2020

Therapists Who Specialize in Addiction: A Grounded Situational Analysis of a Stigmatized Profession

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A DISSERTATION

Submitted to the PhD in Leadership and Change Program of Antioch University

in partial fulfillment for the degree of

Doctor of Philosophy

November 2019

This dissertation has been approved in partial fulfillment of the requirements for the degree of PhD in Leadership and Change, Graduate School of Leadership and Change, Antioch University.

Dissertation Committee

- Elizabeth Holloway, PhD, Committee Chair
- Aqeel Tirmizi, PhD, Committee Member
- William Matthews, PhD, Committee Member

Acknowledgements

As a therapist specializing in addiction, I am intimately involved on a daily basis with the challenges and satisfactions of my working life. I think I have been blessed to take on this particular specialty at a cardinal point in history, during a severe opioid epidemic, and at a pivotal point in the history of the profession and professionalization. As a scholar practitioner, I cannot imagine devoting 5 years of my attention to any other worthy subject, or with any other people, or at any other university. As a woman, I am grateful to be living in a time and place wherein I can indulge my intellectual curiosity—this has not been and is not always the case. This dissertation did not begin, progress, or end in a vacuum. There are so many people I would like to acknowledge in these pages. In the service of brevity, I will for the most part introduce and thank categories, rather than specific people, of whom there are very many indeed.

If I have done my work correctly, the participants in this study will not be identifiable by the readers, but you know who you are. This study arises from you: your experiences, your words, your generosity of time and spirit. I sincerely hope that I have faithfully articulated your challenges and satisfactions in a way that will positively affect your continuing wellness.

My committee chair, advisor, and methodologist, the awesome and amazing Dr. Elizabeth Holloway: you have been with me since the very first day of this journey and I somehow knew we would get to the end of it together. Each student in the healthcare cohort just knew we were your favorite student. As the mug says: “Don’t panic, let it be organic” (Holloway, E., 2015).

Drs. Aqeel Tirmizi and William Matthews: gratitude to my committee members, who suffered through my delighted perseveration on the history of the profession and thought it at least tolerable (and maybe a little interesting?) enough to continue on to the end.

Dr. Harriet Schwartz: Thank you, Harriet, for helping me understand grounded theory a little. Your tutelage was instructive, challenging, and enlightening. I hope you can be proud of the work that has arisen from it.

Thank you, all of my professors, with special gratitude to Drs. Laurien Alexandre (the founder of the feast), Jon Wergin, Lize Booysen, Philomena Essed, and the magical Stephen Shaw.

I feel like I was part of a miracle. Nine people joined this pilot health concentration cohort four-and-a-half years ago, and I am so happy to be finishing with six hearty and hardy souls. The experiment succeeded, even though it was fated not to continue for very long, and now those who follow after us will join a cross-sector cohort with a venerable history. Thank you, Ellen Melis, for being my research buddy, a ray of sunshine, and allowing me to be part of your grounded theory research process in turn. Gratitude and warm hugs to Maria Caban Alizondo, Jody Levison-Johnson, Lynn Redenbach, and Jeff Williams. Thank you to those who disappeared from our cohort along the way, for being fundamental parts of my journey. We traveled in Yellow Springs, Chester, and Santa Barbara in service of this process and found great places to eat and walk and be together in each. I cannot imagine a better group of people to spend every Tuesday night with, and I miss you now that the process is winding down.

To my supervisors, staff, interns, students, and colleagues, current and previous: thank you for your wisdom, patience, and grounding presence in my life.

My friends: Joy, you know this is all your fault.

My family: I am blessed to have a close, supportive, wacky, and wonderful five-generation, two-tree tribe around me, making it possible for me to go off on my adventures in academia while keeping the home fires burning. My mother Sharon and auntie Adrienne

accompanied me to Chester, England in one of the pinnacle academic travel adventures of my life. My siblings (Melissa and Jon) have helped me keep a promise of monthly time together, often with a comedian involved. My adult sons (Jean-Gabriel, Marcel, and Elijah) have schlepped me to and from airports, cooked dinner and reminded me to eat it, and provided more comic relief. Two dogs have slept in my office while I researched and wrote; my ancient old Baloo and his successor, the exuberant puppy Beauregard. The second tree is made up of my wasband's wonderful family, who have no doubt been aware that I have become an absent-minded professor, and a too-often absent auntie and "outlaw" in their lives over the past four-and-a-half years.

My wasband: I still do. Rest in peace, Marcel Homer Stephen Leclaire, II. I dare to hope you are somehow amused by my journey.

My gratitude is bright, passionate, and immeasurable.

Abstract

This study used the methodology of a grounded situational analysis to explore the lives of therapists who specialize in addiction. Historians have researched the history of addiction treatment itself and some have identified parallel processes of discrimination, stigma, and stigma by association for therapist and client, but the complex intersectionality between social processes and organizational issues have been largely invisible. In this study, therapists who specialize in addiction (including social workers, clinical mental health counselors, and alcohol and drug counselors) were asked about their sense of how others see them in their role. These conversations made visible the many, enmeshed challenges faced by these therapists and how the process of professionalization, with its promise of validation, has been thwarted by social and organizational processes. This study presents a comprehensive theoretical model of the supports and the problems facing therapists who specialize in addiction and ultimately supports a theory of how to redress these issues in the face of the increased need and resources available during the current opioid epidemic. This dissertation is available in open access at AURA: Antioch University Repository and Archive, http://aura.antioch.edu/and OhioLINK ETD Center, https://etd.ohiolink.edu/

Keywords: Stigma, Stigma-by-Association, Burnout, Discrimination, Substance Abuse Treatment, Professionalization, Substance Abuse Counselors, Addiction Treatment, Addiction Counselors, Wellness, Recovery, Thriving

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Chapter I: Introduction

The purpose of this study was to examine the macro, meso, and micro social processes affecting therapists specializing in addiction counseling as they manage the competing priorities of valued work with an underserved and suffering population in underresourced and marginalized clinical environments. Researchers focusing in on therapists specializing in addiction have been predominantly interested in organizational factors that might affect the high rates of job turnover and burnout. In this study I sought to understand the lived experience of highly trained clinicians who choose to enter a parallel process with a stigmatized population. In this study, I have created an opportunity for them to speak about the factors affecting their professional lives within their larger context. This is a context that includes administrations, laypeople, and even other counseling professionals who may not fully understand how therapists bring a rich confluence of counseling and medical knowledge to bear to support recovery work.

Rationale for the Study and Research Question

What is the experience of therapists specializing in addiction counseling concerning how they are perceived by their colleagues and the larger mental health community? Through this research, I found a wealth of sensitizing concepts, such as burnout, stigma, and job turnover, given the findings of previous research on the topic. What are the interpersonal consequences, implications, and ramifications of the training, wellness, structural, and compensation levels and how are they manifested on the personal (micro), organizational (meso), and societal (macro) levels? The interviews provided insight for leaders at each level as to what could mitigate toxic factors through the direct experience of the people doing the work making them visible. And, once visible, we can identify the areas ripe for meaningful change.

To look forward, it is important to look backward into the history of the profession for clues as to why this highly trained and specialized group of therapists may be experiencing stigma and stigma-by-association in the present environment. In the pages that follow, I have presented timelines to help show the development of the profession from its earliest days as a quick guide for the reader. I have also discussed why the history of the profession matters to the lived experience of therapists currently specializing in addiction.

A Brief History of America's Response to Addiction

To deeply understand some of the factors affecting marginalization of therapists specializing in addiction, it is perhaps helpful to start with a brief overview of the history of the profession from its earliest beginnings in the temperance and revivalist movements to the present.

Societal, economic, and cultural issues. The story of America's history of response to the addiction of its citizens is perhaps best organized as a cyclic pattern of philosophies and their implementation within the socioeconomic context of the culture. The chronology describes a parallel flow between the recovery community favoring peer recovery in one era and swinging full circle to medicalization with Professionalization in another, with fertile periods between extremes when professionals combined both modalities into wraparound addiction treatment, and deserts during which the legal, medical, and cultural establishments treated addiction as willful criminal behavior. What may be surprising is that none of these patterns are new to the current era, not even the well-publicized and much-lamented opioid epidemic circa 1980 to current day.

Peer recovery versus professionalization. The differences between the peer recovery and Professionalization camps have been, and can still be, rancorous. Researchers in multiple quantitative and qualitative and mixed methods studies have researched whether counselors in

recovery have a higher burnout rate than those who are “just” professional allies (Freudenberger, 1986; Lacoursiere, 2001; Pines & Maslach, 1978). Although research has shown that effectiveness and treatment outcomes do not differ between counselors in recovery and those who are “normies” (a term used to describe people without a personal history of addiction and recovery), lingering expectations have arisen and those espousing the superiority of one over the other philosophy continue to perpetuate these expectations (Culbreth, 2000). As White (2014) explained, “From the very birth of the addiction treatment field, a strain existed between people whose credibility sprang from personal experience of addiction and recovery and those whose credibility was derived from medical or religious training” (p. 46). There is a gyroscopic energy behind this debate, with historical swings between the preeminence in one era of peer recovery to professional recovery in another. Although peers and professionals have all been performing the same work, if sometimes from different philosophical viewpoints and with different modalities, the relationship between career paths has been more of a dialectic than a partnership and with more acrimony than is perhaps helpful.

By the mid-19th century, historians noted that the cultural views on the use of alcohol shifted from a moral view and began to entertain the idea that this was some sort of disease. Considering the hundreds of years preceding this radical change in viewpoint, however, the shift is a relatively new concept (Levine, 1978). According to Levine, prior to this change, the public did not see alcohol as addicting and did not recognize its problematic use as compulsive. The lasting effect of this moral view of addiction remains prevalent: People could stop if they wanted to and they must be weak-minded because they do not.

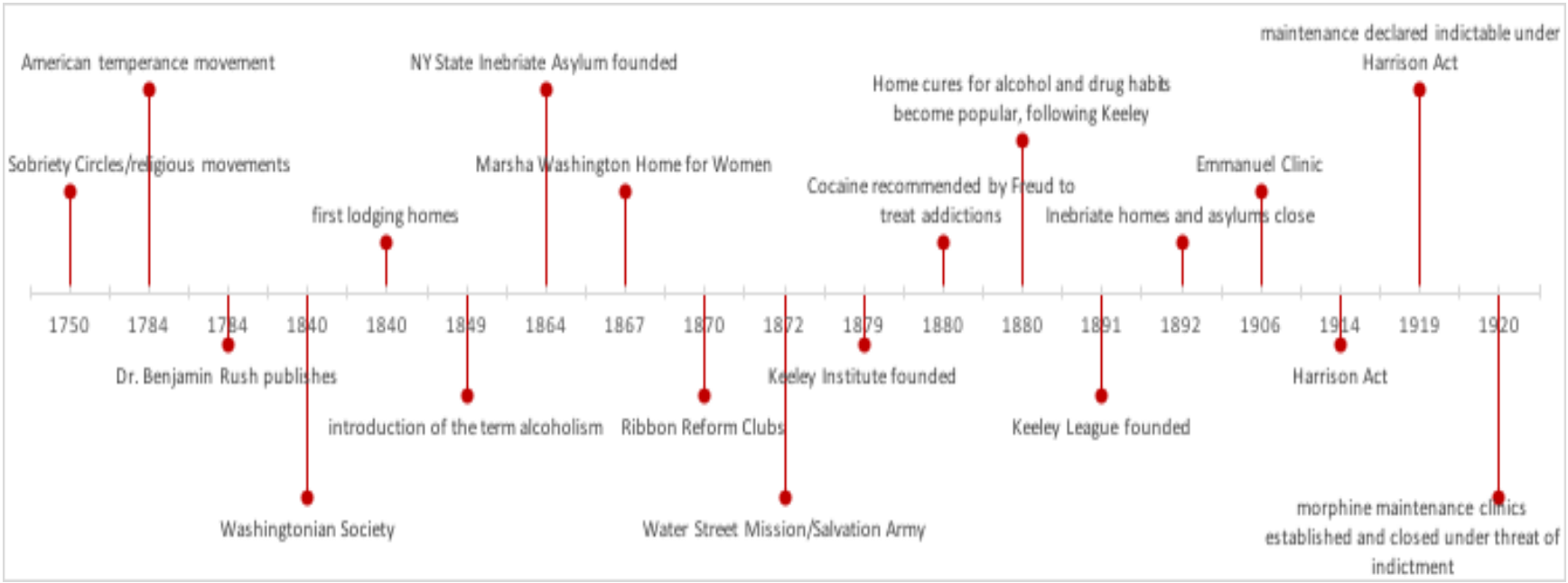

Figure 1.1. Timeline of the development of substance abuse counseling as a mental health profession, 1750–1920: Peer recovery and temperance periods.

A Condensed Chronology of the Profession

All dates, persons, and agencies mentioned in this necessarily abbreviated history come from the heroic work *Slaying the Dragon: The History of Addiction Treatment and Recovery in America* (White, 2014). Figure 1.1 shows a timeline of the development of substance abuse counseling as a mental health profession from 1750 to 1920. These dates are not precise, but to give a sense of how early (or late) certain ideas and movements took hold.

Peer recovery and temperance movements. The earliest precursors of peer recovery and temperance movements were not White men or members of the social elite, but Natives and freed slaves. Predating the American Revolution by several years, Native Christian preachers spoke charismatically about their lives under the slavery of inebriety and promoted conversion to Christianity and abstinence as the cure (Mancall, 1995). Native temperance missionaries and reformers called for a return to traditional, precolonization culture. Frederick Douglass was a leading advocate for temperance, and also an early supporter of women's rights and the emancipation of slaves. His dedication to abstinence came from a personal experience of excessive drinking and an awareness of the damage wrought. By 1845, Douglass had signed a temperance pledge and reportedly maintained sobriety for the rest of his life, becoming a philosophical if not actual founder of the Black temperance and mutual aid societies (Cheagle, 1969). Freed Black men organized separate Washingtonian Societies to offer support for the specific needs of a population unwelcome in the meetings that served White men. These were racially charged times and unfortunately, the temperance movement's support of abolition of slavery and prohibition was to have a negative effect on White membership (Krout, 1925).

White temperance societies followed the powerful formula of charismatic speakers sharing their confessions and redemption stories when they began to appear as early as 1831, with reformed inebriates traveling on the lecture circuit to promote the benefits of avoiding distilled spirits and beginning to receive pay as temperance agents (Steinsapir, 1983). In 1808, the Moreau Society in New York created a template for later temperance societies by instituting a pledge for new members to abstain from distilled liquor and to attend weekly meetings (McCarthy & Douglas, 1949). The Moreau Society provided information and education to a public in the midst of an unprecedented 40-year alcohol binge following the Revolutionary War (Cherrington, 1920). Factors contributing to the dramatic increase in alcohol consumption included availability, a lingering oppositional refusal to drink tea, the manifest inadvisability of drinking available water, increased leisure time, the unappreciated consequences of combat trauma, and a societal shift from drinking beer and wine in social tavern settings to single young men drinking whiskey in frontier saloons (Bremner, Southwick, Darnell, & Charney, 1996; Jacobson et al., 2008; White, 2014).

In 1840, six members of a nightly drinking club who were presumably dedicated to that entertainment investigated a temperance meeting and reported back to the rest of the membership that “temperance lecturers were hypocrites” (White, 2014, p. 13). In response, and perhaps not intuitively, they decided to form their own temperance society (White, 2014). The working classes made up the membership of the Washingtonian Society, rather than the so-called hypocritical upper-class temperance societies of the time. Washingtonian meetings included dramatic rituals of public confessions of the evils of inebriety followed by publicly pledging to abstain. From humble origins, the practice of members bringing in and supporting friends and

neighbors who were still drinking soon began to attract those from the upper classes, as well, and Washingtonian groups spread throughout the United States. Women organized the first Martha Washington Society in 1841 to provide "moral and material support to reforming inebriates, and to provide special support to female inebriates and to the wives and children of inebriates" (White, 2014, p. 16). Although the Washingtonian Society expanded dramatically throughout the United States, there were no societies active beyond 1847 other than the ones located in Boston, and even those were defunct by the 1860s (Maxwell, 1950). White (2014) reported that fatal flaws contributing to the demise of the Washingtonian movement were the loss of credibility that came from dramatically inflated personal confessions and the relapse of well-known speakers, the lack of a central organizational authority, the reliance on a quasi-religious zealotry rather than any therapeutic ideology, and, interestingly, a swing back toward economic prosperity that may have reduced the desperation of the inebriate and the family system concerned. This very early loss of confidence in the authenticity of charismatic, professional advocates of sobriety may be one of the taproots of the distrust among people with addiction for paid caregivers over peer supports. Despite the loss of most of the original Washingtonian Societies by 1847, future movements grew directly from its influence, including Alcoholics Anonymous (AA) in the 1900s.

The ribbon reform clubs of the 1870s were primarily religious in nature, gathering small groups of inebriates and the people who cared about them, with the drinkers declaring their commitment to abstinence by receiving and wearing ribbons. For example, members of the Portland Reform Club (called Murphyites after the group's founder, Francis Murphy) wore blue ribbons to remind themselves of their pledge to abstain (White, 2014). Because many tavern

owners would not allow access to patrons wearing a ribbon, as it might deter people from drinking, a man wearing a ribbon would have to remove the ribbon to enter the tavern and return to drinking alcohol. Presumably, having to physically remove the ribbon created somewhat of an emotional barrier.

Moderation societies were also popular, harking back to Dr. Benjamin Rush's advocacy of abstinence from distilled spirits while continuing to believe in the harmless use of hard cider, beer, and wine (White, 2014). A temperance society in Boston even founded a brewery to provide beer to members who had pledged to abstain from distilled spirits (Eddy, 1887). According to Cherrington (1925–1930), one such harm-reduction group, the Business Men's Moderation Society, organized in 1879, offered a menu of four different pledges equally esteemed among its members: (a) total abstinence for a period defined by the member, (b) total abstinence from all intoxicants except wine and beer, (c) no alcohol consumption before 5 p.m., or (d) agreement not to be treated or treat others with alcoholic beverages (White, 2014).

As Woodman wrote, as early as 1843 moderation was seen as a short-lived experiment, a "gradation in a drunkard's career" (p. v) and the goal for most associations shifted back to total abstinence by 1850 (Woodward, 1981). The harm-reduction philosophy remains an important public health model, most recently foundational in methadone and buprenorphine treatment for opioid addiction. As the name implies, the goal is to reduce the most risky behaviors and to acknowledge that many people with addiction will cycle between abstinence and use (White, 2014). The model continues to be highly controversial. Harm reduction, also referred to as risk reduction, refers to focusing therapeutic supports on reducing harmful consequences of problematic use, aligning with client goals that may or may not include abstinence (Marlatt,

Somers, & Tapert, 1993; Marlatt & Tapert, 1993). In line with the harm-reduction model, abstinence remains the ultimate, if not the most immediate, goal.

In the early 1900s, it was possible to create a busy, sober, social circle through membership within the temperance movement. Recovered inebriates provided entertainment by telling uplifting stories of their troubles with alcohol on par with the excitement and distraction of other traveling religious revival shows (Baumohl & Room, 1987). For a population acculturated to church as a relief from hard work, the festival atmosphere created by speakers for the temperance movement provided a welcome distraction from day-to-day life.

Dr. Rush and the emergence of inebriety homes and asylums. Dr. Benjamin Rush was perhaps the most influential early writer on the subject of American medicine. In 1777, he warned against the use of the distilled spirits increasingly distributed to soldiers (Cherrington, 1920). Like most medical men of the time and in line with a mistaken idea widely held even today, Rush believed that distilled spirits created the problem, whereas beer, cider, and wine were less harmful to the body and soul. Rush advocated that the problem did not emerge from alcohol itself, but from the formulation. Not only did Rush advise the replacement of distilled spirits with what he deemed to be harmless forms of alcohol, he also recommended that opium replace alcohol in medicine. Even so, the general public considered his idea that drunkenness was a disease to be "ludicrous and impracticable" (White, 2014, p. 3). Rush referred to inebriety as "suicide perpetrated gradually," the only cure being abstinence from distilled spirits (White, 2014). In 1810, Rush recommended the establishment of sober houses where helpers could rehabilitate inebriates and to which they could be confined by court order (Rush, 1948). By 1825, however, temperance societies had backed away from the idea of temperance as avoidance of

distilled spirits and were promoting abstinence from alcohol in all forms. According to White (2014), “The plan was a simple one: prevent the creation of new drunkards and let the old drunkards die off” (p. 7). Although he could not have known it at the time, Rush was at the beginning of an epidemic of alcohol use, with a 700% percent increase in the number of distilleries between 1792 and 1810 and an annual per capita consumption of 7.1 gallons of pure alcohol (Rorabaugh, 1979). In 1995, the annual per capita consumption in the United States was 2.17 gallons, and 2.6 gallons in 2010 (Greenfield, Midanik, & Rogers, 2000; World Health Organization, 2011).

With the support of Dr. Rush’s assertion that the chronically intemperate needed medical care, Dr. Samuel Woodward in 1833 joined the call for well-conducted institutions to provide the cure for inebriety. To support this medicalization of care, a later group of doctors called on the alcoholic beverage industry to finance the care of inebriates through taxes on sales. Religious, philanthropic, and temperance organizations financially supported some of the earliest inebriate homes (Baumohl & Room, 1987). In fact, major financial support at the time came directly from the alcohol industry, a community responsibility that continues in some forms to the present era, as evidenced by the calls for responsible use printed at the bottom of industry advertisements (White, 2014).

