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The Party's Over: Treating Grief During Recovery for Alcoholic Women

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Abstract

Society often expects alcoholic women in recovery to quickly move on with their lives. This can be a daunting task since many women experience grief and loss as a consequence of previous addictive behaviors or change in lifestyle. This grief and loss must be treated if alcoholic women are to abstain, long-term, from alcohol use and lead satisfying lives. This article distinguishes between symptoms of depression and addiction-related grief and concludes by detailing a specific model counselors can use to help female alcoholics in the recovery process.

A hallmark of the addictions process is loss (Haberstroh, 2007). As a result, treating the addiction-related grief and loss experienced by clients with substance abuse or addiction issues is essential (Haberstroh, 2007). Giving the female alcoholic client an opportunity to genuinely express emotions regarding losses that have occurred as a result of alcoholism increases the likelihood that sobriety is maintained and recovery occurs (Shallcross, 2011). The addicted client cannot properly address the grief she is feeling and may deny the grief by drinking more heavily. When the client finally seeks professional help for her addiction issues, she may lack the healthy coping skills needed to acknowledge, address, and accept the losses that have occurred (Haberstroh, 2007). The deeply personal losses the client is facing come into sharp focus, and a need to deaden the intense pain may occur resulting in relapse, blocked healing, and may even place the client in continued danger (Boss, 2006; Haberstroh, 2007; Shallcross, 2011). This article intends to assist counselors by defining addiction-related grief and loss and offering a unique treatment model that can be applied when working with female

alcoholics. Definitions and examples of addiction-related grief, program theory and rationale, and specific implementation strategies will be discussed.

Definitions and Explanation of Addiction-Related Grief and Loss

The Impact of and Types of Loss Experienced

Because loss is significantly interwoven with the addiction process, the losses that have occurred might have taken place prior to the onset of addiction, during active addiction, or during recovery (Shallcross, 2011). Losses might include marriages, jobs, income, or children, as well as loss of identity, concept of self, meaning in life, and potential for success. There are gender differences reported in the literature in terms of addiction-related loss. In a study investigating shame in alcoholic women, it was found that women lose much of their self-esteem and positive self-image due to the stigma of their alcoholism (DiBacco, 2010).

Case example. The following case illustrates issues licensed professional counselors face when diagnosing and assisting clients presenting with addiction-related grief.

A client calls and gives an intake at a counseling agency, reporting symptoms of sadness, sluggishness, sleep issues, loss of appetite, and constant stress and worry. The client reports that she knows it is not because of alcohol or drugs because she has been sober for more than 6 months. The client states that she does not understand what is wrong. She explains that she is depressed and has little interest in things that used to bring pleasure.

This type of information gathered as part of an intake assessment is common among licensed professional counselors. The initial reaction of the counselor may be to diagnose the client using *The Diagnostic and Statistical Manual of Mental Disorders* (5th ed.; *DSM-5*; American Psychiatric Association [APA], 2013). As part of this diagnosis, the counselor may compare symptoms of major depressive disorder (MDD) or dysthymia, bereavement, and substance use disorders. This comparison yields many similarities and overlaps (See Figure 1). For example, MDD/dysthymia often follows a severe psychosocial stressor such as the death of a loved one; bereavement is the reaction to the death of a loved one; and substance use disorders are accompanied by symptoms of depression, prolonged sadness, and grief (APA, 2013). Likewise, substance dependence (particularly alcohol or cocaine) may contribute to the onset or exacerbation of MDD; grieving individuals often present with similar symptoms as MDD, and mood disorders such as MDD or dysthymia are often present (APA, 2013). All three disorders include symptoms of marked functional impairment, sleep disruption or prolonged sleep, persistent sadness, decrease in perceived self-worth and lowered self-esteem, feelings of guilt, social withdrawal, preoccupation with the past, and anger (APA, 2013).

