 645-653.

Neimeyer, R. A., & Jordan, J. R. (2002). Disenfranchisement as empathic failure: Grief therapy and the co-construction of meaning. *Disenfranchised Grief*, 95-117.

O'Brien, John M. (2011). Wounded healer: Psychotherapist grief over a client's death. *Professional Psychology: Research and Practice*, *42*(3), 236-243. doi:10.1037/a0023788

O'Brien, K. M. (2001). The legacy of Parsons: Career counselors and vocational psychologists as agents of social change. *The Career Development Quarterly*, *50*(1), 66-76.

O'Halloran, T., & Linton, J. (2000). Stress on the job: Self-care resources for counselors. *Journal of Mental Health Counseling, 22*(4), 354-364.

Papadatou, D. (1997). Training health professionals in caring for dying children and grieving families. *Death Studies*, *21*(6), 575-600.

Papadatou, D. (2000). A proposed model of health professionals' grieving process. *OMEGA-Journal of Death and Dying*, *41*(1), 59-77.

Parkes, C. M. (1965). Bereavement and mental illness. *British Journal of Medical Psychology*, *38*(1), 13-26.

Parkes, C. M. (1998). Coping with loss: Bereavement in adult life. *British Medical Journal, 316, 856-859.*

Pattison, E. (1973). A differential view of manpower resources. In G. Staub & L. Kent (Eds.), *The para-professional in the treatment of alcoholism* (pp. 9-31). Springfield, IL: Charles C. Thomas Publisher.

Patton, M. Q. (1999). Enhancing the quality and credibility of qualitative analysis. *Health Services Research, 34*(5 Pt 2), 1189.

Pines, A., & Maslach, C. (1978). Characteristics of staff burnout in mental health settings. *Psychiatric Services*, *29*(4), 233-237.

Polanyi, M. (1966/1983). *The tacit dimension*. Garden City, NY: Anchor Books.

Pope, K. S. (1991). Dual relationships in psychotherapy. *Ethics & Behavior*, *1*(1), 21-34.

Pope, M. (2000). A brief history of career counseling in the United States. *The Career Development Quarterly, 48,* 194-211.

Preli, R., Protinsky, H., & Cross, L. (1990). Alcoholism and family structure. *Family Therapy: The Journal of the California Graduate School of Family Psychology*, *17*(1).

Prigerson, H. O., & Jacobs, S. C. (2001). Traumatic grief as a distinct disorder: A rationale, consensus criteria, and a preliminary empirical test. In M. S. Stroebe, R. O. Hansson, W. Stroebe, & H. Schut (Eds.), *Handbook of bereavement Research: Consequences, coping, and care* (pp. 613-645). Washington, DCL American Psychological Association.

Prigerson, S. J. H. (2000). Psychotherapy of traumatic grief: A review of evidence for psychotherapeutic treatments. *Death Studies*, *24*(6), 479-495.

Project MATCH Research Group. (1998). Matching alcoholism treatment to client heterogeneity: Project MATCH three-year drinking outcomes. *Alcoholism: Clinical and Experimental Research, 22*, 6, 1300-1311.

Ramsdell, P. S., & Ramsdell, E. R. (1993). Dual relationships: Client perceptions of the effect of client-counselor relationship on the therapeutic process. *Clinical Social Work Journal*, *21*(2), 195-212.

Reamer, F. (1992). The impaired social worker. *Social Work, 37*(2), 165-170.

Richards, L., & Morse, J. M. (2007). Coding. *Read me first for a user's guide to qualitative methods*, (pp. 133-151). Newbury Park, CA: Sage Publications.

Ringold, S., Lynm, C., & Glass, R. (2005). Grief. *JAMA, 293*(21), 2686.

Ritchie, J., Lewis, J., & Elam, G. (2003). Designing and selecting samples. In J. Ritchie & J. Lewis (Eds.), *Qualitative research practice: A guide for social science students and researchers* (pp. 77-108). Thousand Oaks, CA: Sage.

Ritter, A., Stephen, B., Murray, T., Ross, P., Greeley, J., & Pead, J. (2002). The influence of the therapeutic relationship in treatment for alcohol dependency. *Drug and Alcohol Review, 21*, 261-268. doi:10.1080/0959523021000002723

Rogers, C. (1942). *Counseling and psychotherapy: Newer concepts in practice.* Oxford, England: Houghton Mifflin.

Rogers, C. (2000). Interview with Carl Rogers on the use of self in therapy. In M. Baldwin (Ed.), *The use of self in therapy* (pp. 29-38). Binghamton, NY: Haworth.