There really was no appropriate place for inebriates to seek medical help in the 1800s. For the most part, existing facilities did not admit women at all, who during this period were more commonly addicted to narcotics than alcohol (White, 2014). Between 1884 and 1912, the male-to-female ratio for admissions ranged between 3:1 and 9:1 (Lender, 1981). Hospitals and sanitariums refused to take in inebriates due to stigma, lack of understanding of how to treat the

disease, and some legitimate concerns about how difficult such individuals could be as patients (Voegtlin & Lemere, 1942). Given their training, doctors at psychiatric hospitals began to view addiction as a symptom of underlying mental health issues and treated the pathology they understood better. According to American psychiatrist Dr. Karl Menninger, "the prognosis for recovery was better for schizophrenia than it was for alcoholism, and that, if given a choice, [a doctor] would prefer that one of his own family members be schizophrenic than alcoholic" (R. Knight, 1938, p. 359). White summarized the situation: "There has rarely been a treatment method more poorly matched to a problem than that of the use of psychoanalysis in the treatment of addictions" (White, 2014, p. 133). However, Freud's contention that the only thing needed to perform therapy was proper training helped add credibility to the use of recovered addicts as "friendly visitors" and "lay therapists" (White, 2014, p. 134). In 1906, the Emmanuel Clinic employed staff trained in psychotherapy, providing group and individual counseling as well as "friendly visitors" who delivered the equivalent of social work or case management (White, 2014, p. 135). The earliest named recovered alcoholic paid as an alcoholism counselor was Courtenay Baylor, who worked in the Emmanuel Clinic in Boston, Massachusetts, in 1913 (White, 2014, p. 136).

Philosophically, many individuals in the religious and nonmedical culture saw the disease model of addiction as a "medicalization of sin," whereas eugenicists "advocated that alcoholics should be left to die so that alcoholism would eventually disappear" (White, 2014, p. 37). There was a belief that allowing inebriates into psychiatric institutions would be "prejudicial to the welfare of those inmates for whom the institutions were designed" (Parish, 1883). Depending on what social services were available in the area, municipal authorities could send an inebriate to

the “almshouse, the charitable lodging home, the jail, the workhouse, and the newly created lunatic asylum” (White, 2014, pp. 32–33). Some boarding houses offered to take in inebriates and provide some peer recovery treatment, often modeled on the recovery of the owners of the house. By 1864, however, New York, Iowa, Wisconsin, Connecticut, and Minnesota had all created state-operated medical facilities for inebriates (Brown, 1985). In 1893, Massachusetts opened two entirely state-funded hospitals: the Massachusetts State Hospital for Dipsomaniacs and Inebriates in Foxborough and Norfolk. These hospitals remained in operation until 1920, when optimism about Prohibition as a permanent solution fostered the illusion that the inebriate problem was at an end (Jaffe, 1978). The loss of the earliest institutions may also have arisen due to the reality that, despite the focus of medical talent and financial support, addiction did not respond to any known cure and there was little scientific validation or consistent application of the modalities used at the time. Dr. Crothers reported that women were harder to cure from inebriety due to secrecy, unavailability, ignorance, and stigma keeping them out of treatment longer than men, whose disease process was somewhat more visible (Sparks, 1897).

In general, clergy, physicians, and even reformed addicts founded and administered inebriate homes and asylums. Recovered inebriates worked at the facility as managers, physicians, and personal attendants. These jobs would eventually evolve into paid positions, perhaps due to the policy of allowing indigent inebriates to work off their hospital bills (American Association for the Cure of Inebriates*,* 1981). Dr. Crothers was particularly opposed to the employment idea, believing that newly recovered inebriates were perhaps too fragile in their sobriety to work with and for other inebriates (Crothers, 1912). Crothers’ opinion may have given rise to the tradition of requiring 1 year of recovery before a peer could be an AA sponsor

for another addict, and requiring 2 years of recovery before a professional could begin treating others.

The movement toward creating associations of the institutions and human services professionals who treated inebriates also began with the founding of the American Association for the Cure of Inebriates in 1870 (Jaffe, 1978). The Association's primary roles were (a) "professional information exchange"; (b) "political advocacy of legislation establishing and supporting the work of inebriate asylums"; and (c) "the publication of a professional journal and a small number of treatises on addiction treatment" (White, 2014, p. 38).

At the turn of the century, medical professionals including Crothers were calling for the creation of a "continuum of care" that could include: (a) "specialized hospitals that would treat acute cases of inebriety on a voluntary and involuntary basis through residential stays of up to one year"; (b) "institutions that would treat chronic cases of inebriety through residential stays of one to three years"; and (c) "workhouses or farm colonies where incurable inebriates could be formed into military habits of life and work, and kept in the best conditions of forced healthy living" (White, 2014, p. 35).

By 1900, the *Journal of Inebriety* began promoting accreditation standards to govern institutions serving inebriates. These institutions were founded and run by medical professionals who advocated for funding politically, and not for the most part from the political pressure of the average citizen. In fact, staff treated many patients under assumed names due to the stigma attached to their disease (Turner, 1888). The general public still viewed inebriety as a moral or characterological issue, despite advances in medicine pointing to causes such as heredity, trauma, and disease (Kerr, 1894).

To effect a cure, 1 year was the shortest effective treatment period, and many doctors believed some of the most difficult patients would require up to 5 years (Kerr, 1894). Treatments included isolation, detoxification with various chemicals, religious and spiritual instruction, social supports from peers, work and recreation, music, time for self-reflection, moral suasion, acts of service, and the daily institutional milieu; they only rarely included counseling (White, 2014). Medical detoxification treatments included hydrotherapy and induced aversion (the use of emetics and hypnosis). Aftercare was generally overlooked, although many recovered inebriates had been accepted into temperance groups through contact with recovered peers and were thus able to continue their affiliation following release. Complicating factors recognized at the time, and still understood as negatively affecting treatment today, were "hereditary predisposition or brain injury, the lack of an occupation, the absence of family connection, limited education, concurrent nervous disorders, and the use of narcotics or chloral as an aid in sleep" (White, 2014, p. 57). The goal of treatment was the establishment of lifelong total abstinence, often including tobacco (White, 2014). Staff provided no formal treatment in the inebriety lodging homes.

By the mid-1920s, most of the hospitals, institutions, and sanataria founded to treat inebriates had evolved into psychiatric or correctional facilities in the wake of Prohibition, a law that removed addiction from the medical world and placed it firmly in the realm of the criminal justice system. After Prohibition, any provable use of alcohol became a legal offense that paradoxically, like a disease, was "dangerously contagious" (White, 2014). The focus of addiction treatment had shifted from an expensive medical model to reliance on criminalization, segregation of the afflicted from the general population with forced sterilization (eugenics), and reduction in availability and access.

For-profit addiction treatment institutes, or the rise of the charlatans, 1879. There was a predictably wide gap between treatment of the social elite and the poor. Private citizens and charitable groups created sanataria to provide detoxification and periodic "drying out" in a private and luxurious atmosphere for paying clientele (White, 2014). The staff in these facilities sometimes offered outpatient and even more intensive outpatient services similar to those available today. Writing in 1871, George Beard went so far as to draw a distinction between the moral vice of the lower classes and a "disease of refinement" of the social elite (p. 148). The affluent could escape to a local facility where tapered withdrawal would come about by using sedatives and decreasing doses of whiskey, often provided in malted milk drinks, with food and fellowship provided.

By 1880, business-oriented developers began marketing medicinal "specifics" and treatment "cures," with the most famous among them the Keeley "Double Chloride of Gold Cure" purportedly for treating "alcoholism, drug addiction, and the tobacco habit" (White, 2014, p. 68). From the beginning, the general public saw the Keeley Institutes as both miracle workers and frauds. Keeley's medical license was revoked in Illinois for "'unprofessional' advertising," although it was later restored (Morgan, 1989, p. 161). Keeley briefly stopped treating patients with his gold cure for about 18 months between 1885 and 1887 due to reports of serious side effects. It appears that when he returned to his practice, he had removed gold from the recipe, as researchers did not find any in later scientific lab testing. The Keeley Institutes largely drew on recovered graduates of their programs for staffing and as new franchisees across the country. The institutes also became a mail order business and reported unproven success rates of 95% (Keeley, 1897).

The proprietary “Double Chloride of Gold Remedies,” delivered in four daily injections, may have comprised “such diverse ingredients as alcohol, strychnine, apomorphine, aloin from the aloe plant, willow bark, ginger, ammonia, belladonna, atropine, hyoscine, scopolomine, coca, opium, and morphine” (White, 2014, p. 74). What was actually beneficial was a form of holistic treatment that consisted of a combination of medical intervention and supportive detoxification, education about addiction, day treatment and intensive outpatient therapy, with peer recovery provided by recovered staff and affiliation with local AA groups, and clubhouses with aftercare and ongoing supports. While the Gold Remedy was certainly quackery, Keeley and his franchisees promoted the disease model of addiction by employing “more recovered physicians than any program in history” (White, 2014, p. 86). The marketing campaigns decreased stigma by normalizing addiction as a treatable disease and treated (however fraudulently) hundreds of thousands of patients with addiction during a time when the culture demonized inebriety as criminal and amoral behavior (Barry, McGinty, Pescosolido, & Goldman, 2014).

Even the most well-meaning of the available hospitals of the time promoted medical cures that would be questionable today, such as the harm-reduction strategy of trading addictive chemicals (from alcohol to opium, for instance) and the use of electroconvulsive therapy (ECT) and psychosurgery (bilateral frontal lobotomies) (Talbot, Bellis, & Greenblatt, 1951). This idea of substituting one addictive substance for another, less harmful substance is currently in vogue among nonprofessionals in the guise of the marijuana maintenance cure for alcohol use disorders. Even at the time, some medical professionals objected to the substitution method in the strongest possible terms, such as “casting out Satan with Beelzebub” (White, 2014, p. 147).

The emergence of Alcoholics Anonymous. Building on spiritual tenets of the earliest reform societies such the Washingtonians and the popular Oxford Group of the 1920s and 1930s, support for addiction to alcohol returned to the purview of peer support, temperance, and spirituality with the introduction of Alcoholics Anonymous (AA) on June 10, 1935. In the earliest days of what would become a peer support group available in nearly every community nationally and internationally, a small group of people with alcohol addiction met with Bill W. and Dr. Bob in the doctor's home in Akron, Ohio. From these homegrown beginnings grew the peer support movement of today, with its *Twelve Steps and Twelve Traditions* (AA, 1981) and eventually the volume known as the "Big Book": *Alcoholics Anonymous* (AA, 2001) (White, 2014). AA groups expanded into professional medical care of addicts through the establishment of hospitals where prospective AA members could safely withdraw during a time when most community hospitals would not admit alcoholics. The same groups would later abandon this goal, in part due to a change in rules allowing medical detoxification of addiction in 1939; even so, many hospitals continued to lean heavily on the support and experience of AA groups to found addiction treatment units in community hospitals.

The criminalization of addiction, 1907 to present. Prior to 1914, drug addiction was not a criminal act, but a highly stigmatized condition that kept many away from public acknowledgment and treatment of their addictions. Following the criminalization of addiction with the Harrison Act of 1914, public and legal services became backlogged with inebriates, even as repeated cycles of arrests removed people with addiction from paid work and the asylums and hospitals closed in anticipation of Prohibition. Into this era, the eugenics movement interjected the concept of "industrial hospitals" to remove those with addiction from public view

and, more importantly, provide access to “prevent alcoholics from creating new generations of social misfits” (White, 2014, p. 109). Courts could, and did, legally commit men to inebriate farms for one to three years. The culture’s working philosophy of addiction had shifted from treatment to control, including such methods as confinement and involuntary sterilization, following advances in medicine making sterilization surgery effective, because, as was a common misconception, “the children of alcoholized people are born criminals without consciousness of right and wrong, and with a feeble sense of duty and obligation” (Crothers, 1902, p. 20). Medical authorities advocated the “castration of all drunken men and the spaying of all drunken women” (Vines, 1899, p. 1125). A 1905 law identifying those prohibited from marriage included “habitual drunkards” (White, 2014, p. 121). In states where involuntary sterilization had not been legalized, patients were commonly coerced into “voluntary” sterilization by being held in an institution until they agreed to the procedure (Reilly, 1991). The popular philosophy of eugenics promoted the benign neglect of the addict and led to denying “degenerate individuals public relief as a means of speeding their demise” (White, 2014, p. 120). This legacy remains in place today—addiction is still one of the complicating factors allowing the Social Security Administration to deny disability claims, invalidating co-occurring medical and mental health disabilities.

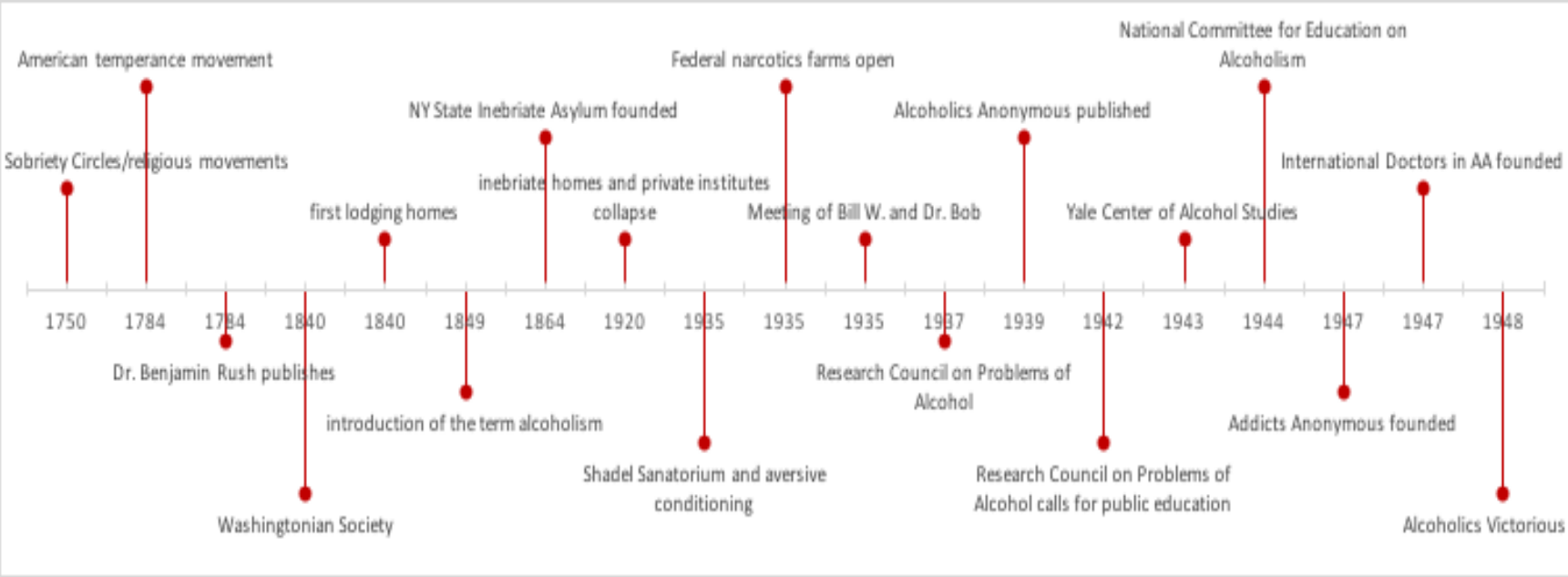

Figure 1.2. Timeline of the development of substance abuse counseling as a mental health profession, 1750–1948: Criminalization period.

After the passage of the Harrison Act in 1914, access to previously unregulated addictive substances such as cocaine and opium were now only available through a physician and with the 20th century equivalent of a "green card." The Harrison Act was interpreted broadly over the next five years through several decisions, including 1919 *Webb v. the United States,* to mandate that the prescription of addictive substances to someone with an addiction even for medical reasons constituted an illegal act. The American Medical Association lobbied against "government intrusion into the practice of medicine," to no avail (White, 2014, p. 151). Despite regular challenges, the Harrison Act remained in its broadest effect through threat of criminal prosecution of physicians (McNamara, 1973). According to White (2014), "More than 25,000 physicians were indicted . . . between 1914 and 1938 . . . 3,000 actually went to jail, while another 20,000 paid substantial fines" (p. 152).

With an estimated number of addicts between 110,000 to 150,000 addicts, state psychiatric hospitals and prisons were not equipped to handle the unexpected population of criminalized addicts (White, 2014, p. 162). By 1928, "more than two-thirds of the inmates at Leavenworth, Atlanta, and McNeil's Island were addicts" (pp. 162–163). The Harrison Act focused public scorn on the narcotic addict and away from the now marginally more acceptable noncriminal with alcohol issues. Congress allocated funds to create two federal narcotics farms to relieve the strain on previous legal and psychiatric detention centers after a riot at Leavenworth in 1928 resulted from overcrowding. The Lexington and Fort Worth farms accepted "people addicted to drugs covered under federal law," and while many were considered "voluntary" patients, most, if not all, came under some form of legal coercion (p. 163). The new farms had "barred windows and security procedures," but were staffed with "physicians,

psychiatrists, nurses, social workers, recreational therapists, chaplains, and aids" (p. 164). After 1948, treatment included methadone for detoxification from morphine and heroin, electroconvulsive therapy, AA meetings, school, church, and vocational training, including working on the farm grounds. Inmate payment was in the form of cigarettes (p. 165). Following release, relapse rates as high as 90% justified the creation of new treatments, including methadone maintenance and therapeutic communities.

After what White identified as "decades with no significant legislative action in support of addiction treatment" (White, 2014, p. 376) between 1969 and 1973, the government's investment in addiction treatment rose from $28 million to $386 million, partially due to the discovery of the existence of middle-class White addicts. Alcohol issues continued to be treated separately from other drugs and with different treatment methods until at least 1990. Most insurance companies refused to provide benefits for addiction treatment, although several states mandated reimbursement by 1974, paving the way for further destigmatization of addiction disorders. By 1972, the Joint Commission on Accreditation of Hospitals had developed accreditation standards for health care systems that included addiction treatment, followed by Medicaid. With these accreditation standards came the necessity of creating a professional field, complete with the standards of education and certification across 12 core functions of drug dependency counseling still acknowledged today. Addiction counseling had now evolved from a paraprofessional role, at least in practice if not in public perception, as professionals by experience declined in the field.

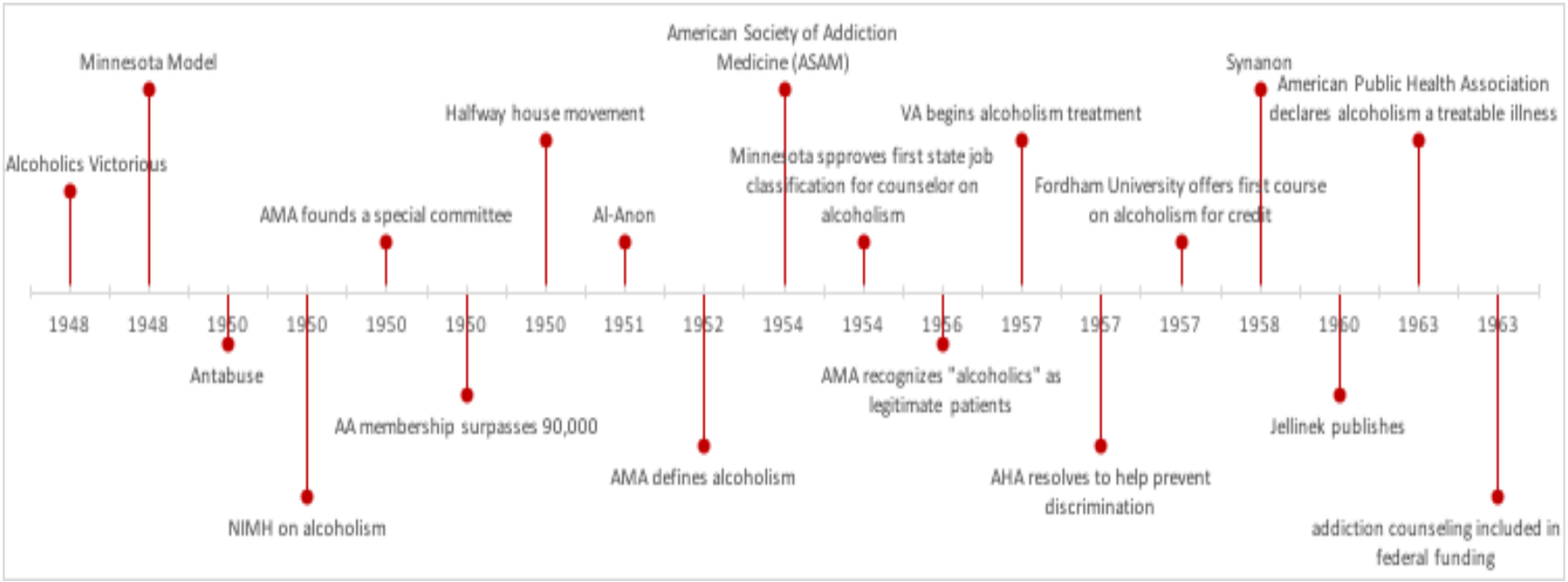

Figure 1.3. Timeline of the development of substance abuse counseling as a mental health profession, 1948–1963: Modern addiction treatment.