How then, might a counselor properly diagnose and treat a client such as the case example given above? If the client has a history of substance abuse or addiction(s), and presents with the symptoms listed above, counselors may wish to consider treating addiction-related grief as part of the counseling process. To aid counselors with this process, a description of a specific model designed to treat the aforementioned symptoms of addiction-related grief and loss follows.

<i>Major Depressive Disorder / Dysthymia</i>	<i>Bereavement</i>	<i>Substance Use Disorders</i>
Often follows a severe psychosocial stressor such as the death of a loved one.	The reaction to the death of a loved one.	Symptoms of depression, prolonged sadness, and grief present.
Substance Dependence (particularly alcohol or cocaine) may contribute to the onset or exacerbation of MDD.	Grieving individuals often present with similar symptoms as MDD.	Mood disorders such as MDD or Dysthymia often present.
Decreased physical, social, and role function.	Prolonged and marked functional impairment.	Repeated failure to fulfill major physical, social, and interpersonal role obligations.
Insomnia / Hypersomnia.	Insomnia.	Insomnia / Hypersomnia.
Sadness; “Down in the dumps.”	Heavy sadness.	Sadness; Symptoms of Depression.
Low self-esteem; See self as uninteresting or incapable.	Morbid preoccupation with worthlessness.	Feelings of worthlessness, low self-esteem, and lack of self-efficacy in ability to overcome.
Feelings of guilt.	Guilt.	Guilt regarding past.
Social withdrawal.		Recurrent social and interpersonal problems; Impaired social functioning.
Brooding about the past.	Preoccupation with past.	Marked preoccupation with past.
Anger	Anger	Anger

Figure 1. Comparison of DSM-IV-TR (2005) Symptoms.

Program Theory, Rationale, and Description

Theories Rooted in Treating Addiction-Related Grief

The program presented is focused on an addiction-related grief and loss treatment adapted from Pauline Boss’ model for treating ambiguous grief and loss (Boss, 2006). An integrative approach to using the model is employed, including solution-focused therapy (DeShazer, 1988), existential theory (Frankl, 1963), and reality theory (Glasser, 1985).

Boss' model encompasses solution-focused brief therapy, existential theory, and reality therapy as part of the process. Boss' model integrates solution-focused brief therapy by infusing past competencies, or strengths, that previously acted as effective strategies for the client (Boss, 2006). Boss' Model further incorporates premises of Solution-focused Brief Therapy by highlighting strengths the client currently holds and, consequently, building resilience (DeShazer, 1988).

The existential approach occurs in the model originated by Boss through a focus on meaning and purpose (Frankl, 1963). Making meaning in the face of adversity is a signature element of Boss' model for treating ambiguous loss. When needed, and when appropriate for the client, confrontation may be applied. This has typically been used when the client appears to be stuck, or is in a blocked state from emoting.

A third approach embedded within Boss' model is Glasser's (1965) reality therapy. Reality therapy may be used when discussing future plans and goals. One of the treatment goals when using Boss' model is to come to a place where the client is able to formulate small goals for herself (Boss, 2006). Helping the client become aware of what she wants for the future, and what she is doing today to obtain her desired goal, is key in building resilience and strengthening her focus on the future (Rice, 2011).

Program Rationale

Pauline Boss' (2006) model for treating ambiguous loss is framed around loss that is unclear in its beginning and its end. Boss defined ambiguous loss as having no clear beginning as well as no true end, making real closure impossible. Using examples of a kidnapped child, Boss illustrated how the family of the child cannot conceive of how the child was lost, nor can they mourn the death of the child.

The conceptual basis for Boss' (2006) model is rooted in stress and resilience. Resilience is defined as having the ability to live, and perhaps even thrive, in the face of extraordinary adversity, propelling the individual into healing and developing a new way of living. Therapeutic goals for Boss' model include 1) guiding and assisting the client in learning how to walk through the losses incurred; 2) building resilience in the face of a major change in life (recovery), and the stressors attached to it, and; 3) rebuilding a life characterized by new meaning, identity, and tools to use to maintain that life (Boss, 2006).