Romanoff, B. D. (1998). Rituals and the grieving process. *Death Studies*, *22*(8), 697-711.

Romanyshyn, R. D. (2010). The wounded researcher: Making a place for unconscious dynamics in the research process. *The Humanistic Psychologist, 38*(4), 275-304.

Rosenberg, J. (2009). Ritualized grieving by an Australian woman for her stillborn twin. *Health Sociology Review, 21*, 406-412. doi:10.5172/ESR.2012.21.4.406

Rubington, E. (1984). Staff burnout in a detox center: An exploratory study. *Alcoholism Treatment Quarterly, 1*, 61-71.

Salston, M., & Figley, C. R. (2003). Secondary traumatic stress effects of working with survivors of criminal victimization. *Journal of Traumatic Stress, 16*(2), 167-174.

Schwandt, T. A., Lincoln, Y. S., & Guba, E. G. (2007). Judging interpretations: But is it rigorous? Trustworthiness and authenticity in naturalistic evaluation. *New Directions for Evaluation, 114*, 11-25.

Sedgwick, D. (1994). *The wounded healer: Countertransference from a Jungian perspective.* New York, NY: Routledge.

Selby, S., Moulding, N., Clark, S., Jones, A., Braunack-Mayer, A., & Beilby, J. (2009). Back home: A qualitative study exploring re-entering cross cultural missionary aid workers' loss and grief. *Omega-Journal of Death and Dying, 55*(1), 19-38. doi:10.219/00M.59.1.b

Shapiro, E. R. (1994). *Grief as a family process: A developmental approach to clinical practice*. New York, NY: Guilford Press.

Shear, M. K., & Smith-Caroff, K. (2002). Traumatic loss and the syndrome of complicated grief. *PTSD Research Quarterly, 13*(1), 1-8.

Sheffield, D. S. (1998). Counselor impairment: Moving toward a concise definition and protocol. *The Journal of Humanistic Counseling, 37*(2), 96.

Shipko, J. F., & Stout, C. E. (2002), A comparison of the personality characteristics between the recovering alcoholic and non-alcoholic counselor. *Alcoholism Treatment Quarterly, 9,* 207-214.

Simpson, D. D., Joe, G. W., Rowan-Szal, G. A., & Greener, J. M. (1997). Drug abuse treatment process components that improve retention. *Journal of Substance Abuse Treatment, 14*(6), 565-572.

Smith, H. I. (2006). Does my grief count? When ex-family grieves. *Illness, Crisis & Loss, 14*(4), 355-372.

Smith, M. J. W., Whitaker, T., & Weismuller, T. (2006). Social workers in the substance abuse treatment field: A snapshot of service activities. *Health & Social Work, 31,* 109-117.

Sobel, S., & Cowan, C. B. (2003). Ambiguous loss and disenfranchised grief: The impact of DNA predictive testing on the family as a system. *Family Process, 42*(1), 47-57. doi:10.1111/j.1545-5300.2003.00047.x

Spidell, S., Wallace, A., Carmack, C., Nogueras-Gonzalez, G., Parker, C., & Cantor, S. (2011). Grief in healthcare chaplains: An investigation of the presence of disenfranchised grief. *Journal of Health Care Chaplaincy, 17,* 75-86.

Stadler, H., Willing, K., Eberhage, M., & Ward, W. (1988). Impairment implications for the counseling profession. *Journal of Counseling and Development, 66,* 258-260.

Stroebe, M., & Schut, H. (1998). Culture and grief. *Bereavement Care, 17*(1), 7-11.

Substance Abuse and Mental Health Services Administration (SAMHSA). (2015). *Recovery and recovery support: Overview.* Retrieved from http:// www.samhsa .gov/recovery

Suri, H. (2011). Purposeful sampling in qualitative research synthesis. *Qualitative Research Journal, 11*(2), 63-75.

Swearingen, C. (1990). The impaired psychiatrist. *Psychiatric Clinics of North America, 13*(1), 1-11.

Thoreson, R., Miller, M., & Krauskopf, C. (1989). The distressed psychologist: Prevalence and treatment considerations. *Professional Psychology: Research and Practice, 20*(3), 153-158.

Tzankow, S. (2010). Ethically responsible recovery: Working counselors in recovery have an obligation to sustain their healing. *Addiction Professional, 8*(3), 34-37.