These developments continued into the 1980s, but progress slowed by the early 1990s under the financial restraint of managed care and health maintenance organizations, with reimbursement dropping from 28 days to a few days of detoxification (White, 2014, p. 400). In response, inpatient programs shifted to outpatient and intensive outpatient treatment and longer-term, inpatient care were once again only available to the most affluent. It is perhaps sad recompense that there is ample evidence that spa-type rehabs have been largely unsuccessful in helping addicts establish sustained recovery (White, 2014). Figure 1.3 shows the development of substance abuse counseling as a mental health profession from 1948 to 1963.

Reviewing the Potential Societal Challenges for Therapists Specializing in Addiction

From the foregoing discussion, some of the micro, meso, and macro challenges to the perception of addiction counselors become visible. There is such a strong, enduring current of addiction counselors developing expertise through their own recovery journeys and in peer recovery that clients and colleagues alike assume recovery in anyone working with addiction. Throughout the history of the addiction therapist profession, private individuals promoted quasimedical miracle cures that were anything but healthy or curative. Clients have faced criminalization as degenerates because of their disease, requiring separation from the rest of the population, and therapists have faced stigma-by-association for treating them. Even if the challenges were limited to these three, the obstacle to equal professional standing would still be daunting.

Introduction of Methodology

In order to understand a small part of the professional lived experiences of therapists specializing in addiction, it is necessary to ask how these therapists perceive themselves and how

others perceive them as professionals. Although there have been excellent studies of job turnover, burnout, supervision, and counselor wellness, none have focused on the emotional state of being a professional in a stigmatized field with limited resources working with colleagues suffering from exhaustion and compassion fatigue. To promote wellness for therapists specializing in addiction, it makes sense to focus on the factors these professionals say helps and obstructs their ability to continue working in their chosen specialty.

Why grounded theory? Given my curiosity about how leadership can enhance wellness among staff therapists specializing in addiction, use of grounded theory "to develop explanatory theory concerning common social life patterns" (Annells, 1996, p. 380) is a useful path to uncover the multiple answers held by the principal actors themselves. I have been sensitized to certain factors in this context through my research and personal interests, but I do not hold my personal perspective (despite my extensive research) as the correct narrative of a singular objective truth regarding answering the research question: How do therapists specializing in addiction make meaning out of how other professionals perceive and treat them, and is that part of what is pulling many of them out of their chosen vocation and out of balance with their wellness?

Why situational analysis? Although therapists specializing in addiction hold part of the story, there are also previously invisible and potentially powerful contextual factors acting on societal and organization levels. Situational analysis provides a platform for the researcher to give voice to the invisible, living and nonliving, cultural and contextual, from which to weave together a narrative sensitive to whatever macro, meso, and micro themes have emerged through grounded theory research. Situational analysis allows for mapping the big picture.

Positionality. As a scholar-practitioner working as a therapist who does specialize in addiction, I acknowledge that, as Kathy Charmaz (2014) has written, I have to fulfill my obligation to be aware of any assumptions, since they will certainly have an influence on the work to come. As a psychologist, I am drawn to the grounded theory methodology and method of gathering information as "inevitably interwoven with and emerg[ing] from the nature of particular disciplines (such as sociology and psychology) and particular perspectives" (Lincoln & Guba, 2000, p. 164). I am a scholar-practitioner with a research question who "seek[s] to understand the everyday exclusion that occurs" to those therapists who specialize in addiction counseling (Holloway & Schwartz, 2018). To this aim, I take a constructivist and postmodern approach to grounded theory.

As a therapist, I have, with other qualitative researchers, developed some comfort with ambiguity (Strauss & Corbin, 1998). I am currently working within a male-gendered workplace and leadership paradigm within which "flexibility (the ability to work whenever asked) and presenteeism (being visibly present in the workplace for extended hours . . . as visible and reflexively-valued evidence of work commitment" are the expectation despite the possibility that women may not "need . . . long hours to complete work and meet deadlines" (R. Fisher, Boyle, & Fulop, 2010, p. 286). My supervision often consists of managing perceptions within this male-dominated paradigm: keeping life, work, and outside issues separate; managing boundaries between self and staff; and fulfilling other invisibly gendered expectations. I do not speak this language and receive each critique as a microaggression. I question whether this is true of others whose work does not conform to traditional, cultural, and invisible expectations, as well as how this might contribute to burnout and adversely affect wellness.

I am also personally curious about why I do not yet appear to be suffering signs of burnout, although in retrospect, I have been at times on the edge of becoming symptomatic. As a clinical supervisor, I work with clients who have co-occurring disorders, serving in a rural hospital system that values nurses and social workers over therapists in general, and practitioners specializing in addiction medicine in particular. I am, according to much of the research, at risk of burnout. I am curious about what wellness supports I have in my job environment and at home that bolster my ability to continue to care, my curiosity, and my loyalty to this job I have held in the current capacity for almost 7 years. I firmly believe the excellent supervision I have had, as well as being a part of a hospital the mission and values of which are in alignment with my own, have insulated me so far. My intention for this research was to acquire more information through grounded theory research with participating therapists who have chosen, as I have, to work with an underserved, marginalized, and stigmatized population.

As a therapist, I have confidence in my ability to interview well and thoroughly, while maintaining a positive relationship with the subject/client. I was interested to find, when I conducted a preconversation in the early stages of preparing for this dissertation, that in the beginning I interviewed like a therapist. Instead of following and mining the research subject's words for their meaning, I would get distracted and follow emotions. I would not have noticed this trend if it were not for my research advisor's careful attention and an opportunity to practice under supervision.

Ethical considerations. As a therapist specializing in addiction and currently working as a clinical supervisor, I became aware of some ethical dilemmas that were potentially salient during the research phase of my study. I live in a rural area and work for the only private,

not-for-profit mental health hospital for co-occurring disorders in a three-state area. Even my commitment to not interviewing people who either work for me currently or have worked for me in the recent past cannot ensure participant anonymity or completely protect against boundary crossing. In order to mitigate the boundary crossings, I used the snowballing technique for finding potential research candidates: This means the people I know best and approached first recommended others they thought were appropriate for this study (and willing to participate). They are therapists whom I may also know and might supervise in the future.

I am committed to not approaching people who currently work in my or any sister department at the hospital where crossover of duties are common. Even though such individuals would be excellent research subjects, there is no way to protect them from the power differential inherent in our job descriptions. I have used an aggregated narrative of the research subjects, because in a small state like Vermont, there is a reasonable expectation that the research subjects would be recognizable.

Following the recording of interviews, I employed a highly recommended transcriptionist whose reliability I confirmed through her meticulous transcription of a preconversation. I also used a coding team and, in the process of conducting interviews, maintained the practice of memoing. I applied for and maintained approval for the research through Antioch University's Institutional Review Board in alignment with and with certification from the collaborative institutional training initiative program (see Appendix A). I followed the direction of my committee to align this research with the highest ethical research practices.

Why This Research Matters

Questioning why therapists specializing in addiction are suffering and leaving the profession at very high rates matters because clients are dying, and stigma-by-association robs clinicians of motivation and dedication through the pernicious erosions caused by burnout, financial distress, and discrimination. With marriage and family therapists, in comparison, researchers classify the burnout rate as low-to-moderate (Rosenberg & Pace, 2006). Many therapists specializing in addiction will change jobs after only 2 years, and some will stop working as counselors altogether (Evans & Hohenshil, 1997). In the state of Vermont, it takes roughly 4 years (2 to 3 years of schooling, including 900 hours at internship and at least 1,000 hours of full-time supervised practice) to become licensed as alcohol and drug counselors. Given these prepractice requirements, there is a pressing need to retain addiction specialists, not lose them before they reach an effective stage of clinical maturation.

This study matters because of the tremendous amount of information about how leaders can promote wellness within their organizations and society at large, that comes directly from talking with therapists specializing in addiction. Given that this specialty is at high risk for burnout, then people who are not suffering burnout can identify best practices in clinical supervision, self-care, and role and job supports.

This study matters because therapists specializing in addiction who are burned out are not good models of sober self-care, wellness, and happiness for clients in desperate need of a means to align themselves with a valued life some of them have not seen within their families of origin or choice.

Finally, this study matters because people are unwell, unhappy, and dying. In Vermont alone, there were 124 deaths related to all drug use in 2017, a decrease of six percent from the previous year. This statistic masks the stark reality that deaths related to fentanyl use increased by more than a third over the same time period, while deaths related to cocaine use doubled (Chen, 2018). The professionals who trained to provide help for the needs of this specific population are not being given the resources, respect, or understanding necessary for them to continue their work.

Chapter II: Literature Review

From the earliest development of grounded theory, Glaser and Strauss (1967) strongly advised against reading extant research related to the subject of interest so as to allow codes, categories, and themes to emerge organically and without prejudice or bias (Glaser & Strauss, 1967). This classical interpretation has evolved into the understanding that human researchers do not approach a subject without some awareness. In addition, there is a practical concern that scholarly writing is not entirely valid without researchers showing some of the literary scaffolding behind their thinking. As Glaser and Strauss (1967) asserted, "The researcher does not approach reality as a tabula rasa" (Ramalho, Adams, Huggard, & Hoare, 2015, p. 3). As a constructivist researcher, I submit a short literature review establishing an academic foundation for a grounded theory study.

Classical Grounded Theory

The originators of grounded theory were quite direct when they urged grounded theorists "to ignore the literature of theory and fact on the area under study, in order to assure that the emergence of categories will not be contaminated" (Glaser & Strauss, 1967, p. 45). Despite the inarguable fact that researchers are human, hence their interest piqued by some aspects related to the subject prior to embarking on a grounded theory study, the "rationale was that refraining from a literature review would allow the theory to emerge from the data, rather than being imposed to it from the existing literature" (Ramalho et al., 2015, p. 3). The researchers continued, "Glaser argued in favor of no reading in the topic of inquiry prior to the research itself" so that "existing theories could not impose themselves on the analysis and the resulting theory" (Ramalho et al., 2015, p. 3). There was little concern that the research produced without

a literature review would perhaps be redundant, because the subjects would be speaking from their own experiences and understanding, thereby providing a unique context.

Evolved Grounded Theory

As grounded theory evolved as a research method, Strauss and Corbin (1990) professed that "literature read before data collection could not necessarily hinder the emergence of the theory," recommending researchers "engage with it and use it in all phases of the research" (p. 56). Ramalho et al. (2015) suggested that previous researchers might rightfully be included in the conversation and that "objective knowledge can be discovered through a grounded theory research by an appropriate use of the research methods" (p. 3).

Constructivist Grounded Theory

Growing out of the classical and evolved grounded theory traditions, constructivist grounded theorists have acknowledged that "to avoid the researcher's influential role in the research process is an unattainable task" (Ramalho et al., 2015, p. 5). A truly grounded theory "depends on the researcher's view; it does not and cannot stand outside of it" (Charmaz, 2014, p. 239). Like any other nonhuman actor in the context, "the researcher's voice in the resulting theory should not be excluded, avoided, or hidden" (Ramalho et al., 2015, p. 5). All researchers have been influenced in their choice of research by some previous acquaintance with the subject, as evidenced in a statement by Ramalho et al. (2015): "It is very unlikely that even without conducting a literature review specifically oriented to the researched area, a researcher will arrive at the research project without a previous reading somehow related to, as well as influential in, the research" (p. 6).

As a researcher working within grounded theory lineage, my task was clear: I must provide a synthesis and analysis of my readings to provide the context necessary to recognize any unique perspectives gathered from the research subjects' lived experiences, as later presented. As an ethical researcher aware of classical grounded theory's mandate, I must also identify my sensitizing concepts and bracket the biases leading to and inherent in my research.

Sensitizing Concepts

Far from being an Achilles' heel preventing an idealistically distant academic perspective, "previously acquired knowledge could be a source of sensitizing concepts that could present an initial idea from where to engage analytically with the collected data, providing a general sense of direction (Blumer, 1954; Charmaz, 2006; Ramalho et al., 2015). Not only in the choice of a subject, but throughout the process, "the researcher's own life experiences have a broad influence in the research process" (Ramalho et al., 2015, p. 7). In the context of the current study, I have both personal and scientific preexisting knowledge of the subject and have organized this inquiry out of curiosity about the societal processes of burnout, stigma, and wellness at work. The literature review that follows will make these preexisting, sensitized concepts visible and explicit through an overview of extant scholarship on burnout, stigma, job turnover, and wellness at work. The chapter includes a review of past and current opioid epidemics in the United States and the ways in which these cyclic waves of need have overwhelmed the available resources, including the individuals responsible for providing aid.

Organization of the Literature Review

The phenomenon of burnout for substance abuse professionals coalesced into a dissertation topic gradually over the past 2 years, as I studied other topics during my doctoral

journey. I wanted to know what the extant literature had to say about the phenomenon of burnout, why substance abuse professionals experienced burnout at such a high rate, and whether stigma-by-association might be a cause. This review will begin with a definition of terms and will then discuss the extant literature, organized thematically by main topics: burnout, stigma and stigma-by-association, job turnover and other organizational and systemic issues, and wellness at work. Each section will include an exploration of the gaps in the literature and coalesce into the rationale for further study.

Definition of Terms

Following is clarification of the terms that were used throughout this study.

Burnout. Maslach (1982) initially defined burnout as a "syndrome of emotional exhaustion and cynicism that occurs frequently among individuals who do 'people-work' of some kind" (p. 99). Maslach has also defined burnout a "psychological syndrome involving emotional exhaustion, depersonalization, and a diminished sense of personal accomplishment that occurred among various professionals who work with other people in challenging situations" (p. 2).

Compassion fatigue. As opposed to burnout, compassion fatigue refers specifically to vicarious or secondary traumatization, defined as the emotional residue or strain of exposure to working with those suffering from the consequences of traumatic events (Figley, 1995). Compassion fatigue differs from burnout in the specificity of antecedent, but can, and often does, co-occur. Compassion fatigue can be caused by exposure on one case or may be due to a cumulative level of trauma. It is best defined as "a syndrome consisting of a combination of the symptoms of secondary traumatic stress and professional burnout" (Newell & MacNeil, 2010;

p. 60). Although some authors have used the terms *burnout* and *compassion fatigue* interchangeably, for the purposes of this research, I differentiate between the terms.

Stigma-by-Association. Stigma affects not only people with mental illnesses, but their families, as well. Such vicarious stigma, termed *stigma-by-association*, is "the process by which a person is stigmatized by virtue of association with another stigmatized individual has been referred to as 'courtesy' or 'associative' stigma" (Goffman, 1963; Mehta & Farina, 1988; Östman & Kjellin, 2002). *Courtesy stigma* has been separately defined as the public disapproval evoked as a consequence of associating with a stigmatized individual or group (Phillips, Benoit, Hallgrimsdottir, & Vallance, 2012). Therapists specializing in addiction counseling are working with a highly stigmatized, underserved population, which may result in stigma-by-association.

These are the sensitizing concepts I carried with me on my research, journey. In order to bring the reader along with me, an exploration of the extant research relating to them will be necessary before moving on to my grounded theory study.

Burnout

Substance abuse professionals have a higher rate of burnout than any other specialized group of health care providers, with estimates ranging from 18.5% (Knudsen, Johnson, & Roman, 2003; Young, 2015) to 25% (Gallon, Gabriel, & Knudsen, 2003; Young, 2015). These figures are higher than those of pediatric oncologists, nurses caring for patients who have HIV/AIDS, and counselors working in the prison systems. Substance abuse professionals change jobs an average every 2 years. The financial and emotional cost to clients, agencies, and overall wellness is great, and the location cure, as told to clients, never resolves the problem. The phenomenon of burnout for substance abuse professionals has coalesced into a major sensitizing

concept gradually over the past 2 years, as I studied other topics during my doctoral journey. I wanted to know what the literature had to say about the phenomenon of burnout, why substance abuse professionals experienced burnout at such a high rate, and whether stigma-by-association might be a causative factor. I continue to attend to the ways my previous exploration of the literature of burnout and stigma may affect my perspective going forward.

The most damaging and most identifiable symptoms of burnout are emotional exhaustion, depersonalization, and a reduction in the sense of personal accomplishment, leading to the identification of burnout as a "work-related mental health impairment" (Awa, Plaumann, & Walter, 2010, p. 184). One of the three components of burnout assessed by the Maslach Burnout Inventory (MBI) self-assesses, emotional exhaustion is defined as "a state that occurs when a practitioner's emotional resources become depleted by the chronic needs, demands, and expectations of their clients, supervisors, and organizations" (Newell & MacNeil, 2010, p. 59). Interestingly, therapists working in agencies with presumably more exposure to other professionals and experienced supervisors "experienced a higher level of emotional exhaustion than did those working in private settings" (Lim, Kim, Kim, Yang, & Lee, 2010, p. 92).

The second component of depersonalization, also defined as cynicism, "refers to the negative cynical, or excessively detached responses to coworkers or clients and their situations" (Newell & MacNeil, 2010, p. 59).

Although a positive sense of personal accomplishment is protective against burnout, a reduction in that inner sense of making a difference has been shown to be the third sign of burnout. The disappointment of working with clients who have a chronic relapsing disorder and the impossibility of guaranteeing long-term remission, despite the clinician's skill and

involvement, added to the demands of paperwork and other administrative tasks, long hours, and relatively lower pay scales, help to create a diminished sense of personal accomplishment (Maslach, 1998; Maslach, Schaufeli, & Leiter, 2001; Newell & MacNeil, 2010).

The Foundational Literature

This review begins, as it must, with the foundational works. The earliest article I found related to the topic of staff burnout was a conceptual paper that explored staff burnout in terms of the physical signs and behavioral indicators (Freudenberger, 1974). The term *burnout*:

> Appears to have been borrowed from the field of rocket engineering, where the term appeared by 1942. As applied to human service workers, the term began to be used in the early 1970s, with the idea that the "fuel" of functioning is exhausted and the person cannot go on with the work. (Lacoursiere, 2001, p. 1840)

The earliest published definition I found was "to fail, wear out, or become exhausted by making excessive demands on energy, strength, or resources" (Freudenberger, 1974, p. 159). Freudenberger reported that burnout was most prevalent within about a year after an individual had begun working in a free clinic. Someone who is burned out can be expected to "block progress and constructive change . . . because he is just too tired to go through more changes . . . He becomes the 'house cynic'" (Freudenberger, 1974, p. 161). Like the analogous rocket, the "dedicated and committed" are the staff members most prone to burnout (Freudenberger, 1974, p. 161).

The next foundational article included a definition of burnout as "a syndrome of physical and emotional exhaustion, involving the development of negative self-concept, negative job attitudes, and loss of concern and feeling for clients" (Pines & Maslach, 1978, p. 233). In their study, the authors used correlational analysis to identify the burnout syndrome as a coping

mechanism, allowing staff to continue working through retreating from "intense work with clients" by using "such techniques as detached concern, intellectualization, withdrawal from clients, and sharp separation of work from home life" (p. 234). The authors identified a sharp difference between staff members with higher education, whom they found to be "more pessimistic about the possible effects of their work . . . When asked to describe themselves, they saw themselves as more tense, distant, and introverted" (p. 235). The scholars also noted that "the longer staff had worked in the mental health field, the less they liked working with patients, the less successful they felt with them, and the more custodial rather than humanistic were their attitudes toward mental illness" (p. 236).

Maslach (1978) continued to work in the area of burnout, publishing a conceptual paper for the American Public Welfare Association. Maslach defined those at risk from burnout as individuals "whose work in one way or another involves continuous direct contact with different kinds of recipients," adding that:

> What is common to all of them is close contact with people, that is often emotionally difficult to handle on a continuing basis—difficult because hour after hour, day after day, year after year, they are dealing with people's problems . . . It is a difficult situation on both their parts . . . What we see happening . . . is a gradual loss of caring about the people they work with. (Maslach, 1978, p. 56)

Critics of the helping professions are not the only ones placing a negative focus on care workers. Maslach found that when helping professionals approached their supervisors and administrators about their feelings of burnout, they were often faced with the response, "What's the matter, can't you take it?" and the expectation that the professionals "adopt a protective façade of being cool and calm and confident as a way of hiding their fears and feelings" (p. 57).

Because coworkers and other peers have adopted that protective façade, helping professionals may have the feeling that they are "the only one[s] who can't handle this job" (p. 58). The author concluded by identifying the source of the problem as lying "more in the situation than in the people . . . the problem is best understood and modified in terms of the social and situational sources of the job-related stresses" (p. 58).

In 1981, Maslach and Jackson coauthor published a psychometric analysis to measure the reliability and validity of the scale that would become the cardinal test of burnout, the MBI (Maslach & Jackson, 1981; Maslach, Jackson, & Leiter, 1996–2016). To assert the relevance of this scale, the authors reported that "burnout seems to be correlated with various self-reported indices of personal distress, including physical exhaustion, insomnia, increased use of alcohol and drugs, and marital and family problems" as well as creating "a deterioration in the quality of care or service that is provided by the staff" (Maslach et al., 1996–2016, p. 100). The authors also found that burnout "appears to be a factor in job turnover, absenteeism, and low morale" (Maslach et al., 1996–2016, p. 100). The results of this research showed that the MBI had both high reliability and validity as a measure of burnout.