Boss' (2006) model is an effective protocol for treating grief. As stated previously, this model can be integrated with solution-focused therapy, existential theory, and reality therapy to treat addiction-related grief among alcoholic women. With regard to the use of solution-focused therapy within the adaptation of this model, Smock et al. (2008) conducted a study comparing the effectiveness of traditional treatment modalities (control group) to the use of solution-focused therapy (treatment group) on substance abuse. Levels of depression, symptom distress, and function within interpersonal relationships and social roles were significantly improved for the clients in the treatment group, versus those in the control group.

The use of existential theory is appropriate when applying the adapted model as well. In a study conducted by Van Vuuren in 2006, the influence of existential counseling on undergraduate students' level of meaning and purpose in life, self-esteem and alcohol outcome expectancies were investigated. The results indicated that existential counseling

had a significant effect on the purpose of life and alcohol outcome expectancies of the participants.

Empirical evidence also exists connecting reality therapy to successful addiction treatment (Wubbolding, 2000). For example, Honeyman (1990) inferred that after receiving reality therapy as treatment, participants felt an overall improved sense of control in their lives. Maintaining control and addressing the accompanying ambiguity can be crucial factors if clients are to overcome addictions.

For the alcoholic in recovery, when addressing addiction-related grief and loss, ambiguity is an ever-present characteristic of life. Not knowing exactly when the individual entered into the actual disease of alcoholism, and after coming into recovery and out of the fog, only to face a multitude of loss, the newly recovering alcoholic has virtually no mindful beginning or end to the losses incurred (Shallcross, 2011). This process mirrors Boss' model of ambiguous loss. Furthermore, making new meaning in life after active addiction, tempering the need to master the disease of addiction, reconstructing a new identity, normalizing the ambivalence and ambiguity present, revising attachments, and discovering hope, all of which are elements of Boss' model, are essential in maintaining, thriving, and moving forward in recovery from alcoholism (Haberstroh, 2007; Leshner, 1997; Mathis, Ferrari, Groh, & Jason, 2009; Shallcross, 2011; Taïeb, Révah-Lévy, Moro, & Baubet, 2008; Moss, 2005).

Program Elements and Implementation

Six main concepts in Boss' (2006) model for treating ambiguous grief and loss are relevant to treating addiction-related grief and loss in alcoholic women. They include: 1) Making Meaning; 2) Tempering Mastery; 3) Reconstructing Identity; 4) Normalizing Ambivalence; 5) Revising Attachments; and 6) Discovering Hope (Boss, 2006). Each concept will now be briefly discussed as related to addiction-related grief. Possible interventions are described to aid counselors in practice.

Making Meaning

According to Boss (2006), meaning is defined as "being able to make sense of an event or situation" whereby finding "some logic, coherence or rational reasoning about what has happened" (p. 74). Once in recovery from alcoholism, women are faced with gender-specific losses that have occurred while in active addiction (DiBacco, 2010). Making meaning of these losses strengthens recovery and relapse prevention (Shallcross, 2011). Laudet, Morgen, and White (2006) found that finding meaning in life enhanced recovery from addiction, gave the person something to count on, and instilled the feeling that trust would always be there.

Making meaning when treating addiction-related grief and loss consists of the following concepts and interventions as adapted from Boss' (2006) model: a) naming the problem; b) dialectical thinking; c) religion and spirituality; d) forgiveness; e) recovery rituals (recovery routine); and f) hope.

Naming the problem. By having a clear concept of what the problem(s) is, the client gains clarity of how to move forward, makes important decisions, and over time, makes sense of exactly what she is experiencing (Boss, 2006). This boosts resilience, allowing the client to live within and move forward, despite the uncertainty she is

experiencing. Once the client is able to name the experience, she is better able to begin to find the meaning of it (Boss, 2006). This concept applies to recovery as based directly upon Frankl's (1963) existential concept that an individual's suffering ceases once the person clearly understands the source of the suffering.