U.S. Census Bureau. (2014, January 12). State & county quick facts: Allegany County, NY. Retrieved from http://quickfacts.census.gov

U.S. Department of Labor, Bureau of Labor Statistics. (2015). *Occupational outlook handbook, Community and social service: Substance abuse and behavioral disorder counselors*. Washington, DC: Author. Retrieved from http://www.bls.gov /ooh/community-and-social-service/substance-abuse-and-behavioral-disorder-counselors.htm

Valle, S. K. (1979). *Alcoholism counseling: Issues for an emerging profession*. Springfield, IL: Thomas.

Van Manen, M. (1984). "*Doing" phenomenological research and writing: An introduction.* Alberta, CAN: University of Alberta, Department of Secondary Education.

Van Manen, M. (2015). *Researching lived experience: Human science for an action sensitive pedagogy* (2nd ed.). Walnut Creek, CA: Left Coast Press.

Vredenburgh, L. D., Carlozzi, A. F., & Stein, L. B. (1999). Burnout in counseling psychologists: Type of practice setting and pertinent demographics. *Counselling Psychology Quarterly, 12*(3), 293-302.

Wallace, S., Lee, J., & Lee, S. (2010). Job stress, coping strategies, and burnout among abuse-specific counselors. *Journal of Employment Counseling, 47,* 111-122.

White, W. (2000). The history of recovered people as wounded healers: II. The era of professionalization and specialization. *Alcoholism Treatment Quarterly, 18*(2), 1-25.

White, W. (2007). Addiction recovery: Its definition and conceptual boundaries. *Journal of Substance Abuse Treatment, 33*, 229−241.

White, W. (2008). Alcohol, tobacco and other drug use by addiction professionals: Historical reflections and suggested guidelines. *Alcoholism Treatment Quarterly, 26,* 500-535.

White, W. L. (1998). *Slaying the dragon: The history of addiction treatment and recovery in America* (p. xvi). Bloomington, IL: Chestnut Health Systems/Lighthouse Institute.

Witmer, J. M., & Young, M. E. (1996). Preventing counselor impairment: A wellness approach. *Development, 34,* 141−157.

Willis, P. (2004). From "the things themselves" to a "feeling of understanding": Finding different voices in phenomenological research. *Indo-Pacific Journal of Phenomenology, 4*(1), 1-13.

Zerubavel, N., & Wright, M. O. D. (2012). The dilemma of the wounded healer. *Psychotherapy*, *49*(4), 482.

Zimpfer, D. G. (1991). Groups for grief and survivorship after bereavement: A review. *Journal for Specialists in Group Work*, *16*(1), 46-55.

Zupanick, C. E. (1994). Adult children of dysfunctional families: Treatment from a disenfranchised grief perspective. *Death Studies, 18*(2), 183-195.

APPENDIX A

ST. MARY'S UNIVEERSITY IRB APPROVAL

IRB APPROVAL

ST. MARY'S UNIVERSITY

If, at any time, you make changes to the research protocols that affect human participants, you must file a "Changes to Approved IRB Protocol and/or Unanticipated Problems" form. Changes must be reviewed and approved by IRB before proceeding with data collection.

Good work on an important aspect of chemical dependency counseling. I look forward to seeing your findings.

Dan Ratliff, Ph.D.
IRB Chair
St. Mary's University

ATTACHMENT: Approval Stamp jpeg file
CC: Julie Strentzsch, PhD, Faculty Sponsor
        Ray Wooten, PhD, Dept Chair
        Melanie Harper, PhD, IRB Area Representative

APPENDIX B

RECRUITMENT LETTER

Letter to xxxx

<div align="center">

Melissa C. Pettit, LPC-S, LCDC

6338 N. New Braunfels #244

San Antonio, TX 78209

(830) 486-5426

melissacpettit@att.net

</div>

January 2014

Dear Chapter, Organization or Group Representative,

My name is Melissa C. Pettit and I am currently a doctoral student at St. Mary's University. I am also a licensed chemical dependency counselor. Presently, I am working on my doctoral dissertation and would like to request permission to recruit volunteers from your organization to participate in my research. Please find attached a brief summary of the study.

The title of my study is Disenfranchised Grief in the Chemical Dependency Counselor: A Grounded Theory Study

How grief is experienced is critical for the resilience of the chemical dependency counselor, particularly for those who come in contact with stories of loss and grief from their clients, or for those counselors who clients die or have a relapse after being in the counselor's care. If a counselor feels their own grief is unsupported, disregarded, unobserved, not warranted, or allowed (self-disenfranchised), the counselor may experience disenfranchised grief.