In 1986, Freudenberger discussed the burnout issues specific to staff in therapeutic communities, as well as comorbid factors contributing to burnout. The researcher identified a longstanding tradition of hiring a "successful" resident of the therapeutic community to take on expanding levels of responsibility, eventually becoming paid staff; however, he cautioned that such a career path might "further estrange them from their outside lives, families, etc., and not allow a gradual healing from trauma and other co-morbid factors" (Freudenberger, 1986, p. 247). This practice, still common among therapeutic communities and peer recovery centers, may also

be a factor in the meta issue of substance abuse counselors viewed as somehow less professional than other licensed therapists. Freudenberger advised: “If the signs of stress exist, the staff person has a responsibility to take care of him/herself and program administrators have a responsibility to call it to his/her attention as well as to offer assistance in overcoming burnout” (p. 250).

Following a review of the literature on burnout and the specific effects on substance user treatment staff and programs, Lacoursiere (2001) discovered that there was “more ‘burnout’ with more work pressure, unclear work policies, and decreased coping ability, with some ‘burnout’ protection from peer and supervisor support” (p. 1839). The researcher identified burnout to be a particular issue for human service workers, because “‘burnout’ is generally considered to require some degree of sustained work in a human service area so that the person who never ‘burns in’ or has fuel for the particular job will not ‘burnout’ either” (p. 1841). The factors most associated with burnout appeared to “include most notably job dissatisfaction, lowered morale, absenteeism, and job turnover” (p. 1843). In an interesting parallel process with clients, where the “implication is that as a result of alcohol and/or drug misuse the person’s ‘fuel’ as a person is essentially exhausted” (p. 1843), the researcher reported that burnout tends to be chronic and, importantly from a systemic point of view, that “generally, it is program rather than patient variables that are more contributory to ‘burnout’” (p. 1853). In an important contextual highlight, Lecoursiere’s review of the literature led to his characterization of burnout as an “appropriate normative response for certain work conditions” (p. 1866). The scholar concluded that several factors can create an environment fertile for burnout, including nonwork variables; lack of credibility; lack of respect from other team members (e.g., stigma-by-association); lack of

understanding, preparation, and acceptance of the role; and caring for patients with co-occurring diagnoses. Lacoursiere also found several factors seemingly protective against burnout, including social support, peer cohesion, supervisor support, work autonomy, efficient work environment, productive stress, clarity of rules and policies, and even physical comfort at the worksite.

Burnout can develop "irrespective of the type of occupation when job demands are high and when job resources are limited because such negative working conditions lead to energy depletion and undermine employee's motivation" (Demerouti, Bakker, Nachreiner, & Schaufeli, 2001, p. 499). This context is especially salient for therapists specializing in addiction counseling who deal with acute, resource-poor, and stigmatized patients.

A review of the later qualitative and conceptual literature on burnout began with a study by Fahy (2007) regarding "the issues of vicarious trauma and compassion fatigue with substance abuse practice" (p. 199). Fahy reported that "part of the answer may lie with the stress and strain of empathic work with poor compensations" (p. 200). In describing the potential environmental and contextual antecedents for burnout, Fahy reported that "Substance abuse treatment has shifted from a largely voluntary, insured, and mildly coerced population to a mandated one" (p. 200). The vicissitudes of human service work in the 21st century may not, however, be the culprit. Rather, Newell and MacNeil (2010) proposed, "The single largest risk factor for developing professional burnout is human service work in general" (p. 59).

Building on the foundational literature and expanding it to uncover whether there are any differences in the burnout process experienced by rural or urban substance abuse treatment counselors, Oser, Bibel, Pullen, and Harp (2013) reported that "rural mental health counselors were at significant risk for burnout, with 65 percent of their sample indicating a moderate or

higher burnout level" (p. 18). Oser et al. further reported that "substance abuse counselors are at high risk for burnout due to low wages and a lack of prestige in their job, combined with the fact that their clients many times deny their problems, lack the motivation to change, are homeless, relapse, are involved with the criminal justice system, have significant health problems such as HIV/AIDS, and many times have co-occurring mental health disorders" (p. 17). The researchers drew an important distinction between burnout and simple occupational stress, defined as "emotional connection" (p. 18). Oser et al. (2013) identified "age, educational level, recovery status . . . caseload, available resources, autonomy, and role expectations" as primary factors associated with burnout (Ducharme, Mello, Roman, Knudsen, & Johnson, 2007, p. 18).

Quantitative research on burnout. Most of the researchers on organizational and leadership factors of burnout used quantitative methods to focus in on individual and organizational factors capable of increasing the likelihood of burnout and turnover intention, as well as to identify protective factors. This makes sense from a business perspective, as many researchers reported on the singularly expensive issue of frequent turnover among substance abuse counselors. In addition, quantifiable, positivist research has long been the gold standard for uncovering objective truth. Interest in burnout and a drive to find ways to cure it also make a great deal of sense from a medical perspective, given that an estimated 40% of the effectiveness of treatment can be ascribed to the therapeutic relationship, and counselors with burnout are often cynical and distant from their clients and coworkers (S. Miller, Duncan, & Hubble, 1997). This finding contrasts with a potential challenge to professionals who work closely with other team members. Results of a later study showed coworker support to be inversely associated with emotional exhaustion, with researchers cautioning that "burnout can be 'contagious' among

staff" (Ducharme, Knudsen, & Roman, 2007). The isolating effects of burnout may deepen and exacerbate the original malady, which includes "three main issues: exhaustion, cynicism, and inefficacy" (Broome, Knight, Edwards, & Flynn, 2009; Maslach et al., 2001).

In studying burnout quantitatively, researchers have variously found specific individual factors to be predictive, such as higher counselor age (Garner, Knight, & Simpson, 2007) or age under 25 years (Oyefeso, Clancy, & Farmer, 2008). Other determinants may be certain personality traits, such as lower adaptability (Garner et al., 2007); the interplay of emotions and work (Vorkapić & Mustapić, 2012); and female gender of the clients, finding that women with substance abuse disorders come to treatment later in the disease cycle, when the disease of addiction is more intractable and acute (Perkins & Sprang, 2013). One researcher reported that substance abuse counselors who have family members with addiction problems or are themselves in recovery may be more susceptible to compassion fatigue and may "engage in more 'emotional labor' than other counselors because of the blending of personal experiences and work roles" (McNulty, Oser, Johnson, Knudsen, & Roman, 2007, p. 171). This increase in emotional labor may correlate with the necessity of working through developmental trauma and other issues related to being an adult child of addicts, as well as the multiplicative effects of stigma and stigma-by-association. Leykin, Cucciare, and Weingardt (2011) and colleagues found that substance abuse counselors who themselves had a history of recovery reported lower burnout scores, as compared to those who were not in recovery. Organizational factors predicting burnout included higher stress and "poorer clarity of agency mission" (Garner et al., 2007).

Gaps in the literature thus far. The authors of the MBI reported that their self-assessment tool had not received testing through clinical research or in use for individual

diagnosis (Maslach et al., 1996–2016). Later authors used the Professional Quality of Life Scale and the General Empathy Scale to identify whether there might be "unique features of substance abuse service delivery" that might be kindling for burnout, a study motivated by a National Association of Alcohol and Drug Abuse Counselors 2007 report (Caruso & Mayer, 1998; Perkins & Sprang, 2013; Stamm, 2013). The foundational authors identified the problem of turnover intention as endemic to the larger topic, many scholars of the early 21st following, researching that line of investigation exhaustively (Lacoursiere, 2001; Maslach & Jackson, 1981).

Conclusions. As with most foundational articles, the researchers curious about the phenomenon of burnout set about the task of identifying the problem; defining terms; and clarifying probable antecedents, symptoms, and preventative measures (Freudenberger, 1974; Maslach, 1978; Pines & Maslach, 1978). These researchers were at the very forefront of uncovering the topic; as such, they did not identify their limitations or know what further frontiers might need attention. By the early 1980s, this work had culminated in the MBI, which became "the measure of choice for any self-reported assessment of this syndrome" (Maslach et al., 1996–2016). Subsequent foundational writers studied the effects of burnout in different settings, such as therapeutic communities, and identified the physical and behavioral symptoms of burnout (Freudenberger, 1986). Lacoursiere (2001) summarized the original work of the late 20th century with case studies and a glossary but offered no insight into the landscape beyond. Decades later, researchers investigating burnout continued to call for studies that will "build a more robust knowledge base about the prevalence, causes, and effects of burnout in this field" (Paris & Hoge, 2010).

Stigma

I am aware of my own tendency not to lead with the information that I am a substance abuse counselor. My other licenses and specialties receive top billing on my business card and in my direct speech as I introduce myself to other professionals. Educated as I am against it, I continue to perpetuate the self-stigma that goes along with stigma-by-association. In addition, as an evolutionary psychologist and communal mammal, I am aware of the power of stigma. I stand with the constructivist researchers in believing that it matters little if there is *objectively* stigma-by-association if it can be identified as *subjectively* perceived and it affects the actions, opportunities, and happiness at work of addiction counselors.

Stigma and mental health. Maslach (1978) explored a bidirectional issue of stigma in the helping professions early in burnout research, identifying stigma focused on the patients from the helping professionals, critics of the helping professions, and helping professionals toward themselves. The researcher was beginning to view stigmatizing behaviors as a coping mechanism related to burnout, which:

> Crystallizes into a cynical and dehumanizing perception of clients that labels them in derogatory ways. Seen by professionals as deserving of their problems, an automatic tendency to blame the victim sets in that in many cases appears to cause the quality of client services to deteriorate. (Maslach, 1978, pp. 56–57)

This article shows some evidence of stigma-by-association, not yet a named concept, as a "tendency of . . . critics of the helping professions, to view the problem as being a problem of bad people. . . . What is wrong with psychiatrists, with cops, with welfare workers is the kind of people they are. Coldhearted." (Maslach, 1978, p. 57). Such a pejorative view of those helping professionals who experience the depersonalization and cynicism that can arise from the very act

of doing their jobs adds to the stigma felt by those who struggle with the decision to stay in the profession and get help or to change jobs.

In an article describing the issues of stigma as they relate to general mental health professionals, Schulze (2007) found that "patient contacts are not at the forefront of stressful experiences in psychiatry. They do not even appear among the ten most frequently mentioned stressors" (p. 148). This article begins with a discussion of mental health professionals as themselves acting in stigmatizing ways toward patients and their families. Focusing on stigma-by-association, the psychiatrists who were interviewed described the three main areas in which they had perceived themselves as stigmatized and discriminated against: in their relationships, the lack of appreciation they perceived because of "stereotypical public images of psychiatry," and the barriers to their work created by lack of parity between medical and mental health treatment (p. 147). The researcher concluded with a call for psychiatric professionals to act as "de-stigmatizers of mental illness and those suffering from them" through "increasing awareness of stigmatizing aspects of clinical practice"; "meaningful user and family involvement"; "recognition of challenging stigma and discrimination as an inherent part of the profession"; and "campaigning for adequate resources for treatment and research" (pp. 150–152).

In an article introducing the topic of the "stigmatization in and of organizations" for the *Academy of Management Review,* Paetzold, Dipboye, and Elsbach (2008) proposed the potential for positive effects of stigma, both individually and systemically, as a powerful tool to reduce negative behaviors. The authors also purported that "stigmatized individuals . . . are subject to discrimination that includes bullying, harassment, and social rejection" (p. 187). Paetzold et al.

made reference to an earlier article when they noted that “stigmatization can undermine the cohesiveness, morale, and effectiveness of an entire organization” (p. 187). This introductory article proposes that the cardinal negative issue with stigmatization (i.e., stigma-by-association) is that it “can lead to challenges of the validity of the stigma that can produce positive effects for individuals, groups, or organizations” (p. 191). In effect, the researchers seemed to be concerned that stigma-by-association might dilute the strength of “good” stigma to control the behavior of those who ought to behave better.

Interviews with psychologists in the United Kingdom found a distressing barrier to receiving support for burnout-related symptoms that was “more evident for participants experiencing difficulties historically more stigmatizing in wider society” (Charlemagne-Odle, Harmon, & Maltby, 2014, p. 249). As identified in other areas of this critical review, these symptoms pose an especially troubling cycle for substance abuse professionals who may find themselves in a downward spiral of using alcohol and other drugs in an attempt to deal with symptoms related to burnout.

Stigma-by-association is a powerful force for those working with and relating to people on the receiving end of stigmatization. Asserted Oser et al. (2013), “The social stigma associated with substance abuse and dependence taints both the clients who experience substance use disorders and the counselors who treat this considerable health concern” (p. 23). Stigma spills over of the boundaries of the stigmatized individual and onto those who are in some way related to that person. The researchers continued, “As substance abuse remains socially stigmatized, providing treatment to individuals with substance use disorders is both a low prestige and low paying occupation” (Oser et al., 2013, p. 23). Substance abuse counselors may not be entirely

aware of this phenomenon: “counselors in this study did not directly tie burnout to the social stigma” and, therefore, may be particularly susceptible to the effects of differential treatment among other helping professionals (Oser et al., 2013, p. 23). Research with affected family members who are supporting an adult family member with an addiction showed they “also experience blame and shame because of their family member’s substance abuse” (McCann & Lubman, 2017, p. 2). The researcher found two major themes family members used to distance themselves from the effects of stigma-by-association: “engaging in secrecy, and minimizing contact with others” (i.e., isolating; McCann & Lubman, 2017, p. 1).

The interconnected nature of stigma, stigma-by-association, shame, and blame was found in parallel between clients and caregivers (Phillips et al., 2012). The puritanical tendency to blame and shame indeed seems to spill over onto caregivers for people with stigmatizing conditions. Perhaps substance abuse counselors are blamed for their clients’ relapsing and antisocial behaviors. Perhaps the general public has an expectation that a good enough counselor would be able to fix the client. Given the effects of internalized stigma, one expectation may be that when clients experience a relapse, counselors distrust their own competence. People with substance use disorders are likely to be blamed for their condition, and this contagion of “proximal social context,” or “stigma-by-association, suggests that the personal and professional relationships with, or even being in close proximity to, stigmatized others can lead to the devaluation of nonstigmatized targets” (Baldwin-White, 2016; Hebl & Mannix, 2003; Hernandez et al., 2016; Neuberg, Smith, Hoffman, & Russell, 1994; Pryor, Reeder, & Monroe, 2012).

Conclusions. The extant literature clearly identifies stigma and stigma-by-association as damaging to clients and counselors in helping relationships. Given this acknowledged issue,

uncovering the lived experience of therapists specializing in addiction counseling could be especially helpful in clarifying the toxic relationship between stigma, stigma-by-association, and burnout. I am most curious about the specific issue of stigma-by-association as a precursor of burnout among substance abuse professionals, a topic found at the intersection of burnout, stigma-by-association, and addiction professionals. I am interested in obtaining the perspectives of other substance abuse professionals about whether they are aware of financial, professional, or personal inequities in respect and status between themselves and members of other caring professions, as well as how these inequities play out in their organizations and over time. In other words, I wish to determine whether addiction counselors have experienced the glass box of reduced opportunities and narrowed professional expectations to work with people who have addiction among other mental health disorders. It seems plausible that health care professionals working with the most stigmatized of clients may experience higher rates of burnout in light of stigma-by-association.

Attrition in the Helping Professions

Much of the quantitative research to date has used the fulcrum of frequent job changes to signal wellness deficits in the Community of addiction professionals. The statistics are, indeed, attention-grabbing and worthy of discussion. According to Evans and Hohenshil (1997), "76.2% of the participants, though satisfied with their present job, indicated that they would leave the position within the next five years. This included 17.75% who indicated they planned on leaving the profession of substance abuse counseling altogether" (pp. 1–2).

Fahy (2007) echoed previous writers in identifying secondary traumatic stress as a "condition and compassion fatigue as a process . . . most accurately describing what happens to

unsupported workers over time" (p. 202), findings echoed by Bride and Walls (2006). Therapists specializing in addiction counseling appear to be demotivated by reduced opportunities for advancement (Evans & Hohenshil, 1997). As stated by Newell and MacNeil (2010), the "organizational factors shown to contribute to professional burnout include excessively high caseloads, lack of control or influence over agency policies and procedures (i.e., autonomy); unfairness in organization structure and discipline, low peer and supervisory support, and poor agency and on-the-job training" (p. 59). These factors were alternately labeled in an earlier article as "organization setting and bureaucratic constraints, inadequate supervision, lack of availability of client resources, and lack of support from professional colleagues" (Newell & MacNeil, 2010, p. 59).

Organizational and systemic factors. Turning toward the organizational and systemic issues of counselor turnover, Young (2015) identified clinical staff turnover resulting from burnout as "one of the most challenging issues facing the substance abuse treatment field" and "an unpleasant and dysfunctional experience that both counselors and organizations would like to change" (p. 675). Echoing Maslach and Leiter (1997), Young stated the "larger the gap, or mismatch, between a person and their work, the increased likelihood of burnout" (p. 676). Maslach and Leiter's model identifies the six main domains of the job environment that need to match as workload, control (identified in other research as autonomy), reward (personal achievement), Community, fairness, values, and the overall interaction of the six areas.

Focusing on the somewhat unique experiences of indigenous alcohol and other drug workers' experiences and perspectives on well-being, stress, and burnout in Australia, Roche et al. (2013) found that "excessive workloads, juggling multiple responsibilities, community

proximity and expectations, loss and grief issues, lack of resources, and racism" were significant stressors kindling burnout experiences (p. 529). Indigenous counselors working in mixed-race agencies were especially at risk if they were the "'catch-all' worker for indigenous clients or the sole isolated worker" (p. 529). Again, it appears that isolation, whether through geography, culture, or stigma, may be a major factor in burnout.

Turnover intention. Many of the quantitative articles written in the first decade of the 21st century showed the specific systemic issue of turnover intention as a motivator for predicting burnout. This is, indeed, a problem on a huge scale, with one author reporting, "In the USA Pacific Northwest . . . agencies, on average, experienced a 25 percent turnover rate per year" (Duraisingam, Pidd, & Roche, 2009, p. 218; Gallon et al., 2003, p. 183). Knudsen, Ducharme, and Roman (2006) found that "management practices in therapeutic communities, and perhaps in other types of substance abuse treatment facilities, likely play a substantial role in counselors' well-being and in their decisions to leave their jobs" (p. 173). The authors drew a distinction between "procedural justice," which they found to be more important than "distributive justice" in predicting burnout, in which procedural justice ("the extent to which the processes through which organizational decisions are made are perceived to be fair") is "associated with a constellation of positive work attitudes"; in turn, distributive justice describes only "how fairly the workloads and rewards are distributed" (Knudsen et al., 2006, p. 175). These echoed the findings of other scholars that autonomy in the job plays a protective role against burnout (Ducharme, Knudsen, & Roman, 2008; Lacoursiere, 2001). These authors found that "policies that lead employees to perceive that they are valued and integral members of the organization" can create a social climate protective against turnover (Ducharme et al., 2008,

p. 83). This was echoed in a later study that examined the supportive effects of a psychoanalytic reflective practice group on personal achievement and depersonalization during a major transition in work environment, role, and expectations, at a time when presumably the counselors' sense of autonomy had been severely tested (Menon, Flannigan, Tacchi, & Johnston, 2015). In addition, clinical supervision has been found to be negatively associated with emotional exhaustion and turnover intention (Ducharme et al., 2008; Lacoursiere, 2001; Powell, 1991).

Another factor affecting job turnover appears to be the within-profession practice of elevating star performers into roles they are perhaps unprepared to fulfill (Powell, 1991). This is a parallel process to the elevation of successful clients within therapeutic communities and peer recovery centers into positions of responsibility, where turnover rates are similarly high.

Also protective against annual turnover rates reported to be 30% to 50% among substance abuse counselors were the research projects counselors were involved in that resulted in organizational benefits (Knudsen, Ducharme, & Roman, 2007; Powell, 1991). The probable corollary to this finding, of course, is that research projects, with their demands on time and energy, could exacerbate burnout if the research was not seen to be beneficial, leading the authors to support the argument that researchers may need to consider whether clinical staff involved in research should be covered by human subject protections (Hilton, 2006; Knudsen et al., 2007). In addition, the expectation of continuing education, while adding to job demands, predicted lower burnout scores immediately and 6 months after training, with the most positive effects occurring with trainings designed to be flexible and customizable (Leykin et al., 2011).

McNulty et al. (2007) found that the special needs of clients with substance use disorders were contributing to burnout and an "average annual turnover rate of 18.5 percent" (p. 166). The authors characterized clients with substance use disorders as "extremely difficult to treat and may arguably be among the most difficult of all human service clients with whom to work" (McNulty et al., 2007, p. 172). They echoed an earlier work that reported "a mismatch between the composition of clients and the generally well-educated middle-class counseling workforce" as a contributor to high turnover rates (McNulty et al., 2007, p. 173). This class differential may be particularly difficult to tolerate, given the reflection of the vicissitudes of the lower-socioeconomic contexts of clients in the authors' statement that "the substance abuse counseling occupation rarely allows for substantial upward mobility" (McNulty et al., 2007, p. 169). In fact, as recipients of stigma-by-association, substance abuse counselors may find themselves with reduced resources, both on the job and in their personal finances, to carry out their work (Phillips et al., 2012). Although some authors found that the chronic relapsing nature of addiction contributed to turnover intention: "addiction clients treated in even the 'best' facilities are prone to high rates of relapse, yielding frustration among clinicians who invest significant emotional resources in building their therapeutic alliance" (Ducharme et al., 2008, p. 83).