In counseling, the counselor and client may collaboratively make a list of the losses that have occurred, naming the loss, the context surrounding the loss, and the main cause. This allows the client to develop a framework from which she may begin to genuinely express her emotions regarding the losses (Haberstroh, 2007). The counselor may keep the list as a working document, so that he or she can refer to it later in the counseling process when needed.

Dialectical thinking. Taking a solution focused approach, the counselor may guide the client to understand the possibility of holding two opposing concepts simultaneously (Boss, 2006). Boss (2006) stated that in order to boost resilience and decrease stress, the client may discuss inherent ideas, work, life symbols, past rituals, and future hopes that are worth celebrating. The use of personal strengths in substance abuse treatment has shown promise in the prevention and reduction of substance use in females (Froeschle, Smith, & Ricard, 2007).

When treating addiction-related grief and loss, and when applying solution-focused techniques, the counselor and client may collaboratively make a list of the client's strengths, beginning with the prompt: "Even with everything I have been through, today my strengths are...". The counselor may then ask the client to practice expressing opposing ideas using the strengths list. For example, the client might say "While in active alcoholism I neglected my children, but today I am determined to stay sober and be a good mother", or "While in active alcoholism I lost my marriage, but today I am loveable."

Religion and spirituality. Spirituality can be therapeutic to the healing process (Boss, 2006) and has been suggested as a strong reinforcement in building recovery and maintaining sobriety (Streifel & Servaty-Seib, 2009). By honoring the client's spiritual beliefs, counselors may help guide the active use of spiritual (and religious, if applicable) beliefs that build resilience.

Laudet et al. (2006) found that elements of recovery including spirituality and religiousness (among others) did in fact enhance quality of life in recovery from addiction-related disorders.

During session, the counselor may initiate a discussion about the existence or non-existence of a higher power. From there, the counselor may guide the client in reflection of how spirituality may play a part in her recovery. This may be a brief intervention, or it may be an ongoing discussion during subsequent sessions.

Forgiveness. Applying Victor Frankl's (1963) groundwork of the connection between forgiveness and meaning, counselors help clients gradually shift from a focus of resentment towards others and self to forgiveness (Boss, 2006). By learning to forgive others and self, the client learns to overcome resentments and anger. This shift helps fill a spiritual void and moves the client forward in recovery and improved well-being (Lyons, Deane, & Kelley, 2010). Webb, Robinson, Brower, and Zucker (2006) found a positive correlation between forgiveness of self, by others, and by God. This forgiveness was also positively correlated with enhanced recovery from addiction.

One specific technique that utilizes forgiveness as part of the healing process involves having the client list all of the people she perceives as being a part of the overall problem. A brief discussion of each listed person can lead into soft confrontation about things that she can/cannot change, and parts she did/did not play. Likewise, once the client is able to see the true and continued source of the losses, she is better able to forgive. The act of forgiveness itself can serve as a catalyst to healing.

Recovery rituals. Boss (2006) stated when there is loss, rituals help people find meaning. During this step, the counselor's goal is in assisting clients toward the development of new, as well as the modification of old, rituals that aid in their ability to move forward (Boss, 2006). Fiorentine and Hillhouse (2000) investigated the effects of addiction on clients completing a drug/alcohol treatment program who continued with prolonged participation in integrated recovery activities. Those involved in these integrated recovery activities showed higher levels of abstinence than those in the control group, thus inferring greater possibility of long term recovery (Fiorentine & Hillhouse, 2000).

To establish new recovery rituals, the counselor may guide the client in the formulation of a plan or routine that includes treating her alcoholism on a daily basis. Options for a recovery routine might include: attending group counseling, individual counseling, AA/NA 12-Step meetings, working with a sponsor, helping fellow alcoholics in recovery, journaling, prayer and meditation, and physical activity.