Specifically, I am looking into understanding how this disenfranchised grief may not only affect the counselor's client relationships, but also how does the counselor recognize and deal with their own possible grief that may arise during the course of therapy. For those of us who are counselors, this information is vital or other mental

health care practitioners to gain insight into how our grief experiences not only impact us, but also impact our understanding of how our clients are affected by our disenfranchised grief. Such information can also impact the quality and efficacy of the service we offer to clients. Participation is a low risk undertaking using surveys and interviews and would welcome any other organizations..

I appreciate your consideration of this request and it is my hope that you, too, see the importance and need for my research. I would like very much to present my study before your group members in hopes that they may want to be part of such an ambitious and valuable study. Please concur.

Thank you.

Sincerely,

Melissa C. Pettit, M.Ed. ABD

APPENDIX C

QUALTRICS SURVEY

INFORMED CONSENT, DEMOGRAPHIC QUESTIONNAIRE

**CONSENT BY PARTICIPANT FOR PARTICIPATION
IN A RESEARCH PROJECT**

Dear Participant,

I want to invite you to participate in an exploratory research study entitled: Disenfranchised Grief in the Recovering Chemical Dependency Counselor.

The purpose of this study is to create a grounded theory that unfolds understanding and approaches for providing assistance to Recovering Substance Abuse Counselors, who have experienced disenfranchised grief as a result of their work.
Grief that is experienced without recognition and/or validation is referred to as "disenfranchised grief".

This demographic questionnaire available on this site will be used in order to gather basic information for the interview. It is expected that you will take between 10 to 15 minutes to take this survey. If you decide to participate you will be contacted via the information that you leave at the end of the survey. You will be asked to partake in a face-to-face interview through a virtual platform such as Adobe Connect or Vsee or a live interview at the Family Life Center in St. Mary's University, on a later date. The interview will last approximately 60 to 90 minutes during which you have will have the opportunity to share your experiences related to your work as a Recovering Substance Abuse Counselor and experiences of grief related to your role. By participating in the interview you will be audio recorded using Adobe Connect or Vsee or if live, digitally recorded. Once recorded, interviews will be transcribed for the purpose of comparing experiences of several participants. You will be contacted a second time after the initial interview in order to review your responses and make clarifications on any information that you may want to add to the study. The total amount of time commitment for this entire process will be a minimum of 90 to 120 minutes.

I do not forsee that you should experience any physical risks as a result of your participation in this project. Should any anticipated issues occur you will be advised that you may end the study and contact the principle researcher, Melissa Pettit, LPC-S, LCDC, as well as speak to the Chair of the research committee, Dr. Julie Strentzsch.
YOUR ANSWERS WILL REMAIN CONFIDENTIAL. The information given will be stored separately from the recordings, transcripts, and other research data in order to ensure confidentiality of your responses. Your name will only be known to me and you will have the opportunity to choose a pseudonym in order to keep your privacy.

Any questions about this research, or any related problems may be directed to the principle investigator: Melissa C. Pettit, LPC-S, LCDC, (830) 486-5426. You may also contact the faculty adviser for this project, Dr. Julie Strentzsch, (210) 438-6405.

ANY QUESTIONS REGARDING YOUR RIGHTS AS A RESEARCH PARTICIPANT MAY BE ADDRESSED TO THE ST. MARY'S UNIVERSITY INSTITUTIONAL REVIEW BOARD HUMAN SUBJECTS (210-436-3736). ALL RESEARCH PROJECTS THAT ARE CARRIED OUT BY INVESTIGATORS AT ST. MARY'S UNIVERSITY ARE GOVERNED BY REQUIREMENTS OF THE UNIVERSITY AND THE FEDERAL GOVERNMENT

I voluntarily give my consent to participate in this study by checking "yes" below: Clicking "yes" below acknowledges voluntary participation in this research project. Such participation does release the investigator(s), institution(s), sponsor(s) or granting agency(ies) from their professional and ethical responsibility.

○ Yes

○ No

>>

Have you been a Substance Abuse Counselor for 2 or more years?

○ Yes
○ No

>>

Do you have at least 2 years of continuous recovery?

○ YES
○ NO

>>

Have you experienced what you perceive to be an "unrecognized" or "unsupported" loss during your work as a Chemical Dependency Counselor?

○ NO
○ YES

>>

Have you felt that if you expressed feeling grief in your job, that you would not be supported?