Conclusions. With job turnover statistics like the ones reported previously, it is no wonder the business of health care has been interested in understanding burnout. It seems that a measure of autonomy, an ability to leave work behind, resilience and flexibility, and good enough clinical supervision may reduce the frequency with which therapists specializing in addiction counseling leave both their current jobs and the specialty profession as a whole.

Between 2001 and 2010, most researchers used quantitative methods to tie antecedents of burnout to leadership, organization, and system in an effort at prevention, with the unifying terms *turnover intention* and *job satisfaction* guiding their studies (Ducharme et al., 2008; Duraisingam et al., 2009; Garner et al., 2007; Knudsen et al., 2006; Knudsen et al., 2007; Knudsen et al., 2008; McNulty et al., 2007). Later scholars followed up on previous research, returning to contextual issues related to the increased incidence of burnout among substance abuse counselors and how burnout might increase turnover intentions (Roche et al., 2013; Vorkapić & Mustapić, 2012; Wallace, Lee, & Lee, 2010; Young, 2015). This leads to the question of how do we effectively provide support for our therapists specializing in addiction counseling? It is obviously not enough to avoid hiring, promoting, and maintaining tyrannical clinical supervisors (Ashforth, 1994). Following is an exploration of what the literature has to say about wellness-at-work practices that do reduce burnout and job turnover over the long term.

Wellness at Work

Holistic healthfulness at work is far more than simple job satisfaction, since the organizational intention ought to be to prevent a "work-related mental health impairment" (Awa et al., 2010, p. 184). Many writers on wellness and well-being have used these phrases interchangeably, but they actually point readers toward different focal points. According to Ellis (2017), "when you think about wellness, think prevention and health. When you think about well-being, think happiness." How can leaders and organizations provide a positive work environment for therapists specializing in addiction counseling with an eye toward preventing burnout and purposively creating a fertile environment for the much-broader concept of well-being? By what means can we identify the elements involved in creating that work

environment? What is actually important to the therapists doing this important work? According to Eger and Maridal (2015), the livability factors of well-being include "living standard, health, freedom, personal and community relationships, peace, and security" (p. 45). What do these livability factors mean in the context of wellness in therapists' professional and personal lives?

Suggestions to organizations for enhancing wellness. Important to the conversation on systemic and organizational implications on wellness, Freudenberger (1974) identified burnout as a serious occupational hazard. The researcher also explored what preventative measures a clinic staff could take to avoid burnout among its dedicated members. Freudenberger suggested weeding out those unfit for the work by providing training programs that would identify candidates who would be unsuited to the helping professions and discover the differences between the realistically dedicated or committed person and an unrealistic dedicated person. The researcher advised not sending the same staff member into a given job situation over and over; limiting the number of hours a single person works; encouraging time away from the work through vacations; maintaining group cohesion; encouraging continuing education; making a space for staff to share experiences; bringing in volunteers to share the workload; and encouraging physical exercise.

On an organizational and systemic level, Pines and Maslach (1978) found burnout risk increased under certain conditions: "larger ratio of patients to staff"; "the higher the percentage of schizophrenics [sic]"; and a "High frequency of staff meetings correlated with very negative and dehumanizing attitudes toward patients. It also correlated with avoidance of contact with patients and job-oriented rather than patient-oriented goals"; and "Longer work hours were correlated with more staff stress and negative feelings" (pp. 234–235). Staff members liked their

work when “staff–patient interaction was good”; working with a “less seriously ill” population; they could “afford to take time-outs—to withdraw temporarily to other work activities—when they did not feel like working directly with patients”; and “Work was perceived as less stressful if the general workload was shared” (pp. 234–235).

In a literature review of research interventions such as “cognitive behavioural training, psychotherapy, counseling, adaptive skill training, communication skills training, social support, relaxation exercise or recreational music making” that initially showed significant positive improvements, Awa et al. (2010) found that the improvements often disappeared 6 to 12 months after the completion of the intervention and required ongoing “booster sessions” (p. 187).

Newell and MacNeil (2010) reported a general lack of training for social work students in the preventative self-care necessary to avoid secondary traumatic stress and professional burnout; unknown, however, is what are the protective factors that could be taught to up-and-coming interns during their graduate school internship experiences? As an adjunct professor providing supervision and training for first- and second-year interns for the Antioch University New England School of Clinical Mental Health Counseling, I am personally aware and involved in the students’ establishment of their self-care plans at the beginning of each semester. Each subsequent self-care plan after the very first internship semester involves a scaling back of wellness activities in light of the demands of schooling, internship, working for pay, and all the other responsibilities of being a householder. Antioch counseling training programs may give the nod to self-care as a concept, even Antioch does not lead the way by modeling exquisite self-care. Another issue facing my and other students’ future wellness, if they

remain working in underserved communities, is that "professional isolation may be largely to blame for the high rate of burnout in rural areas" (Oser et al., 2013, p. 18).

Charlemagne-Odle et al. (2014) found that psychologists were ambivalent, if not openly resistant, to engage in psychotherapy, especially when the underlying issue was burnout due to a fear of being judged and perceptions of how a good psychologist is defined. The psychologists interviewed perceived "discouraging messages that it was unacceptable to need personal support as a psychologist" (p. 246). Worse, these interviews unearthed the damaging habit of psychologists to try to provide therapy for themselves, which "is ineffective, causing a false sense of security, intense self-criticism, and professional doubt" (p. 249). Another barrier to treatment for psychologists appeared to be an "uncomfortable conflict of role identity" (p. 251). It would be interesting to know whether this same challenge holds true for other therapists, including substance abuse counselors.

In identifying factors protective against burnout and turnover intention, Duraisingam et al. (2009) reported on sources of satisfaction, such as "client interactions, commitment to treatment and personal growth" (p. 219). Researchers have cautioned against significant predictors of burnout, including low job satisfaction, high work stress, low workplace social support, and low pay (Duraisingam et al., 2009; Gallon et al., 2003). Other authors found self-distraction, behavior disengagement, humor, and venting to reduce the effect of job stressors, including workload, role conflict, and job ambiguity (Wallace et al., 2010). Also protective, although somewhat indicative of a dark humor reminiscent of an old method of waiting for clients to "hit bottom," are the "very low expectations" of the possibilities of long-term abstinence of their clients that substance abuse professionals bring to their work

(Vorkapić & Mustapić, 2012, p. 195). In a small study in Israel, not only organizational factors, but the therapeutic orientation of cognitive behavioral therapy as opposed to psychodynamic or ecosystemic modalities, was found to offer a lower level of burnout and a higher sense of professional efficacy (Tartakovsky & Kovardinsky, 2013). In further support for the protective quality of autonomy in the workplace, "workers with higher levels of self-efficacy are less apt to experience burnout and therefore, more likely to continue in their chosen profession" (Baard, Deci, & Ryan, 2004; Baldwin-White, 2016).

The importance of good enough clinical supervisors and leaders cannot be underestimated in the promotion of wellness and resilience in health care workers in general (Bride & Kintzle, 2011). Leadership has been found to be a "highly emotional process with significant consequences" (Glasø & Einarsen, 2006, p. 65). Negative emotions are not the only feeling states that are contagious. Bono and Ilies (2006) found that leaders' "positive emotional expressions positively affected followers' mood" (p. 327). The authors also noted that "the behavior of leaders and managers can make a difference in the happiness and well-being of the followers by influencing their emotional lives" (p. 331). However, Breevaart, Bakker, Hetland, and Hetland (2014) found the combination of high job demands and low leadership support (hindrance) are prescriptive for burnout and job demands may be fixed and unaffected by good-enough leadership. Organizations in general search for highly qualified clinicians to perform supervisory roles for which they may not be trained or suited (Powell, 1991).

Conclusions. From the literature, we get very little sense of how to actually support therapists specializing in addiction. What is apparent is what to avoid, most of which constitutes sound business practice in general: Do not micromanage knowledge workers; do not overstress,

overwork, and underpay your staff; and provide consistent and good-enough clinical supervision and enrichment.

From this review of the literature on wellness, it seems clear that the needs of therapists specializing in addiction counseling have been imagined, posited, perhaps surveyed and researched fairly extensively, if not exhaustively, and often captured as part of surveys targeting general mental health and health services providers. The specific context of people working in the addiction specialty would benefit from hearing their voices.

Historical and Current Context of Opioid Addiction Treatment

Following is a brief history of opioid addiction treatment in the United States as it relates to the issues of acuity, resources, stigma and stigma-by-association, and burnout of therapists specializing in addiction. By all objective reports, the US is in the middle of an epidemic; as such, some new resources have been brought to bear on the issue, while other previously available strategies have been discontinued. In a parallel process with the advent of psychotropic drugs leading to the closing of private and public mental institutions, clients with opioid addiction may have access to medically assisted treatment (such as buprenorphine, methadone, and naltrexone), but no longer have access to medically assisted inpatient detoxification as a precursor.

Opioid epidemics. The United States has a chronic, relapsing opioid addiction use disorder. Americans currently use 80% of the world's supply of all opioids and 99% of hydrocodone (Manchikanti, 2007). In the first 20 years since Purdue Pharmaceuticals introduced oxycontin (between 1996 and 2016), opioid drug overdoses in the United States tripled (Rudd, Seth, David, & Scholl, 2016). The demographics of the addicted population have shifted, from

marginalized and oppressed populations in urban centers to White emerging adults (age 18 to 25 years) (Cicero, Ellis, Surrat, & Kurtz, 2014; Courtwright, 2009; Quinones, 2015). Hydrocodone with acetaminophen (also known by the brand name Vicodin) was the most written prescription from 2006 through 2011 (Manchikanti et al., 2012). These statistics, and other seemingly never-ending waves of bad and worse news, have brought the country's attention to the problem of opioid addiction in the opening years of the 21st century. This is not the first opioid epidemic, however: the country has been plagued by citizens' addiction to painkillers and the devastation it causes since before the widespread marketing of heroin by Bayer Pharmaceuticals in 1914, having faced several epidemics since then. Perhaps the more important question for policymakers and health care providers in 2018 is: What policies and procedures help reduce overdose deaths and promotes functionality for our addicted citizens? Finding the answer requires a review of the epidemics of the past century.

The first opioid epidemic, circa 1900. The nation's first Opium Commissioner, Hamilton Wright, was appointed by Theodore Roosevelt in 1908 in response to the President's concerns over a national crisis of opiate addiction (Miroff, 2017). In a pattern that would be repeated several times in the nation's history, the roots of the epidemic began during the Civil War, with veterans returning home with "soldier's disease" (what we would now call posttraumatic stress disorder, hooked on morphine. Morphine had been invented in the 1820s but then, as now, it was the introduction of the hypodermic needle that paved the road to recreational use (Miroff, 2017). Preparations such as paregoric were marketed and prescribed to middle-class women to treat infants' colic and cough, and laudanum (a potent mixture of opium and alcohol) to treat themselves for "female problems" (Courtwright, 2009). In 1898, the Bayer Company

introduced heroin as a wonder drug. Heroin was widely prescribed and supported by the medical community, perhaps because at the time there were few effective medicines for pain (Moghe, 2016). The *Boston Medical and Surgical Journal* declared in 1900 that heroin was "not hypnotic, and there's no danger of acquiring a habit" (cited in Miroff, 2017). Heroin was not declared illegal until 1924. By that time, most doctors were aware of its addictive properties and were less likely to prescribe opioid pain relievers. As would be true in future epidemics, medical professionals had promoted the use of the new wonder drug without waiting for scientific corroboration of the manufacturers' claims, retreating after the human effects were all too visible.

Opioid Commissioner Wright became a major force behind the Harrison Narcotics Tax Act of 1914, which taxed and regulated any product containing opium or cocaine. The subsequent broadening of scope of the Harrison Act carved out a fertile landscape for the first opioid epidemic in 1918, reducing access to formulations of opioids that were at the very least under some medical supervision. In the period immediately prior to the Harrison Act, physicians were believed to have been overprescribing narcotics to their patients. Clinics, opened to provide a harm-reducing legal dose of narcotics to drug addicts prior to the Harrison Act, were suddenly threatened with indictment and closed, creating a black market and raising the cost of narcotics "as much as 50% immediately" (Musto & Ramos, 1981). This is a startling echo of the most recent overprescription of painkillers in the 1980s and 1990s, followed by the effects of the sudden withdrawal of access that precipitated (and, indeed, maintains) the current opioid crisis. Physicians, who up until 1914 had been able to prescribe narcotics to their patients, were now legally barred from prescribing them. As authorities arrested physicians prescribing narcotic

medications across the country, communities faced the immediate decision of what could be done for their addicted populations (White, 2014). The numbers of uncovered addicts were staggering: Memphis tasked just one doctor to provide daily dosing of morphine to a clientele made up for the most part of married women; he quit in the first week due to the enormity of the problem ("Drug Addicts in the South," 1919). A drug clinic in New York City, opened in 1919, enrolled more than 3,300 addicts in the first week ("Drug Treatment," 1919). Nearly all clinics serving those addicted to narcotics closed between 1921 and 1922, removing access to treatment for all but the most affluent. In addition, physicians were excluded from the treatment of narcotic addiction in response to a climate of blame, naming those same overprescribing physicians as the cause of the problem (White, 2014). Compare this to Vermont's otherwise liberal and affirming Medicare and Medicaid policy that bars opiate addicts from receiving medical detoxification in hospital because, unlike alcohol and benzodiazepine withdrawal, opiate detoxification is not specifically (only incidentally) life threatening. The philosophical tide had turned away from the medical model of addiction, and public health authorities declared "addiction a voluntary, self-indulgent, malevolent behavior" (White, 2014, p. 158).

Where did all the addicts go? For the 40 years, between 1920 and 1960, narcotic addicts were now at the mercy of illegal providers and quasimedical promoters of cures (Bishop, 1920). In 1938, Dr. Henry Smith Williams:

> Charged that the administrative misinterpretation of the intent of the Harrison Act had: 1) turned law-abiding, addicted American citizens into outcasts and criminals, 2) created a billion-dollar-a-year illicit-drug industry, 3) led to the persecution and prosecution of some 25,000 physicians whose only crime was fulfilling their pledge to relive the suffering of their patients, and 4) filled federal

> prisons with addicts who did not deserve to be there and could not be adequately cared for in such a setting. (White, 2014, p. 159)

According to White (2014), the supposed deviousness and duplicity of opioid addicts are a response, not an organic cause, of the stigmatized and stereotypical criminality of addicts. Faced with no legal choices for cure or relief, in the mid–20th century as today, addicts resorted to criminal behavior. Physicians continued to be the main source of opioid supply, although perhaps unwittingly, as patients sought multiple prescriptions from separate doctors (something also known as doctor shopping). Patients who were able to qualify for care due to chronic illnesses such as "neuralgia, chronic diarrhea, asthma, chronic bronchitis, tertiary syphilis, tuberculosis, diabetes, and cancer" could legally be maintained on narcotics, although it was still technically illegal (White, 2014, p. 160).

As described in an earlier section, two federal "narcotic farms" were opened in the 1930s: the Lexington Narcotics Farm in Lexington, Kentucky, in May 1935 and the Fort Worth facility in Fort Worth, Texas, in 1938. The typical length of treatment was 1 to 3 years, with common stays between 2 and 10 years. Addicts received methadone and such treatment modalities as electroconvulsive therapy and segregation from their normal lives. The predictably high relapse rate in the wake of release from narcotic farms promoted an expansion of community-based models of treatment, including therapeutic communities, and expanded 12-step supports, among them Narcotics Anonymous.

The second opioid epidemic, 1950–1970. The country's harsh stance against narcotic addicts was under siege in the wake of a dramatic rise in heroin addiction among returning veterans of World War II and the Korean War. The country was forced to face the reality that the

punitive, legal indictment of addiction had been unsuccessful in preventing narcotic use. By 1968, research had shown that either methadone maintenance or outpatient counseling could be provided to three patients for what it cost to maintain one in a therapeutic community (White, 2014).

By 1972, the Food and Drug Administration had approved the use of methadone and naltrexone for treating heroin addiction, marking the remedicalization of opioid addiction (Joseph, Stancliff, & Langrod, 2000; White, 2014). Research showed that with stable doses of methadone at blockade levels, "the patient becomes functionally normal" and that the treatment was "corrective, but not curative" (Dole, 1988). Recovery became defined as functionality, not complete abstinence. Following federal approval of methadone maintenance, diffusion spread from the original 22 patients in 1965 . . . to more than 80,000 patients in 1976 (White, 2014).

The 1980s marked a federal backlash against medically assisted treatment in both the Carter and the Reagan administrations, and the public funding dropped by more than half (Jaffe & O'Keefe, 2003). The emergence of HIV/AIDS and the known disease vector of shared needles paradoxically rescued medically assisted therapy. Methadone maintenance was highly stigmatized, as it remains today, and myths about methadone treatment and clinics were widely believed. It is still somewhat common for clients considering methadone or buprenorphine to express concern about methadone making their bones brittle over time. Today, over half of all outpatient medically assisted treatment providers are operated by for-profit organizations. Methadone was still considered a short-term therapy, with evidence-based medically assisted treatment eroded by an antithetical government by way of the 1988 White House Conference for a Drug Free America, calling for an end to methadone treatment and decreased funding.

Effective doses were reduced to low-threshold amounts and treatment waiting lists grew (Cushman & Dole, 1973). Methadone maintenance was relegated to private, for-profit corporations, which provided fewer services to generate greater profit. A retreat from effective doses of methadone, combined with a philosophy of tapering off maintenance, contributed to the stigma and discrimination that became attached to methadone treatment as fewer patients were able to successfully return to full functioning (Cushman & Dole, 1973). This stigma came in spite of the assertion that effective methadone maintenance was "corrective but not curative" and therefore needed to be a lifetime regimen (Dole, 1988).

Narcotic antagonists emerged in the early 1960s in an attempt at extinguishing the drug-seeking behavior by blocking the euphoria associated with use. Narcotic antagonists, such as naltrexone, were used throughout the 1960s and 1970s, with some success at preventing relapse. These drugs, separately or in combination, remain popular treatment options.

The current epidemic. Following publication of an 11-line letter to the editor of the *New England Journal of Medicine* in 1980, Jane Porter and Dr. Hershel Jick would contribute scant research that became the scientific basis of an unprecedented expansion of the use of opioids to treat pain, and, by extension, the current opioid epidemic (Leung, Macdonald, Stanbrook, Dhalla, & Juurlink, 2017; Porter & Jick, 1980; Quinones, 2015). This was not, later rebranded, a landmark study proving opioids to be nonaddictive when used at any amount. Rather, it a small research study indicating that a hospital-based population of mostly terminal patients who were under strict prescribing guidelines did not, interestingly enough, develop an addiction to opioid painkillers. Even so, this small study later became the constitution of the pharmaceutical industry.

Current state of treatment. Treatment professionals, insurance companies, and governmental agencies can learn a significant amount about treating addiction from the history lessons of the past century that are applicable to slowing and eventually arresting the current opioid epidemic. Treatment professionals have learned that medically assisted treatment can be corrective, but not curative. Partial agonists like buprenorphine, euphoria blockers like naltrexone, replacement therapy like methadone, and rescue agents such as Narcan are part of the 21st-century treatments. In general, addicts who are not selling drugs are not incarcerated. Vermont, small but hard-hit by the epidemic, has been a leader in implementing these treatments (Simpatico, 2015).

In 2014, Vermont Governor Peter Shumlin reported an opioid addiction epidemic in the state (Simpatico, 2015). Shumlin dedicated the entire State of the State address to the issue, stunning most treatment providers in Vermont and issuing a call to action that caught many unprepared. The response has been twofold by way of the widely emulated hub-and-spoke medically assisted treatment delivery model and a police force equipped to rescue rather than incarcerate addicts (Audette, 2017).

There are eight methadone and buprenorphine hubs accessible within each of Vermont's 14 counties, with another scheduled to open in St. Albans in 2019. The hubs provide daily dosing and other forms of treatment, including individual and group therapy and case management. Local hubs employ nursing and counseling staff to support the spoke offices. Spokes consist of doctors who have been certified to provide medically assisted treatment services, with strict limits on how many patients each can serve. This limitation arose in response to the legacy of

overworked physicians in the wake of the 1920s closures of narcotic farms and inebriate asylums.

Police departments, ambulance crews, and indeed any citizen in Vermont who is concerned about the epidemic loss of lives to opioid addiction can receive training to administer Narcan, a drug that reverses opioid overdose. Addicts do not have to worry about being incarcerated for possession after rescue with Narcan (Audette, 2017). Although state and federal law enforcement agencies do aggressively prosecute sales, the end-market addict is not treated criminally for their addiction.

At the time of this writing, the Vermont Department of Health's Alcohol and Drug Abuse Program financially supports addiction treatment for anyone without means of paying for services through its community partners, as does Vermont Medicaid under the Affordable Care Act of 2010 expansion. It remains to be seen what will happen in the new climate of reducing access to health insurance under an administration antithetical to the Affordable Care Act.