Hope. Finding meaning also includes finding hope for the future (Boss, 2006). In recovery from alcoholism, there is support for the importance of finding hope. For example, a recent study exploring the relationship between hope and self-esteem and self-regulation in men and women in recovery found robust significance (Ferrari, Stevens, Legler, & Jason, 2012).

Tempering Mastery

According to Boss (2006), how an individual copes is dependent upon her beliefs about mastery and her agency (p. 98). Boss defined mastery as having the ability to manage one's life. Agency is defined as the ability to extend or exert one's own power in order to manage her life (Boss, 2006). Boss cautioned that when a client values mastery too little or too much, resilience may weaken. Furthermore, Boss stated "insisting on fixing an impossible situation can be destructive" (p.100). Alcoholism is not, practically speaking, an acute illness; rather, it is a chronic, relapsing, and re-occurring disorder (Leshner, 1997). In other words, the disease of alcoholism is not fixable or curable; it is only treatable.

Boss' (2006) elements of Tempering Mastery that apply to treating addiction-related grief are as follows: a) externalizing the blame; b) identifying past competencies; and c) mastering one's internal self. These applicable elements will be discussed in the following sections and include specific counseling techniques to aid with treatment.

Externalizing the blame. Regardless of the individual's worldview, it can be beneficial for individuals to credit their feelings of helplessness and lack of mastery to an external source (Boss, 2006). With regard to alcoholism or substance abuse disorders, use is often considered a maladaptive or avoidant coping strategy characterized by behaviors such as risk taking, attention seeking, and the like (Kuper, Gallop, & Greenfield, 2010). A pilot study investigating mindfulness-based relapse prevention revealed lower rates of

post-treatment substance use, decreases in cravings, and increases in acceptance and awareness when the client was able to recognize old behaviors and lifestyle (Bowen et al., 2009).

Once the client is able to see the difference between her behaviors while in active alcoholism as compared to her behaviors when sober, she is able to gain some clarity about the source and cause of her losses. One recommendation for intervention made by the authors is to refer to the client's list of losses, and discuss how she would handle the situation *today*, while sober. Counselor and client may then begin to discuss at length the insights, attitudes, and feelings associated with behaviors as a sober person versus behaviors when in active addiction.

Identifying past competencies. Boss (2006) suggested the importance of looking for past evidence of resiliency. DeShazer (1988) utilized exception questions to determine methods that worked previously for clients. As a result, during this step, counselors might ask clients to discuss things that worked in the past and listen to success stories of others in recovery.

Mastering one's internal self. When the client's perceived external world is unmanageable, learning to manage her inner world is helpful and may reduce stress (Boss, 2006). Furthermore, when a circumstance cannot be changed, counselors can help the client reframe her thinking about the situation, shifting the perception to where it is no longer immobilizing (Boss, 2006). For women in recovery from alcoholism, the internal self (or self identification) includes intention, self-efficacy, coping skills, self-esteem, attitudes, beliefs, and perceived self-worth (Moos, 2008). Ostafin, Marlatt, and Greenwald (2008) studied the role that self-regulation, or control, plays in alcohol consumption and abstinence. They concluded that when drinkers experience conflict between wanting to drink and wanting to restrain from drinking, they are likely to drink when their self-control resources are depleted (Ostafin et al., 2008).

Possible interventions that help the client master the internal self include reading relevant literature, working with a sponsor, journaling, and existential self-reflection processed during the session. Additional techniques that might be used by the counselor include self-esteem building, reflection on positive attributes of the client's life, and strengths building.