○ YES
○ NO

>>

Do you feel like you should be able to "handle" loss, and that you are responsible to help others "handle" their losses?

○ Yes
○ No

>>

Have you felt that your loss was not a "typical" or "normal" loss?

○ YES

○ NO

>>

Have you felt that the population that you work with has a lot of unsupported losses?

○ YES

○ NO

>>

Professional Licensure

◉ Licensed Chemical Dependency Counselor

◉ Licensed Professional Counselor

◉ Licensed Social Worker

◉ Licensed Marriage and Family Therapist

◉ Psychologist

Work environment

◉ Chemical Dependency Treatment Facility

◉ Hospital

◉ Private Practice/ Group Practice

◉ Other

Current Age

Gender

◉ Male

◉ Female

Marital status

○ Married
○ Single
○ Partner

Ethnicity

○ African American
○ Hispanic
○ Asian
○ White
○ Native American
○ Other

Would you be willing to participate in this study: Disenfranchised Grief in the Recovering Substance Abuse Counselor?

○ YES
○ NO

>>

Would it be ok if I contacted you?

○ YES
○ NO

>>

What would be the best way for us to communicate? Please indicate below.

>>

We thank you for your time spent taking this survey.
Your response has been recorded.

VITA

Melissa C. Pettit
San Antonio, Texas
78209
(830) 486-5426

EDUCATION:
Ph.D. St. Mary's University, Department of
Counseling and Human Services, degree expected
August 2017
M.Ed., Sul Ross Rio Grande College, July 1997
B.A., University of Hawaii- West Oahu, August 1995

DISSERTATION:
"Disenfranchised Grief and the Substance Abuse
Counselor: A Heuristic Inquiry"

This study generated an inquiry of how substance
abuse counselors experience and manage
disenfranchised grief in their work with the substance
abuse population.

Dissertation Committee Members: Dr. R. Wooten
(chair), Dr. D. Comstock-Benzick, Dr. J. Parsons

LICENSES:
Licensed Professional Counselor – 2001
Licensed Professional Counselor-Supervisor - 2006
Licensed Chemical Dependency Counselor - 2013

**EXTENSIVE PROFESSIONAL
COMPETENCIES:**
Play Therapy/ Filial Therapy – 2001
Sexual Assault First Responder and Counselor –
2002
Grief/ Bereavement/ Hospice Trained Counselor –
2005
First Responder Crisis Intervention Specialist- Levels
I and II - 2015
EMDR – Levels I and II – 2016

PROFESSIONAL EXPERIENCE:
United States Department of Defense-Worldwide
Military Family Life Consultant/ Counselor
2009 - present
*Behavioral health counseling to Service Members
and their families to augment existing military
support programs that support operational readiness.

La Hacienda Substance Abuse Treatment Center,
Hunt, Texas
*Licensed Professional Counselor-Supervisor &
Licensed Chemical Dependency Counselor*
2012 - present – PRN status
(work performed one weekend per month on average)
*Conduct psycho-education presentations on
substance dependence, basic pharmacology and
neurophysiology of addiction; as well as conduct
focus groups, individual and family counseling
sessions and treatment plans for chronic relapse and
dual diagnosis patients.

Private Practice, Uvalde, Texas
Licensed Professional Counselor   2001 - 2009
*Provided psychotherapy to a wide variety of clients,
with emphasis working with children and families.
Specialization in Play Therapy, substance abuse,
domestic issues, and filial therapy.
Maintained contracts with the following:
   -38th Judicial Substance Abuse Treatment Center
   -CDI Head Start Program Mental Health Consultant

Uvalde County/ Hill Country MHMR
Case Manager – child and adult   1998 - 2001
*Conducted intake and diagnostic evaluations, crisis
screening and CBT counseling services consistent
with HSHS curricula. Also appointed as clinical files
quality and compliance auditor.

United States Navy - Gulf -War Veteran with
decorated and honorable discharge – Worldwide
USN Hospital Corpsman   1990-1994
*Performed and assisted in the prevention and
treatment of disease and injury, while assisting other
healthcare professionals in providing medical care to
Navy people and their families.

TEACHING EXPERIENCE:
St. Mary's University CN3300 Sec A
Introduction to Substance Abuse

PRESENTATION(S):
Texas Counseling Association Conference- San
Antonio, Texas   - 2013
Co-presenter on topic of PTSD
 *My portion of presentation concerned role of TBI
and PTSD in returning military members, its
symptoms and known treatments as well as the
impact on the untreated patient and the family unit.