America in the midst of an addiction epidemic, and the mortality and morbidity rates show no signs of ebbing. Some of the treatment modalities currently in use will prove effective, others less so. As an optimist, I can only hope the lessons learned from this resurgence of addiction will be retained and serve as a baseline for the next epidemic. Like any addict, the United States has a chronic, relapsing disorder. Due to the epidemic, therapists already in danger of burnout have faced higher caseloads, greater human suffering, higher rates of client relapse, and attenuation of resources over the past 20 years that are just now being redressed with government funding and enhanced access to pharmacological supports—and this not even in all

states. Current research has not yet given voice to the experiences of therapists specializing in addiction.

Conclusion

Therapists specializing in addiction counseling are prone to higher-than-average rates of burnout and job turnover; subject to stigma and stigma-by-association; and, in the high tide of the current opioid epidemic, are working with more clients with fewer resources. It is perhaps no wonder these professionals not only leave their current jobs at a rate of 30 to 50 percent annually, but also exit the profession overall within an average of 5 years. Leaders, supervisors, and organizations can do better, but only if there is awareness about what would actually help support clinical staff. To find that path, I needed to uncover the perspectives and experiences of the therapists working in this important specialty. A qualitative grounded theory situational analysis is an appropriate means to identify the issues important to members of this population, as well as the contexts within which they live and work. The research findings (found here in Chapters IV through VI) provide further understanding of the supports that are lacking and the wellness supports organizations must employ to encourage a strong, committed, and healthy workforce.

Chapter III: Methodology

I chose grounded theory with a situational analysis (or a grounded situational analysis) as the appropriate research method for this study (Clarke, 2005). As discussed in the literature review, previous researchers sought to explain burnout, stigma and stigma-by-association, and job turnover through the use of surveys, quantitative study, and, to a lesser degree, mixed methods study. The grounded situational analysis filled in an important missing piece of the puzzle by creating space for an exploration of the lived experience of therapists specializing in addiction from the position of a curious and respectful listener. I wanted to understand, and explore, the professional identity of therapists specializing in addiction more deeply and in a more nuanced way.

One research question was employed for these interviews: "As a therapist specializing in addiction, how do you see and present yourself as a professional?"; with a follow-up question available for clarification as needed: "What is your sense of how others perceive you in your role?" These questions were designed to elicit therapists' thoughts and feelings about how therapists specializing in addiction perceive themselves, and what is their sense of how they are perceived among the psychological community at large. How aware are these therapists of their own, and their colleagues', commitment, energy, and compassion for the work and for themselves? How much do they feel pressure from the glass box of addiction counseling? What macro, meso, and micro factors are they aware of that add to that pressure? How do therapists specializing in addiction create meaning around working with a stigmatized population? What self-care and organizational wellness efforts have been helpful in supporting therapists who may already be showing signs of burnout? How do therapists specializing in addiction survive and

perhaps thrive within the context of their working lives? Answering these questions and others requires appreciative inquiry and dialogue with the therapists themselves.

I am intimately aware that my doctoral studies have been a "research apprenticeship . . . a process of knowledge acquisition and skill development" (Birks & Mills, 2011, p. 34). The following discussion presents the methodological foundation of constructivist grounded theory and provides an overview of the method as employed for the current study.

Defending Methodological Fit

I wanted to understand the professional identity of addiction counselors in a deeper and more nuanced way, to unearth the macro, meso, and micro social processes affecting therapists specializing in addiction counseling. I was not entirely disinterested in the quantitative or mixed methods research on job turnover rates and strategies to address compassion fatigue, but I was more interested in what it feels like, on a human, person-centered level, to be a therapist specializing in addiction. I do not believe that identifying percentages of burnout or attempting a specific intervention for counselors who are burned out for the purposes of surveying pre- and post- would answer this core question. I did not need to know whether a specific counselor was burned out by the objective measure of the MBI, as created by Maslach et al. (1996–2016). Rather, I wanted to know if, whether, where, why, and how they feel burned out. I did not seek to uncover whether they were survivors of stigma-driven microaggressions; I want to know how it feels to them that they have been stigmatized from their lived experiences. This information was important to me because I, too, am a therapist specializing in addiction, and I also experience this problem in practice. A grounded situational analysis was an appropriate means to achieve a deeper understanding of this internalized context in a way that allowed me to speak to

others who were facing the same dilemmas while striving to live and work meaningfully as addiction specialists.

Grounded Theory Design

Grounded theory was created in opposition to the prevailing positivist epistemology, a philosophy that presupposes the existence of an objective reality, identifiable by research, with the researcher separate and apart from that which is researched. Inclusive qualitative, and especially grounded theory, researchers attempt "to remain sensitive to the interpretations and meanings given to the situation by those whose social world is being studied" (Heath & Cowley, 2004, p. 143). As opposed to the previous Newtonian view of an identifiable (and theoretically singular) reality, "postpositivists claim that reality exists and can be probabilistically, but not fully, apprehended (critical realism)" (Annells, 1996, p. 384).

For many years, even in the so-called soft sciences, it was difficult to gain scientific credibility and peer-reviewed publication without having used quantitative methods. Glaser and Strauss "defended qualitative research at a time when quantitative methods had gained dominance in sociology and throughout most of the academy" (Bryant & Charmaz, 2010, p. 406). Since the emergence of grounded theory, there has been a "distinct turn of the social sciences toward more interpretive, postmodern, and criticalist practices and theorizing" (Lincoln & Guba, 2000, p. 163). In the beginning, "qualitative researchers attempted to defend their practice through the framework of quantitative inquiry with its emphases on reliability and validity. Qualitative sociologists focused on making their studies objective through the accuracy and thoroughness of their data collection" (Bryant & Charmaz, 2010, p. 406). This reaction to

the expected use of quantitative research in scholarly writing undergirds Glaser's insistence on the importance of following formal (read here *original* or *classic*) grounded theory.

However, as grounded theory began to evolve and to leave behind its reactionary beginnings, researchers realized the potential of grounded theory:

> to uncover the elusive qualities of the workplace, take the researcher beyond hegemonic understandings of organizations, hold as central the participants and their stories, portray complex interactions, include an intersectional stance, and make visible the role of silence. (Holloway & Schwartz, 2018, p. 497)

The distinction may come down to whether "[you] consider yourself an objective instrument of data collection *from* participants, or a subjective active participant in data generation *with* participants" (Birks & Mills, 2011, p. 52, italics in original). Given my curiosity about how leadership could enhance wellness among staff therapists specializing in addiction counseling, grounded theory's aim "to develop explanatory theory concerning common social life patterns" (Annells, 1996, p. 380) seemed to be a useful path to uncover the multiple answers held by the participants themselves.

Although grounded theory may have been founded in reaction to the positivism of scientific research in a parallel process with the epistemology, it has emerged from and through the evolving body of research. Unlike the dialectic of hypothesis versus reality in hard science inquiries, in grounded theory, "the researcher begins with an area of study and allows the theory to emerge from the data" (Strauss & Corbin, 1998, p. 12). Far from researchers being able to, and therefore professionally required to, identify an objective truth, "reality exists only as multiple mental constructions, maintaining that there is no differing social and natural world reality and

that there is no ‘true state of affairs’ to be apprehended probabilistically, partially or otherwise” (Annells, 1996, p. 386).

To the constructivists, even classical grounded theory, the champions of which are most often found in the formal school of thought championed by Barney Glaser, has been overly influenced by its foundational reaction against hard science, quantitative, and positivist context. In an interesting echo running parallel to the beginnings of the postpositivist epistemology, “constructivist grounded theory arises from a relativist epistemology, challenges positivist assumptions in earlier versions of grounded theory, and aligns the method with interpretive inquiry. It treats grounded theory strategies as flexible guidelines that serve as heuristic devices” (Bryant & Charmaz, 2010, p. 408). As a constructivist evolution of grounded theory, situational analysis centers on the perceivable culture surrounding an issue, “which means gathering extensive rich data about research participants’ lives and worlds through sustained interaction rather than limited interviews or isolated visits” (Bryant & Charmaz, 2010, p. 408).

Situational Analysis

Situational analysis takes hold of grounded theory at the postpositivist stage, moves it through constructivism, and, as Clarke (2005) wrote, moves it firmly forward into the postmodern arena. Situational analysis is “the most popular form of qualitative analysis in the social sciences and humanities today” (Clarke, Friese, & Washburn, 2015, p. 11). Clarke developed situational analysis to “explicitly address what she saw as shortcomings of the (grounded theory) method . . . (including) positivist tendencies, a lack of reflexivity, oversimplification instead of addressing differences, and a lack of analysis of power” (Clarke et al., 2015, p. 12). If, as Mead and Blumer contended in the very beginning of valuing the

individual in interaction with the world around and within, then it is not possible to overemphasize "recognizing the importance of macro and meso political, social, and cultural forces that impact the micro social processes of the human experience" in seeking to understand a phenomenon (Blumer, 1954; Clarke, 2005; Holloway & Schwartz, 2018; Mead, 1934). We risk missing much if we attempt to view a system from one level of the always "multi-paradigmatic" landscape (Serpa & Ferreira, 2019). In fact, Clarke (2005) purported that "everything in the situation *both constitutes and affects* most everything else in the situation in some way(s)" (p. 72, italics in original). Viewing the situation as a landscape can be most helpful here. Nested within a country's borders (macro) are towns (meso) and homesteads (micro). What happens at each level affects and is affected by what happens at any other level.

Situational analysis not only invites information from nonliving actors within the problematized context, but also treats context and culture as important sources of knowing. With a broader lens, "situational analysis moved sociopolitical and discursive context from background to center, offering an important and effective counterweight to the increasingly intrapsychic focus of much current grounded theorizing in the practice disciplines" (Kearney, 2007, p. 147). Unlike previous scientific methods that, in my most simplistic understanding of the technique, attempted to arrange beans in one container and buttons in another, "[Clarke] aimed to explore differences rather than commonalities and to replace the static conditional matrix with more fluid and multi-relational representations of networks of influence, intentionally stopping short of formal theorizing" (Kearney, 2007, p. 147). In situational analysis, beans and buttons have relationships and are interacting within the culture of interest; therefore, the network between them is an important focus of curiosity. As Clarke and Friese

(2007) noted, both contemporary and postmodern constructivist practices of grounded theory attempts "relational analyses[:] taking each element in turn, thinking about it in relation to the other elements on the map, and specifying the nature of that relationship" (p. 373). Further, the authors posited, "relations among the various elements are key" (Clarke & Friese, 2007, p. 376).

Concern for the lived experience of the marginalized members of a culture, agency, or community has been a strong ethical current propelling the postmodern turn. As argued by Benzies and Allen (2001), "A concern with the point of view of the individual necessitates a consideration of both micro and macro social contexts in which action is constructed. The researcher must also attend to the past experience of the individual and the history of the group" (p. 545). Because grounded theory is developed based on the voices of those within the context in question and does not exclude outliers from the research findings, it can reveal "interactions [that] may be rare but highly influential; it allows for noticing those players that might otherwise be overlooked and unheard" (Holloway & Schwartz, 2018, p. 499).

In many of these situations of interest, there is a rare opportunity to "problematize the workplace, not the marginalized individual" (Holloway & Schwartz, 2018, p. 502), but only if the researcher is attending to the dynamics that might point out the missing voice. According to Clarke and Friese (2007), "postmodernism has shifted emphases to partialities, positionalities, complications, tenuousness, instabilities, irregularities, contradictions, heterogeneities, situatedness, and fragmentation" (p. 367). The voices of those most affected in problematizable situations may not be heard in the normal process of doing business—and even in the normal process of scientific research—without the researcher directing energy, attention, and curiosity to those actors who are not immediately visible. As Kearney outlined (2007), "Drawing on

Foucault, Clarke called attention to the power relationships creating and created by discourse, and offered a means to represent invisible and silent sociocultural forces that impinge on action" (p. 147). It is the space between actors that holds important, and unnoticed, information, with Clarke and Friese (2007) continuing, "The complications, messiness, and denseness of actual *situations* in social life are central concerns" (p. 368, italics in original).

Historically, even what we think of as clinical scientific research has been used as a method of oppression (Hauser, 1995; Kincheloe, Steinberg, & Gresson, 1997). For the postmodern grounded theorist, there is an "ever deepening recognition of the always already political nature of the practices of research and interpretation" (Clarke & Friese, 2007, p. 368). As Lincoln and Guba (2000) reported

> Knowers are not portrayed as *separate from* some objective reality, but may be cast as unaware actors in such historical realities ("false consciousness") or aware of historical forms of oppression, but unable or unwilling, because of conflicts, to act on those historical forms to alter specific conditions in this historical moment ("divided consciousness"). (p. 177, italics in original)

As Oliver (2012) reported, with postmodern grounded theory there is an opportunity to do research with "an explicit emancipatory goal to challenge the structures that generate the processes participants use to manage particular phenomena or events" (p. 375). Having sailed around the postmodern turn, situational analysis grounded theory offers a powerful microphone for the oppressed and a method by which the oppression may become visible by "focusing on marginalized, excluded, and silenced dimensions of social life, postmodernism destabilizes what has been deemed natural, normal, normative, and true" (Collins, 1998, p. 124; Olesen, 2007, p. 421).

How Do Grounded Theorists Cultivate Credibility?

A key point of contention between quantitative and qualitative researchers has been how to ensure reliability and validity without double-blind trials and randomized sampling. Not only was the sample in my study not randomized, the individuals I interviewed for the most part all lived within a three-state area, were predominantly White females (given the demographics of the people who become therapists in this region), and some even graduated from the same university as did I (Antioch University, New England campus, School of Clinical Mental Health Counseling). How can this narrow focus on a specific situation be valid, and speak to an issue that may, in fact, be generalizable to the larger population of therapists specializing in addiction, if the interview subjects, for example, might know in advance the topic of the dissertation? In this transparent approach to interviewing, with its keen attention on leveling traditional and contextual power imbalances as much as possible, how can the researcher ensure that the "results" are "true"?

While all research subjects may seem from a superficial glance to be vanilla, there are as many kinds and nuances of vanilla as there are interviewees, and each was valued and represented as authentically and uniquely vanilla. Further, if there were another vanilla out there, previously unapproached and unheard, the hole that missing flavor left in the network would be visible and redressable. As Lincoln and Guba asserted (2000), validity relies on "the extent to which a text has the quality of polyvocality" (p. 182). Outliers are sought, appreciated, and included. According to Bryant and Charmaz (2010):

> Merely because one has collected a limitless number of seemingly identical observations, one has no certainty that generalizing from these observations produces a valid conclusion. One aspect of the problem of induction is that of

> failing to see the exception. . . . In other words, similarity is in the eye of the researcher. (p. 45).

Grounded theory is built through the moment-in-time relationship between the interviewer and the interviewee, and seeks to level power imbalances through "reciprocity, or the extent to which the research relationship becomes reciprocal rather than hierarchical" (Lincoln & Guba, 2000, p. 182). Similarly, Oakley (1981) noted that there will be "no intimacy without reciprocity" (p. 61). Power and control are shared, perhaps even balanced more on the side of the interviewee, by

> Scheduling interviews at a time and location of the participant's choosing; using a relatively flexible and unstructured approach to questioning so that participants assume more power over the direction of the conversation; sharing the researcher's understanding of the key issues arising; and assuming an open stance towards the participant. (Mills, Bonner, & Francis, 2006, p. 10)

This sharing of power and control may be somewhat fraught for the interviewer with bias arising from experience with and curiosity about the subject in question. Birks and Mills (2011) noted a need for

> Yielding of control over the flow and content of the interview; a focus on the benefits to participants, who gain greater insight into their own worlds through the research process; the creating of spaces for participants' voices in the interpretation of data and the eventual findings; and ensuring that researchers act as advocates for participants. (Birks & Mills, 2011, pp. 57–58)

This sense that the interviewees might actually gain insight and understanding about their own situations through the process of naming their reality embodies a respect for the "sacredness, or the profound regard for how science can (and does) contribute to human flourishing" (Lincoln & Guba, 2000, p. 182).

A valid grounded theory must meet four criteria: credibility ("reflects logic and conceptual grounding"), originality ("including reference to the significance of the study"), resonance (the theory must have "meaning and scope for all those for whom it may be relevant"), and usefulness ("in relation to knowledge development and practical application"; Birks & Mills, 2011, p. 146). Small samples and limited data do not pose problems; what is important is the richness of the lived experience.

Study Design

To explore the lived experience of therapists specializing in addiction, I needed to find them, speak to them, and treat their words with respect. The following provides an overview of how I conducted this study.

Purposive sample. At the beginning of the process of interviewing, I did not know how many interviews I would need to conduct, although theoretical saturation had often been attained by other scholars after speaking with a heterogeneous sample of between 20 and 25 people (Dr. Harriet Schwartz, private conversation). To that end, and to flatten the power imbalance inherent in doing research, I used the snowballing method to identify potential candidates from other interviewees. My criteria were that the interviewees be willing to participate, be therapists who are currently or have previously specialized in addiction counseling, and who were not direct or closely peripheral staff working at the same hospital where I practice (see ethics application in Appendix A). The pool of potential interviewees was not, and was not meant to be, random or anonymous. I live and work in a small, rural, underserved community, and if I did not know the interviewees personally, I know of them. This reality underscores the absolute necessity of maintaining sensitivity to ethical issues and boundary crossings, as I might at some

time in the future be a close colleague or even a direct supervisor of some of these interviewees. I changed the order of interviews so that they did not intimate an association to early or late interviews, and I anonymized interviewees by using the naming convention Participant # and using she/her pronouns. I did this because if I combined actual quotations from the interviews, with even a very common name and the gender, that person could easily be identified from the context of their comments. In earlier conceptualizations of this research, I myself made procedural and structural comments about the organization for which I currently work that have since been removed, because the potential readership of this research casts a wider net that could predictably include my supervisors. I am personally aware of the power imbalance and how it affects what and how participants will speak.

Interviewing. At its foundation, grounded theory with situational analysis is research incorporating talking with the people involved in the process highlighted by the curiosity of the researcher; therefore, "the person doing the research is the 'research instrument'" (Clarke & Friese, 2007, p. 372). This is a study incorporating interviews and field notes about the interviews, transcribed or remembered through impressions created during the interviews. Unlike strict quantitative research, the interviewer does not disguise the purpose of the interview and is free to share the research question and her theoretical sensitivity, as appropriate. In my study, I used two basic research questions, and the interviewee took the discussion into the areas of her curiosity, interest, and relevance. These questions, although very similar, focused on slightly different aspects of the counselor's experience:

1. As a therapist specializing in addiction, how do you see and present yourself as a professional?

2. What is your sense of how others perceive you in your role?

I was most interested in understanding more deeply the professional experience of therapists specializing in addiction counseling. The interviewees largely controlled the conversation, having the ability to highlight what was important to them. If I maintained a prospector's lens of only looking for the nuggets that sparkled because of my inherent curiosity, I would have missed the surprises that came up and the work would be less rich because of that blindness. From these interviews came the rich, surprising, and energizing codes that became the building blocks of the grounded theory.

Coding. I relied on transcribed recordings of my interviews, which I broke down line by line into codes and concepts. When analyzing data, three components merit the researcher's consideration: "conditions—why, where, how and what happens; inter/actions and emotions; [and] consequences—of inter/actions and emotions" (Birks & Mills, 2011, p. 94). In an echo of the situational analysis mapping I used in the dissertation, in grounded theory, "initial coding results in messy and intricate diagrams, which will evolve into neat and simple diagrams as you move into intermediate and advance coding stages" (p. 100). I also relied on a coding team, including my committee chair and two volunteers who coded interviews independently for comparison with my own codes, to bracket my innate biases as much as possible.

Line-by-line coding. Coding progressed by breaking the transcription into what emerged in small segments of the conversation, not merely in each response or paragraph, but line by line. This process allowed for a "heuristic device that leads the researcher to study each line of data to discern the action it indicates" (Bryant & Charmaz, 2010, p. 410). It becomes easy to translate what an interviewee said into what the interviewer expected to hear if the conversation is taken

in meaningful chunks. Breaking it up allowed for more curiosity and left room for the authentic meaning the interviewee intended. According to Holloway and Schwartz (2018), "the coders pay close attention to the language and structure, intonation, and metaphor embedded in the conversation" in order to avoid hearing only what we wanted or expected to hear (p. 515).

In vivo coding. Throughout the process, each interview was coded separately and generated its own codes that could then be compared with other sets of codes from other interviews. Codes are "important words or groups of words (usually verbatim quotes from participants) are themselves used as the label" (Birks & Mills, 2015, p. 10). Coding did not wait for all the interviews to be completed but was begun with the receipt of the first transcript and continued throughout. As with interviewees, researchers' experience is always and ever in process, even as they attempt to gain some idea of patterns and important concepts. This initial coding allows the researcher to begin to see recurring ideas in the data and to affix the interviewees' descriptive words to those ideas. Coding begins to create the concepts the researcher will then compare across individuals to determine macro-level theories. According to Holloway and Schwartz (2018), "grounded theory researchers strive to move from participants' descriptions of their experience to conceptual understandings and theoretical propositions" (p. 514).