Reconstructing Identity

Boss' (2006) model stated that the trauma from ambiguity significantly disrupts the client's capability to clearly think about who she is, including expectations of what she is supposed to do. During the process of recovering from alcoholism, trauma can be explained in terms of "the management of a spoiled identity," wherein "the addict has to restore her damaged sense of self" (Taïeb et al., 2008). Identity in this context is defined as "knowing whom one is and what roles one will play" (Boss, 2006, p. 116). In a study conducted in 2000, Downey, Rosengren, and Donovan found that clients with addictive behaviors are greatly motivated to change when there are discrepancies and conflicts realized between identities. For example, when engaged in substance abuse, incongruent client identities and valued self-standards cause cognitive dissonance leading to a need for balance (Downey et al., 2000). Reconstructing identity is, therefore, an important concept requiring the counselor to assist the client in defining boundaries, selecting major

developmental themes, developing new values and views, and breaking through resistance to change (Boss, 2006).

Normalizing Ambivalence

In Boss' (2006) model, when the adjective *ambiguity* is employed to describe loss, she defines it as having "no validation or clarification of the loss," (p. 144). *Ambivalence*, then, refers to conflicting feelings and emotions associated with the ambiguity of the losses that have occurred. In recovery, the client discovers that addiction-related loss could be both tangible and intangible (Haberstroh, 2007), or ambiguous. The client may think it easier to feel ambivalent to the overwhelming host of emotions, confusions, and fear in moving forward (i.e., "I will think about that later."). As a result, counselors must offer the client opportunities to express genuine feelings and emotions that underlie unresolved addiction-related losses (Habertsroh, 2007). In doing so, resilience will increase (Boss, 2006). Yeh, Che, and Wu (2009) conducted a qualitative study investigating the experiences of individuals who had achieved remission from alcoholism. It was found that in all cases, the participants partially attributed their achieved recovery to working through the ambivalence they felt about their addiction (Yeh et al., 2009).

To normalize ambivalence, Boss (2006) suggested the following interventions: a) normalizing guilt and negative feelings; b) regaining personal agency; c) seeing the community as family; d) reassigning everyday roles and tasks; e) asking questions about context and situation; f) bringing ambivalent feelings into the open; g) managing the ambivalence once in the open; h) valuing diverse ways of managing ambivalence; and i) developing tolerance for tension.

Revising Attachments

Traditionally, attachment is defined as "the relational and reciprocal connection to a constant other" (Boss, 2006, p. 164). In recovery, attachment may take on a similar concept. In her dissertation, *Unresolved Grief and Loss Issues Related to Substance Abuse*, Moss (2005) found that clients "grieve their addiction in very much the same manner as one grieves the loss of a loved one" (p. 2).

With the disease of alcoholism, true closure is not possible due to the fact that alcohol is everywhere in society. Therefore, helping the client develop a perceptual shift in the relationship, one that accepts the ambiguity of absence and presence, is helpful (Boss, 2006). Counselors may also need to help the client revise her attachments in terms of social support.

A model created by Longabaugh, Beattie, Noel, Stout, and Malloy (1993) proposed the use of support systems that promote abstinence from alcohol and increase sobriety outcomes. Hence, in counseling, helpful interventions are those that help the client revise attachments to people, places, and things different from her alcoholic past.

Discovering Hope

According to Boss' (2006) model, the grieving individual has come full circle; the work of finding meaning, tempering mastery, reconstructing identity, normalizing ambivalence, and revising attachment, together develop hope. Once again, Boss' model can be integrated for use with alcoholic females suffering from addiction-related grief.

Clients gradually see that hope is embedded in change, rather than in the strongly held status quo. Boss defined hope as the belief that there is a future good; that suffering can cease, and that there is comfort for the individual in the future. In recovery from alcoholism, individuals with strong beliefs in hope for their future may be more able to generate and implement strategies for preventing relapse (Mathis et al., 2009). Furthermore, researchers implore “recovery from addiction involves a re-orientation from self-deception to the pursuit of higher ideals. New meaning and hope in life is required” (Sellman, 2009, p. 10). For an alcoholic in recovery, hope is discovered in finding spirituality, imagining options, laughing at absurdity, redefining justice, finding forgiveness, and acceptance.