Focused coding. The codes lift us into ever higher levels of abstraction, the next being focused coding, that "involves the categorical naming of the codes in an effort to group them together meaningfully" (Holloway & Schwartz, 2018, p. 517). I created categories from initial codes to organize data into ever-more-meaningful chunks that were still grounded in the words of the interviewees.

Axial coding. An even higher level of abstraction involves "looking for the relationships among larger concepts in the framework" within which "categories describe concepts" (Holloway & Schwartz, 2018, p. 518). At this intermediate level of coding, data are "put back together in new ways . . . making connections between [and within] categories" (Strauss & Corbin, 1990, p. 96).

Mapping

In situational analysis, the researcher seeks an understanding of the context within which interviewees exist. According to Clarke (2005), it is important to ask, "Who and what are in this situation? What elements 'make a difference' in this situation?" (p. 87). The situational analyst seeks to understand the "spatial and structural aspects of the organization, technological impacts, temporal elements such as historical or seasonal influences, and contested and political issues in the culture of the organization" (Holloway & Schwartz, 2018, p. 512). Situational analysts undertake a holistic, multidimensional understanding of the lay of the land known as mapping. For the purposes of this study, I drew several maps to highlight the micro (individual), meso (organizational), and macro (societal) factors visible at each level, identified as follows.

Situational maps. Situational maps "lay out the major human, nonhuman, discursive, and other elements in the research situation of inquiry and provoke analysis of relations among them" (Clarke, 2005, p. 99). The network within which interviewees exist become visible and, importantly, exiled components of the network can become visible through the process. According to Clarke and Friese (2007), "situational maps and analyses do a kind of 'social inversion' in making the usually invisible and inchoate social features of a situation more visible" (p. 391). These maps are "used to provoke analysis of relations among the different

elements, called relational mapping" (Clarke et al., 2015, pp. 13–14). Situational maps can be built, according to Clarke and Friese (2007), through asking the fundamental, and often ignored, "empirical questions . . . 'Who cares and what do they want to do about it?'" (p. 370). In a parallel process with beginning to notice codes and concepts, maps are created that are, and ought to be, preliminary and tentative.

Messy maps. In the beginning, maps ought to "capture the messy complexities of the situation in their dense relations and permutations" (Clarke, 2005, p. 100). The fundamental importance of messy maps is that "they intentionally work *against* the usual simplifications so characteristic of scientific work" (p. 100, italics in original). Situational analysts are not trying to sand off the rough edges or delete outliers at this (or any) stage of their research. These are mind maps of the raw data emerging from the research, and, as such, are a snapshot in time of the process of making meaning.

Ordered maps. Arising from the understandings gained through the use of initial "messy" maps, ordered maps begin sorting elements identified into categories. These categories often encompass specific, though permeable, areas of effect. In this landscape, what happens at any level affects and is affected by what happens at any other level to a greater and lesser extent. The focusing tool of situational analysis allows the researcher to purposively change perspective and lens so that some of the most closely enmeshed elements become visible as separate arenas.

Social worlds/arenas. These maps attempt to identify the "'basic social processes' that construct and constantly destabilize social worlds' relations and arenas maps" (Clarke et al., 2015, p. 14). Situational analysts attempt to build social worlds/arenas maps to "lay out the collective actors and the arena(s) of commitment and discourse within which they are engaged in

ongoing negotiations—mesolevel interpretations of the situation" (Clarke, 2005, p. 99). These provide a higher level of abstraction and begin to "offer *interpretations* of the broader situation, taking up its social organizational, institutional, and discursive dimensions" (Clarke et al., 2015, p. 14, italics in original).

Positional maps. Positional maps "lay out the major positions taken, and *not* taken, in the data vis-à-vis particular axes of variation and difference, concern, and controversy around issues in the situation of inquiry" (Clarke, 2005, p. 99; Clarke et al., 2015, p. 14). Positional maps are important in that they continue to give voice to the underrepresented. Their purpose is to "allow multiple positions and even contradictions to be articulated" (Clarke et al., 2015, p. 14).

Categories

In the ongoing process of examining transcripts for nuggets of embedded information, codes develop into concepts and concepts become the "categories (that) describe concepts" (Holloway & Schwartz, 2018). Categories are the important extracted and central ideas distilled from the interviews. These categories have made it through the furnace of constant comparison and have been found to emerge from many interviews and many conversations. According to Birks and Mills (2011), "any concept that is relevant will persist, and any that is not will eventually self-extinguish" (p. 174). Over time and through working with these concepts, a category develops as "a descriptive or explanatory idea, its meaning embedded in a word, label or symbol" (Birks & Mills, 2011, p. 86). Categories thus identified through constant comparative analysis may later become the salient dimensions building the situational analysis.

Constant comparative analysis. Comparing codes, concepts, and categories is an ongoing process of continually comparing new data and previously collected and reassessing codes and focused concepts derived from these codes (Glaser & Strauss, 1967). Categories are aggregates of codes and concepts, but they are not ossified structures that, once found, are considered to be final truths. These nuggets continue to withstand the rarefying fires of comparison, as the "constant comparative method of GT allows for the movement back and forth from the already-analyzed data and new data being collected" (Holloway & Schwartz, 2018, pp. 517–518).

Theoretical sampling. As part of the constant comparative method, researchers return to the source in theoretical sampling, a strategy that "enables you to confirm, clarify and expand these categories" (Birks & Mills, 2015, p. 69). This process "begins as the researcher seeks to go back to initial interviewees and ask more detailed questions, seeks new sources of information relevant to the concept of interest, or recognizes a player who may bring a different perspective to the social situation being studied" (Holloway & Schwartz, 2018, p. 518). Possible only later in the process, theoretical sampling "provides a means for researchers to check, elaborate, and assess their emerging categories and to obtain the data to help them demonstrate how their analytic categories fit together" (Bryant & Charmaz, 2010, p. 411).

Theoretical Saturation

The finish line of grounded theory research, and the beginning of the final push toward the integration and completion of a distinct research moment, is the point at which no new codes emerge from the research. To ensure that the integrity of the process, and not the exhaustion of the researcher, has chosen this point, a grounded theorist must have a team, partner, or mentor

who have been involved throughout the process and can help pinpoint a valid stopping point in gathering data. There is a postpositive understanding that theoretical saturation will be subjective, and that the result "will be no single 'conventional paradigm' to which all social scientists might ascribe in some common terms and with mutual understanding" (Guba & Lincoln, 1994, p. 183). One more interview might well set what has gone before on its head, and the trepidation that something has been missed may haunt the researcher. It is at this time that an experienced advisory team is fundamental to the research process.

Substantive Theory

Theory arises from the process of the "integration of the 'attributes, interconnections, contexts, processes, and implications' that emerged from the data" (Schatzman, 1991, p. 309; quoted in Holloway & Schwartz, 2018, p. 521). Here, again, the research team shapes the direction of the research with the understanding that this theory is only one of perhaps many that could have arisen from the same data by a different researcher.

Theory Development

According to Glaser and Strauss in a seminal explication, grounded theory:

> Must fit the substantive area for which it will be used; must be readily understood by laymen in this area; must be general enough to work in the diversity of the substantive area and not just in specific situations; and it must provide control over the structure and process of the situations as they change over time. (Birks & Mills, 2015, p. 144)

A grounded theory is not envisioned as an ethereal thought exercise engaged in to assuage boredom for a hyperintellectual academic elite. Without the grounding effect of being primarily useful, especially to those living within the problematized situation, there would be no good enough reason for engaging in the process.

Visual Modeling

An important final development in the research is the creation of a visual model, bringing together all the elements in an understandable graphic that is accessible and provides a summary for the whole. According to Birks and Mills (2011), "the effective use of theoretical coding is achieved through written discourse or visual modeling (or likely both) in the presentation of your final theory" (p. 122). Grounded theorists level power and influence differentials by disseminating findings through more than one channel of learning, at the same time seeking a level of holistic understanding necessary to create the model.

Contextual Reflexivity

The dictates of ethical research insist that the researcher reveal the scaffolding of her sensitizing concepts and bracket her own biases through constant reflection on all visible levels of the process. Internally, "reflexivity can assist the researcher in positioning himself/herself and gaining a better sense of the choices, and their rationales, made before and during the research" (Birks, Chapman, & Francis, 2008; Ramalho et al., 2015). Throughout the grounded theory process, "the constant comparative method promotes reflective thinking by constantly comparing the data, codes, categories, and memos among themselves" (Charmaz, 2006; Glaser & Strauss, 1967; Strauss & Corbin, 1990). This meta awareness is crucial to the authenticity and believability of a study. The three main checks and balances in this process are provided through memo writing, working within and from interviews, and having strong peer and mentor advisors involved throughout the process.

Memo writing fosters reflective thought and maps the emergence of concepts (Birks et al., 2008; Birks & Mills, 2011; Charmaz, 2006; Glaser, 1978; Strauss & Corbin, 1990). Memos

are especially important in grounded theory research to "aid the researcher to use the literature as a tool towards the engagement of a theoretical dialogue with the data, without allowing such literature to define the research" (Birks & Mills, 2011; Lempert, 2007). Unmapped ideas flowing from the literature and from the researcher personally are more than sensitizing concepts; they can become unexamined biases.

Honest and open wrestling with ideas arising within and from interviews can help "the researcher to identify his/her own assumptions brought to the research process but also serve as data to be used in the research" (Ramalho et al., 2015, p. 8). The process requires awareness of self, interviewee, and the space between, since "the researcher's subjectivity plays a key role in enabling or dis-enabling the research participants' narratives during their interaction" (p. 8).

Peer and mentor relationships also promote an ability to "reflect on his/her assumptions, emotions, perspectives, and expectations" (Ramalho et al., 2015, p. 8). Coding team members, closer to the classical ideal of tabula rasa but still sensitized to the ideas being researched, provide a welcome safety net for codes and themes invisible to the main researcher due to unidentified biases. An advisor who is instrumentally involved at all levels of the research and follows the memos and the coding will also help bracket the biases all researchers bring to their work.

Memo Writing

Honoring the parallel process of researcher and interview subjects, grounded theorists keep notes about context, feelings, and ideas generated through the process of talking with interviewees, advisors, and others. According to Birks and Mills (2001), who wrote an excellent, practical, step-by-step guide to conducting grounded theory, "memos are written records of a

researcher's thinking during the process of undertaking a grounded theory study" (p. 11). These memos become an important record of the meta process of doing the research and involve "writing about tentative ideas and emergent categories and includes the crucial intermediate stage of writing between coding data and writing the first draft of a paper" (Bryant & Charmaz, 2010, p. 410). In fact, Clarke and Friese (2007) warned that "inadequate memoing is the major problem of almost all qualitative research projects—scribbled notes are always better than nothing and thoughtful memoes on the computer are intellectual capital in the bank" (p. 371). In parallel with the process of codes becoming concepts becoming categories, researchers will eventually end up writing memos about earlier memos; therefore, the memos themselves should be considered data (Lempert, 2007).

Keeping notes on experiences and impressions is not just an aid to remembering the overarching context of the interview. Memos are in large part the "audit trail of the procedural aspects of undertaking a grounded theory study" (Birks & Mills, 2015). To enhance credibility as a researcher, I need to provide a path for other researchers to follow to independently judge the credibility of my findings. While no other researcher will have exactly the same theoretical sensitivity as I bring to my research, my findings should, from an external reader's perspective, add up. In short, I needed to be able to show my work.

Field Notes

According to Birks and Mills (2011), "Field notes should be made after you conduct interviews to retain details of the physical environment, to record your immediate responses to the interaction and to capture participant non-verbal behaviour that will not be revealed through transcription" (p. 76). It is advisable to make process comments to get nonverbals into the

transcript and onto the data record, such as, “You smiled when you said that; what does that mean?”; not all of the context of the interview will be recorded through the words of the conversation (H. Schwartz, personal communication, May 15, 2019).

Positionality

In service of trustworthiness as “a central criteria of rigor for constructivist research” (Holloway & Schwartz, 2018, p. 498), I can report an awareness of some of the sensitizing concepts and contexts I carried with me into my research. As a scholar-practitioner working as a therapist currently specializing in addiction, I acknowledge that, as Charmaz wrote, I have “an obligation . . . to recognize our taken for granted assumptions about the world and how they influence our actions as researchers” (Birks & Mills, 2015, p. 53). As a psychologist, I am drawn to the grounded theory methodology and method of gathering information as “inevitably interwoven with and emerg[ing] from the nature of particular disciplines (such as sociology and psychology) and particular perspectives” (Lincoln & Guba, 2000, p. 164). I am, despite the whiff of faithlessness and informality, firmly in the postmodern, constructivist camp and my situational analysis dissertation followed the path laid by Strauss and Clarke. I am a scholar-practitioner with a research question that “seek(s) to understand the everyday exclusion that occurs” to those therapists who specialize in addiction (Holloway & Schwartz, 2018, p. 497). To this aim, I took a constructivist and postmodern approach to grounded theory.

As a therapist, I have, with qualitative researchers, “learned to sustain a fair amount of ambiguity” (Strauss & Corbin, 1998, p. 5). I am currently working within a male-gendered workplace/leadership paradigm within which “flexibility (the ability to work whenever asked) and presenteeism (being visibly present in the workplace for extended hours . . . as visible and

reflexively-valued evidence of work commitment" are the coin of the realm despite the possibility that women may not "need . . . long hours to complete work and meet deadlines" (Holloway & Schwartz, 2018, pp. 502–503). I do not speak this language of managing perceptions within this male-dominated paradigm, keeping life, work, and outside issues separate; managing boundaries between self and staff; and other automatic expectations. I tend to process each critique as a microaggression.

I am also aware of my tendency not to lead with the information that I am a substance abuse specialist. My other licenses and specialties get top billing on my business card and in my direct speech as I introduce myself to other professionals. Educated as I am against it, I continue to perpetuate the self-stigma that goes along with stigma-by-association. And, as an evolutionary psychologist, symbolic interactionist, and communal mammal, I am well aware of the power of stigma. I stand with other constructivist researchers in believing that it matters little if there is objectively stigma-by-association if it can be identified as subjectively perceived by therapists specializing in addiction counseling and it affects their actions, opportunities, and happiness at work through the power of their own words.

Chapter IV: Phase I of the Research—Grounded Theory

The next two chapters move from the general to the specific, from grounded theory and situational analysis as research theories to the current research itself. The grounded theory research discussed in this chapter will create a foundation on a micro level, from the participants' lived experiences and in their own voices, for Chapter V, which is the situational analysis of the complex contextual elements experienced by therapists who specialize in addiction that constitutes Chapter V. Chapter IV begins with an overview of the research process, including background information about the interviews themselves, the coding process, and the dimensional analysis process. The chapter presents the primary dimensions and the core dimensions that emerged from this analysis. This chapter concludes with a summary of the grounded theory findings and sets the stage for a well-grounded situational analysis.

Overview: The Interviews

The research began with approval from Antioch University Institutional Review Board (IRB) approval from Antioch for this research design and the approval of my dissertation committee to proceed with recruiting and interviewing. Participants who agreed to take part in the interviews completed a demographic questionnaire and signed a consent form. No participants were members of a vulnerable population in reference to the research questions (see Appendix A). I was prepared to conduct interviews to theoretical saturation, which my methodologist advised might happen between interview 20 and 25. In actuality, I reached saturation by interview 17, due in large part to the homogeneity of the interviewees.

Between November 2018 and May 2019, I interviewed 19 therapists, either in person or via the Zoom virtual platform, who self-identified as "specializing in addiction" (see Table 4.1).

Participant therapists engaged in a wide-ranging discussion of 1 hour or more. The original question ("As a therapist specializing in addiction, how do you see and present yourself as a professional?") evolved quickly based on the first five interviews, becoming "How do you think you're perceived as a therapist specializing in addiction?" This revision was a necessary due to the first five interviewees asking for an explanation of the question; therefore, I realized the question was inadequate to elicit the kinds of pressures and supports they had experienced, necessary to provide information relevant to this study. Therapists in this study were homogeneous by race, with all self-identifying as White. Their experiences diverged sharply in terms of age and years of work experience (although one did not necessarily predict the other), the setting in which they currently or most recently worked, current or most recent position or job title, and average caseloads (see Table 4.1).

Table 4.1

Demographics

Participant	Age	Gender	Race	Work setting	Years of experience	Caseload	Position in Agency
1	41–50	Other	White	Fee-for-service	21–30	31–40	Licensed clinician
2	65–retired	Female	White	Private practice	21–30	21–30	Licensed clinician
3	51–65	Male	White	Education	31+	21–30	Director
4	51–65	Male	White	Private practice	21–30	21–30	Licensed clinician
5	41–50	Male	White	Private practice	1–5	31–40	Unlicensed clinician
6	41–50	Female	White	Private practice	11–20	41–50	Licensed clinician
7	65–retired	Female	White	Community mental health	31+	21–30	Clinical manager
8	51–65	Male	White	Community mental health	11–20	21–30	Clinical supervisor
9	65–retired	Female	White	Not-for-profit or hospital	31+	11–20	Clinical manager
10	51–65	Female	White	Private practice	31+	21–30	Licensed clinician
11	31–40	Female	White	Residential	6–10	1–10	Clinical supervisor
12	31–40	Male	White	Community mental health	11–20	11–20	Director
13	51–65	Female	White	Not-for-profit or hospital	21–30	21–30	Licensed clinician
14	51–65	Male	White	Private practice	6–10	21–30	Licensed clinician
15	51–65	Female	White	Corrections	11–20	21–30	Clinical manager
16	51–65	Male	White	Residential	1–5	31–40	Unlicensed clinician
17	65–retired	Female	White	Residential	31+	21–30	Licensed clinician

Not only were the participants in this study homogeneous racially and by career and specialty, but they also all lived and worked in rural sections of New England at the time of the interviews, creating some interesting challenges in protecting their confidentiality as I was committed to do. The particular pressures and supports identified by therapists working in rural areas uncovered during these interviews receive further exploration during the dimensional analysis. This geographic region is small, with the professional community accordingly smaller.

Professionals in this area and field may have attended the same graduate program, worked within the same organization, or, at the very least, attended the same continuing education conferences or professional events.

Without blurring the demographic information, it may be possible to identify an interviewee by quotation alone. To this end, specifiers are general and vague. I used several strategies to maintain participant privacy to the extent possible. First, I assigned each participant a number in lieu of using names (e.g., Participant 1, Participant 2, etc.) In addition, I removed or modified other therapists' names that may have emerged during interviews. Second, I created generalized job descriptions rather than using the therapist's actual job title. Job titles tend to be organization-specific and could therefore point toward a specific agency. I attribute all participant quotes to "she," regardless of the therapist's gender identification. This precaution was based on the practical reality that fewer men participated, with a response rate of 36% (n = 7). This ratio is not just a regional anomaly, as it actually mirrors the 2004 National Treatment Center counselor characteristics of the male-to-female ratio of 60 to 40 (Roman, Johnson, Ducharme, & Knudsen, 2004, p. 8).

To hear men's voices as clearly as possible in the final grounded theory dimensions and subsequent situational analysis, I was careful to include an interview with a male therapist within the first five interviews, during the stage of initial coding, before any intermediate categories had begun to solidify through the constant comparative process. All subsequent codes, including those coming from the rest of the interviews with male therapists, underwent comparison against the codes generated by the first five.

There was quite a wide range of ages represented among participants. The final classification was designated 65–retired, because this group of participants showed persistence in career well beyond the official Social Security retirement age. As seen in many context areas, exploration of this age range helped to uncover the effects of pressures and supports.

The terms *director, clinical manager,* and *clinical supervisor* are distinct, with an impact on therapists working in these positions. A clinical supervisor has managerial duties and is responsible for maintaining a theoretically reduced productivity requirement, while at the same time and within the same department providing clinical and administrative supervision for direct staff and interns. A clinical manager may have a small caseload but is primarily involved in managing the department, may be public-facing, and may provide supervision for one or more clinical supervisors, interns, and direct staff. A program director is responsible for managing more than one department, with a staff of clinical managers and supervisors, and may maintain a small caseload of clients.

Overview: Coding and Categorizing

Initial coding. For the first five interviews, three focused coders (including myself) used NVivo software on both Mac and PC platforms, coding the transcribed interviews phrase-by-phrase and line-by-line. Having a coding team was important, as the codes arising from the first five interviews created the intermediate categories against which I compared and contrasted all later codes. The coding team's input provided a control mechanism against the impact of the researcher's sensitizing concepts, personal interests, and potential biases.

Thousands of initial codes developed. In fact, there were times when the sheer volume of codes threatened to cause "analytic paralysis," a research-related illness marked by nausea, eye

strain, and panic (Clarke, 2005, p. 84). What became immediately clear was that all three coders and the team methodologist, although sometimes using different words for coding, were highlighting the same concepts as interesting and worth quoting.

I continued to code each of the next five interviews, with all members of the coding team coding three of the five. All coded one overlapping interview out of this second batch, identifiable to the methodologist and myself, but not to the other coders. This strategy solidified the impression that all coders were noting the same concepts as related in important and interesting ways to the research question. At the end of this stage, the coding team retired with my gratitude. I met virtually with one member of the coding team to gather her impressions and any concerns, at which point she stepped away from the project with my thanks.

I coded the final nine interviews with the remaining member of the coding team providing moral support, software coaching, and cheerful encouragement. I also relied on my methodologist, who oversaw the multiple iterations of NVivo and Excel documents throughout the comparison and categorization processes.