Future Research Implications

Although the authors have applied Boss’ (2006) grief model for treating ambiguous grief and loss to treating addiction-related grief and loss, studies are needed. In the past, and after a thorough review and investigation of the literature, studies have been conducted that have established the phenomenon of addiction-related grief and loss as a true event in the recovering alcoholic’s life (Denny & Lee, 1984; McGovern & Peterson, 1986 Moss, 2005). However, these studies have either focused on the presence of addiction-related grief in a group setting, or in an individual counseling setting with cocaine addicted clients. Studies are needed to investigate treating addiction-related grief in an individual counseling setting focusing on alcoholics.

Furthermore, it appears that the literature reports adequately on the existence of addiction-related grief and loss; however, there is a significant lack of research in how to *treat* addiction-related grief and loss in a manner that will reach best possible counseling outcomes.

Conclusion

Addiction-related grief and loss is a true, present, and confounding phenomenon for clients in recovery. The authors have applied Boss’ (2006) model of treating ambiguous grief and loss to female clients suffering from addiction-related grief and loss. Boss’ (2006) model demonstrated positive outcomes when treating ambiguous grief and loss in counseling; therefore, the model has been effectively integrated with solution-focused brief therapy, existential theory, and reality therapy techniques and applied to treating a similar phenomenon, addiction-related grief and loss.

References

- Boss, P. (2006). *Loss, trauma and resilience: Therapeutic work with ambiguous loss*. New York, NY: W. W. Norton & Company.
- Bowen, S., Chawla, N., Collins, S. E., Witkiewitz, K., Hsu, S., Grow, J., Clifasefi, S., Garner, M., Dougalss, A., Larimer, M. E., & Marlatt, A. (2009). Mindfulness-based relapse prevention for substance use disorders: A pilot efficacy trial. *Substance Abuse*, 30(4), 295-305.

- Denny, G. M., & Lee, L. J. (1984). Grief work with substance abusers. *Journal of Substance Abuse Treatment*, 1(4), 249-254.
- De Shazer, S. (1988). *Clues: Investigating solutions in brief therapy*. New York, NY: W.W. Norton & Company.
- DiBacco, N. (2010). "The Emotional Road to Recovery: Tracking the Mind and Body Experience of Shame in Women Recovering From Drugs and Alcohol", Dance/Movement Therapy & Counseling Theses. Paper 24.
- Downey, L., Rosengren, D., & Donovan, D. (2000). To thine own self be true: Self-concept and motivation for abstinence among substance abusers. *Addictive Behaviors*, 25, 743-757.
- Ferrari, J. R., Stevens, E. B., Legler, R., & Jason, L. A. (2012). Hope, self-esteem, and self-regulation: Positive characteristics among men and women in recovery. *Journal of Community Psychology*, 40(3), 292-300.
- 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(1), 65-74.
- Frankl, V. (1963). *Man's Search for Meaning: An Introduction to Logotherapy*. New York, NY: Pocket.
- Froeschle, J. G., Smith, R. L., & Ricard, R. (2007). The efficacy of a systematic substance abuse program for adolescent females. *Professional School Counseling*, 10(5), 498-505.
- Glasser, W. (1965). *Reality therapy. A new approach to psychiatry*. New York, NY: Harper & Row.
- Glasser, W. (1985). *Control theory: A new explanation of how we control our lives* (1st ed.). New York, NY: Harper & Row.
- Haberstroh, S. (2007). Facing the music. *Journal of Creativity in Mental Health*, 1(3-4), 41-55.
- Honeyman, A. (1990). Perceptual changes in addicts as a consequence of reality therapy based group treatment. *Journal of Reality Therapy*, 9(2), 53-59.
- Kuper, L. F., Gallop, R., & Greenfield, S.F. (2010). Changes in coping moderate substance abuse outcomes differentially across behavioral treatment modality. *American Journal On Addictions*, 19(6), 543-549.
- Laudet A. B., Morgen, K., & White, W. L. (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 problems. *Alcoholism Treatment Quarterly*, 24(1-2), 33-73.
- Leshner, A. I. (1997). Addiction is a brain disease, and it matters. *Science*, 278(5335), 45-47. doi: 10.1126/science.278.5335.45.
- Longabaugh, R., Beattie, M., Noel, N., Stout, R., & Malloy, P. (1993). The effect of social investment on treatment outcome. *Journal of Studies on Alcohol and Drugs*, 54(4), 465.
- Lyons, G. C. B., Deane, F. P. & Kelly, P. J. (2010). Forgiveness and purpose in life as spiritual mechanisms of recovery from substance use disorders. *Addiction Research and Theory*, 18(5), 528-543.
- Mathis, G. M., Ferrari, J. R., Groh, D. R., & Jason, L. A. (2009). Hope and substance abuse recovery: The impact of agency and pathways within an abstinent

- communal living setting. *Journal of Groups in Addiction & Recovery*, 4(1-2), 42-50.
- McGovern, T., & Peterson, A. V. (1986). Distinguishing between depression and grief in Alcoholism: A pilot clinical study. *Alcoholism Treatment Quarterly*, 3, 31-45.
- Moos, R. H. (2008). Active ingredients of substance use-focused self-help groups. *Addiction*, 103(3), 387-396.
- Moss, D. A. (2005). *Unresolved grief and loss issues related to substance abuse* (Doctoral Dissertation). Available from ProQuest Information and Learning Company. (UMI No. 3174154)
- Ostafin, B. D., Marlatt, G. A., & Greenwald, A. G. (2008). Drinking without thinking: An implicit measure of alcohol motivation predicts failure to control alcohol use. *Behaviour Research and Therapy*, 46(11), 1210-1219. Retrieved from: <http://dx.doi.org.lib-e2.lib.ttu.edu/10.1016/j.brat.2008.08.003>
- Rice, M. (2011). *Choice theory with addicted populations*. Mesa, AZ: Madeira Publishing Company.
- Sellman, D. (2010). The 10 most important things known about addiction. *Addiction*, 105(1), 6-13.
- Shallcross, L. (2011). Don't turn away. *Counseling Today*, 53(12), 30-38.
- Smock, S. A., Trepper, T. S., Wetchler, J. L., McCollum, E. E., Ray, R., & Pierce, K. (2008). Solution focused group therapy for level 1 substance abusers. *Journal of marital and family therapy*, 34(1), 107-120.
- Streifel, C., & Servaty-Seib, H. L. (2009). Recovering from alcohol and other drug dependency: Loss and spirituality in a 12-step context. *Alcoholism Treatment Quarterly*, 27(2), 184-198.
- Taïeb, O., Révah-Lévy, A., Moro, M. R., & Baubet, T. (2008). Is Ricoeur's notion of narrative identity useful in understanding recovery in drug addicts? *Qualitative Health Research*, 18(7), 990-1000.
- Van Vuuren, C. H. (2006). *The influence of existential group counselling on the purpose in life, self-esteem and alcohol outcome expectancies of under-graduate students* (Doctoral dissertation, Stellenbosch: University of Stellenbosch).
- Webb, J. R., Robinson, E. A., Brower, K. J., & Zucker, R. A. (2006). Forgiveness and alcohol problems among people entering substance abuse treatment. *Journal of Addictive Diseases*, 25(3), 55-67.
- Wubbolding, R. E. (2000). *Reality therapy for the 21st century*. Philadelphia, PA: Brunner-Routledge.
- Yeh, M. Y., Che, H. L., & Wu, S. M. (2009). An ongoing process: A qualitative study of how the alcohol-dependent free themselves of addiction through progressive abstinence. *BMC Psychiatry*, 9(1), 76.

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