Intermediate categories. Sorting through and creating intermediate categories from the initial codes required hundreds of hours and resulted in a granular knowledge of the codes and categories necessary to move forward into dimensional analysis. Throughout the coding process, I created, broke down, and rebuilt intermediate categories on Excel spreadsheets, gathering thousands of codes together into meaningful alignments based on what was emerging as important and interesting from the interviews. Here again, I received valuable assistance from a fellow researcher going through the same process who had used Excel spreadsheets to help in the organization process. In essence, these categories show the iterative brainstorming process of the

constant comparative method, as we identified what themes and ideas emerged from interviews, as well as how—or if—they related to themes and ideas in earlier interviews? We challenged ourselves to determine where these elements fit, and into what scaffolding of meaning making. These intermediate categories underwent comparison and organization into the final categories. The list of intermediate categories was as follows:

Table 4.2

Intermediate Categories

Administrating
Advocating
Discrimination
Education and Experience
Expectations of Stakeholders
Family or Nonwork
Feelings
Feeling Positive about Clients
Financial Factors
Heavy Workload
Isolation of Clients
Place of Work
Positive Feedback from Clients
Positive Traits for Addiction Specialists
Preferred Specialty
Professionalization
Punishment
Quitting or Reprioritizing
Self-Care and Wellness
Territoriality
Working Relationships

Final categories. A visual representation of the final categories appears in Figure 4.1. Each category contains multiple codes, with code itself usually containing more than one quote

from the transcriptions. For example, the first category on the top left, “burning out,” contained 21 separate codes, including a subcategory of “distancing self emotionally” that itself contained another seven codes.

Figure 4.1. Final categories arising during the constant comparative process.

Dimensional Analysis

Dimensional analysis is a tool that incorporates "analytical processes involved in the definition and interpretation of data" that have evolved from the grounded theory method (Kools, McCarthy, Durham, & Robrecht, 1996, p. 313). The primary and core dimensions underwent an iterative process of categorizing and organizing into meaningful groupings without assigning "relative importance, relationship, or meaning" (Kools et al., 1996, p. 317). From the original 21 intermediate categories emerged three primary dimensions and one core dimension, with any marginal or outlying dimensions integrated within. None of the original categories disappeared during this iterative process of reassessing their interrelationships and organizing into meaningful groups. The context, conditions, processes, and consequences organized through the dimensional analysis are noted here and more fully explored and expanded on in the situational analysis of Chapter V. Primary dimensions support the core dimension, a dominant theme that emerged from the research: developing skills over time through the pressure and supports of each primary dimension, and learning by experience when to use the skill sets, creates an environment within which the core dimension can (but does not always) emerge. This core dimension receives exploration at the end of the dimensional analysis, but it is not the end point of a therapist's career. In fact, all the dimensions analyzed here are analogous to nonlinear developmental stages in a therapist's working life. In line with clients, therapists who spend much of their time in the process of thriving can still relapse into the primary dimensions in their overwhelming daily work lives.

Table 4.3

Primary and Core Dimensions

Dimension type	Dimension
Primary	• Tending and pruning • Juggling • Struggling • Thriving
Core	

Primary Dimension 1: Tending and Pruning

Tending and pruning is a learned skillful behavior set that develops under the conditions of supervision, lifelong learning, taking time away, and deciding to quit (see Table 4.4). The processes of taking time away and deciding to quit are necessary skills therapists develop to create spaces of wellness within the turbulent career as a therapist specializing in addiction.

Table 4.4

Primary Dimension 1: Tending and Pruning

Primary dimension	Conditions	Processes	Impacts
Tending and pruning	• Supervision • Life-long learning	• Taking time away • Deciding to quit	• Developing a productive, nurturing, valued career

Throughout the interviews, many participants reported having experienced times when their work families broke up, their jobs ended, their personal lives required more immediate attention, and they made change to support themselves. Although some did, indeed, leave the profession entirely due to burnout, many used the time to refresh and renew. This was especially true of those who had good-enough supervision and access to continuing growth and education.

Supervision. Many participants identified the importance of getting good clinical and peer supervision, not just administrative. Scholars have consistently found good-enough

supervision to have a positive impact (Culbreth, 1999; Kennard, Stewart, & Gluck, 1987; McNeill, Stoltenberg, & Pierce, 1985; Spooner & Stone, 1977). As Participant 8 said, "I was doing my best, but again, how much does our good work depend on good supervision and good training?" A fully developed supervisory relationship makes emotional room for critical feedback and counselor development, which Participant 15 noted about her current supervisor: "I'm open to hearing things." Openness is especially important when a therapist has to allow herself to be vulnerable and open to potential criticism to get the feedback and support needed around a difficult subject. Participant 1 explained:

> The agency and my colleagues are just so incredibly supportive of each of us going to that fragile vulnerable place to be able to talk about those scary things that are just— They tell you in your ethics class, "Make sure to talk about this," but if you're in an agency that's not welcoming to that, you don't talk about it and that's the most dangerous thing. . . . [My supervisor is] the one that really is helping to keep us open-hearted and focused on the love and compassion and connection that we have.

Clinical supervision has a protective role against emotional exhaustion and turnover intention, a condition especially salient for this discussion (Knudsen, Ducharme, & Roman, 2008; Oser et al., 2013). Many study participants are currently in clinical supervisory positions, the space between being and having supervisors, and thus unable to vent with the staff they work most closely with. This is important, as supervision is a "career-sustaining behavior" (Sobon, Davison, Snider, Steenbergh, & Sneed, 2010, p. 26). Participant 18 reported that the agency she joined as an unlicensed post-graduate hired a consultant to identify problems in the system:

> The state paid for this researching team to come in and figure out what was wrong with the system at this place I worked at and the researchers said that people aren't getting proper supervision. It was all about taking care of your clinicians, anyways . . . . The woman in charge was basically like, "We're not going to do any of that and we're going to do stuff that's taking care of the clients." I got

> pissed and I was like, "You need to take care of the clinicians, like good business—this is a little bit of a business here is you take care of your employees and they take care of your customers. You don't just take care of the customer." I gave my notice that day. I didn't even have a letter written. I was just like I couldn't believe that. I was like, "I'll get you the letter by Friday, but I can't. . . ."

Participants became especially vocal with regard to the turbulence caused by not having access to adequate training and supervision, not having clinical supervision by therapists in similar disciplines, or even having to survive toxic supervision (West & Hamm, 2012; Whitley, 2010). As Participant 18 noted, "I've had a lot of really bad supervisors. . . . I still haven't had good supervision since I left [grad school]." Participant 11 reported on her current supervisory relationship: "is not a good relationship. . . . I have gotten to a place where I have figured out how to keep it civil. . . . That type of anger just then made me not want to come to work, and that's not helpful for anybody."

At their worst, toxic supervisors may withhold resources necessary for continuing to perform the work, let alone flourish in it. Participant 18 eventually left a position in large part because her supervisor was getting paid directly for her work, was responsible for writing her a check, and was not prompt or diligent in this important task: "I'd have to wait." Participant 12 reported that her last supervisor was someone who had never run a team before and did not understand the ethical considerations inherent in clinical work. She related, "I didn't align . . . so I chose to move on." In one particularly moving story, Participant 15 shared a particularly memorable story:

> I requested time off from my supervisor. It was a requirement [that I] attend an international session . . . and I requested time off. It was a requirement through my organization to do that a month in advance. I did it seven weeks in advance. . . . Then I went to my supervisor face-to-face and he said that we should talk about it and I said "That's what I'm doing." . . . I went up to him and he blew me off.

> Then I sent him e-mails and he blew me off, and that was the tipping point. I realized that he is not going to allow me to have this time off, even though I had 160 hours of vacation time and I was requesting about a week and a half off. So that was it. . . . Then I waited to that 30-day mark and then I put in my notice.

Without good-enough supervision, therapists may not feel safe enough to maintain an open, vulnerable attitude toward exploring their work and its effects on their clients, colleagues, and themselves with an external advisor. Without good-enough supervision, therapists may stop learning and growing, in an effort to adapt to what their supervisor considers acceptable practice. Without good-enough supervision, therapists may tender their resignation.

Life-long learning. The condition of life-long learning was a frequent topic within the interviews. As Participant 9 shared, "I really do think of myself as a lifelong learner." Participant 4 reported, "I have to keep kind of learning new approaches to the work. . . . I'm almost always doing some kind of continuing education." Therapists with higher levels of education appear to also have higher levels of cognitive flexibility, with more resources available in order to adapt modalities that better align with client needs (Sias, Lambie, & Foster, 2006).

To maintain licensure in alcohol and drug counseling in Vermont, for example, therapists must provide proof of 40 hours of continuing education biennially, which the Director of Professional Regulation must then approve (Vermont General Assembly, 2018). Previous to November 2018 in Vermont, the continuing education workshop title had to specifically state "addiction," "substance abuse," or a related term for the state to grant approval. The state of Massachusetts also requires 40 hours of continuing education biennially, whereas the requirement in New Hampshire is 48 hours of approved continuing education. As Participant 6

reported, this can create serious barriers to self-directed or -preferred learning opportunities, even when they are clearly evidence-based addiction therapeutic modalities:

> This leads to why I decided to drop my MLADAC [master's level license for alcohol and drug counseling] . . . . I e-mailed [the MLADAC board] and said, "Hey, I want to do this 72-hour, 9-month certificate program [for mindfulness-based cognitive therapy]. Due to the time and investment in cash, I'm not doing any other training this year." Never heard a response. Nine months went by of monthly e-mails; never heard a response. Never got any answer. Would occasionally get that, "Well, we'll talk about it" response. I sent, I would say, a total of 12 e-mails. . . . In November, they finally said, "No, we're not going to accept the CEUs." I said, "Can I appeal or not?" They said, "Well, you can appeal, but we probably won't accept it." I . . . sent a 35-page document outlining . . . week by week, all the topics . . . sent all that to them and the response is, "Yeah, we're not accepting it." By then, it was April and my license was due for renewal in June and . . . I made the decision to not renew.

Therapists specializing in addiction receive significantly more co-occurring (mental health and addiction) training than social workers, with the suggestion that social workers need "tailored training and licensure changes . . . to enhance social workers' capacity for competent (co-occurring disorder [COD]) treatment" (C. M. Fisher, McCleary, Dimock, & Rohovit, 2014). This may have been in part due to the requirement that continuing education hours needed to be explicitly addiction-related to receive approval for licensure renewal. Under this scenario, many broad mental health conferences added the words "and Addiction" in their titles in order to attract therapists specializing in addiction. As justification for COD training, Participant 11 said, "You consider the person as a whole . . . you consider all their mental health pieces that are impacting their behavior."

Taking time away. Participants talked about the vital process of taking time away, either through vacationing or by doing nonclinical work, as a refresher for their "day job." Participant 5 identified her current strategy as not to "advertise myself as a substance abuse

clinician." Clearly, this phrasing has not created a barrier for clients seeking support for addiction and co-occurring issues; however, she has stopped actively marketing herself at medically assisted therapy clinics like she did when she was establishing her practice. The participant related, "I don't go to like the local MAT places and drop off my cards and that kind of stuff . . . . I still look for ways out sometimes. Like maybe I'll go train elephants in Asia or something. That sounds good." Participant 19 shared, "I did just take a vacation and I'm taking another one."

Taking breaks was an important self-care strategy on the micro and macro level. Participant 19 said, "I take a walk around the block," and "I do go on retreat." Participant 18 added that, when she was establishing her private practice, she "would go to the office for 4 hours and read . . . [or go] to the gym," setting up her schedule the way she wanted it to continue once her available sessions filled in with clients, and establish a rhythm to her day that continues now that her schedule is full. She reported having always heard building breaks into the work schedule was a good self-care practice, but she put it in practice only after leaving her first postgraduate clinical job where she did not give herself time away, within or from her work day, saying, "I was super burnt out."

For several participants, taking time off was not an option, sometimes due to financial pressures, so they turned to doing nontherapeutic jobs between or while maintaining a practice. Participant 12 reported that she was working up to 70 hours a week, mostly in direct therapeutic service, but also as a server in a restaurant. She said, "It was with a different end of the spine. . . . I refill[ed] my well by talking with and interacting with people . . . . I could get just, 'Here's your pizza.' That's easy."

Participant 13 reported taking a break from therapy to become a house parent at a residential school for seventh and eighth grade boys. She shared that one of her colleagues at the school told her, “You’re the only person that’s come here that’s ended up looking less stressed.” She attributed her reduction in stress within an arguably pressurized job as being related to a reduced scope of practice—in order words, she said, “I don’t have to solve that problem.”

Deciding to quit. Several participants talked about job turnover as a necessary, if painful, process. Participant 6 compared specializing in addiction at a previous job was like being in a domestic violence situation, saying, “Talk about an abusive system. I can’t stay and I can’t bear the thought of leaving [it] behind, because that’s what it feels like . . . . I can’t afford it spiritually. I can’t afford it financially. I can’t afford it emotionally.” Participant 15 shared that she had to choose between the job she cared about and the clients she cared for versus continuing to work for a supervisor who had no intention of providing space for self-care and wellness practices. Participant 3 reported her feelings toward her supervisor: “All right, if you’re really not listening to me, then I’m not going to waste my energy. I’m going to find some other things to do here or leave.” Participant 13 identified her thought process as a gradual granting of permission: “Maybe I can be just done fighting this now . . . . OK, maybe I can just be done now.”

Several participants reported that family considerations were fundamental in deciding to quit their current job, or even their career. Participant 1 reported that she left her current job(s) when “my family fell out of the second priority . . . . I was taking care of my family financially . . . and trying to fit family in there somewhere”; however, she was working at least 65 hours a week between two jobs she valued.

Therapists specializing in addiction learn to cultivate their careers through obtaining good-enough supervision, treating learning as a lifelong process, taking time away when necessary to refresh and renew, and sometimes leaving a job situation that no longer supports their ability to flourish. Mindful tending and pruning requires a willingness to acknowledge difficulties in a particular job environment in the service of the greater whole of the therapist's career.

Primary Dimension 2: Juggling

The primary dimension of juggling emerges through the conditions of Professionalization and having a personal recovery history, performing multiple roles, and managing expectations of external stakeholders. The processes necessary for these conditions is learning to balance competing priorities, including wearing multiple hats and meeting (or not) the expectations of external stakeholders. The impact of learning how to juggle competing priorities and expectations is developing the flexibility to change focus as required.

Table 4.5

Primary Dimension 2: Juggling

Primary dimension	Conditions	Processes	Impacts
Juggling	• Professionalism • Personal recovery history • Wearing multiple hats • Expectations of external shareholders	• Balancing competing priorities and expectations	• Developing the flexibility to change focus, as required

Many participants spoke about the social processes they had to manage, often without sufficient supervision, resources, or community supports. This dimension revealed the pressure of maintaining dual licensure and difficulties with licensing boards that falls under the macro systemic processes in the situational analysis presented in Chapter V.

Professionalization. Over the past decade, there has been a steady shift from "professional ex-addict(s)" who were primarily trained in the "apprenticeship model" to therapists who take on an addiction specialty within their mental health Master's degree curriculum, where the health professional model includes practica and internships in addiction treatment (Amodeo, 2006, p. 170; Kerwin, Walker-Smith, & Kirby, 2006; White, 2000, p. 2). This change, further discussed in Chapter V as a macro or societal process, parallels the parity laws between medical and mental health and addiction insurance benefits (Barry, Huskamp, & Goldman, 2010). Even several years after retirement, Participant 13 took pains to correct the term *therapist specializing in addiction* in reference to her career: "We very much referred to ourselves as counselors rather than therapists . . . . I know I have an issue with [the term]."

Professionalization disrupted the well-established process of passing knowledge and providing counseling from a personal recovery history, with predictable pushback. Despite the law, parity for addiction counseling lagged behind parity for mental health, which itself was hardly universal (Busch et al., 2014). One reason, as Participant 15 reported, might have been the lower certification standards. As such, the participant offered, "Standards of credentialing need to be strengthened . . . . One just needs a bachelor's degree and a certain amount of hours" to earn a certification in alcohol and drug counseling in Vermont. Far from strengthening the credentials in the context of the opioid epidemic, Participant 19 noted, "The state just lowered the bar" by removing the requirement that a licensed alcohol and drug counselor provide treatment for people who have lost their driving privilege due to impaired driving. She continued, speaking about confusion regarding the widening scope of practice of peer recovery coaches:

> I do not feel that [my client] in any way has the skill set, the stability or the capacity to do this. She's on disability. People on disability are allowed to make a certain amount of money and here's a way where she can make a lot of money. She's going to get mileage to go to people's houses. She's already referring to them as her clients, which I don't think that's the language maybe that they're taught. I don't know, because I haven't seen the training. That's not a peer-to-peer word.

Dual licensure. An area of contention is the requirement for two licenses to practice as an addiction therapist, when most clinical professions use the term "specialty" to denote a concentration in a specific field of care. Therapists and social workers trained in mental health who specialize in addiction face the expense of earning and maintaining two separate licenses (dual licensure). As Participant 6 reported, "Being dually licensed, I had to do two separate renewal applications. I had to pay two separate fees . . . . That's a big chunk of money." In Vermont, where licenses are valid for 2-year periods, licensed mental health counselors pay $150, with licensed alcohol and drug counselors paying an additional $270, figures that are separate from professional dues at the local and national level and malpractice insurance premiums that are generally paid annually. Participant 3 reported:

> They [the licensing board] made it difficult, too, having your [alcohol and drug counselor license] LADC. There was more paperwork involved. They were paranoid. They would check everything. You had to send in all the paperwork, all the CEUs, and if [the forms] weren't signed right, they would send them back. I'm not sure it was the recovery; they were used to everybody being a crook.

Participant 3 decided to give up her LADC and continue working with her mental health license, saying, "I don't need the grief." I refer to this regressive process as De-specialization, a giving up of credentials and even licensure under economic, personal, and professional pressures.

There are 24 acknowledged specialties within the medical community and there is a clear and well-defined process involved in the choice of career and research focus. Medical students

generally take on residencies (medical internships) and become certified in their chosen specialty. Participant 5 related, “Having a separate license perpetuates this idea that it’s some other kind of condition that adds to the taboo and stigma around [addiction].” Participant 8 related, “A supervisor . . . had encouraged me to get another license because I’d be more marketable. The implication of that is I’m not marketable enough. Isn’t that an interesting subtext?” Participant 13 remembered: “There was something about this funny little push to get more people into addictions counseling.” The tendency toward dual licensure seems to have peaked in 2009, prior to Medicaid accepting LADC billing for addiction-related treatment (Knopf, 2009).

In 2009, the Council for Accreditation of Counseling and Related Educational Programs (CACREP) created a set of specialty standards related to addiction counseling to standardize the education and preparation of therapists specializing in addiction, which became effective in July of that year (Hagedorn, Culbreth, & Cashwell, 2012; G. Miller, Scarborough, Clark, Leonard, & Keziah, 2010). As of 2010, there were still no “uniform national curriculum standards in the United States” (G. Miller et al., 2010, p. 51). The graduate trainee “does not see an NBCC credential for mood disorders or . . . a licensure for anxiety disorders,” sending a “mixed message” that perhaps working with clients who have addiction issues is more difficult and complicated than those with other diagnoses (Morgen, Miller, & Stretch, 2012, pp. 58–59).

Scope of practice. Scope of practice remains an issue for many of the therapists I interviewed. For therapists specializing in addiction to have a license, rather than a certification in addiction counseling requires a Master’s degree from presumably a social work or clinical mental health or psychology program. Even then, single licensure at the LADC level narrows the

therapist's scope of practice, as noted by Knopf (2010): "LADCs could never treat or bill for someone with a mental health disorder but no substance abuse disorder." Participant 2 reported she "decided not to take the LADC exam because of scope of practice . . . . I would have needed to narrow my expertise." She identified the difference between a therapist and a counselor as "therapist equals deeper, long-lasting work; counselor equals skills and a practical education . . . . It's all contrived specialties." Participants recounted coping with of Professionalization and medicalization, from their beginnings as counselors through the push for licensure, and then dual licensure, leading some to earn—and then give up—their dual licenses.

Having a personal recovery history. Participant 4 reported that working in addiction is "a field that draws wounded healers," whereas Participant 18 described her role as "being a bridge between recovery and clinical worlds." A relatively high percentage of therapists specializing in addiction who are also in recovery themselves, variously estimated at 37% to 57% percent (Knudsen et al., 2006; McNulty et al., 2007). As noted by Participant 2, one major difference between general social workers or therapists and those who specialize in addiction is "self-disclosure as a tradition of recovery counselors." Participant 16 reported, "I realized this isn't peer-to-peer recovery, but I think that it does something to help build the therapeutic relationship. If it helps somebody to hear that I've been where they've been, then so be it."

There is a general concern about dual relationships among therapists and clients, considered risky boundary crossings at best and boundary violations at worst (L. E. Kaplan, 2005). This concern is even greater in rural areas, where therapists in recovery may have been peers in recovery with people who then present for professional treatment at their agency. Participant 18 said her supervisor told her not to attend local 12-Step meetings because:

> Clients were there. [The agency] wanted a counselor in recovery, but they didn't want me going to meetings that clients were at . . . . They wanted me to go . . . an hour one-way away. It was killing me . . . so I stopped going to meetings.

Participant 18 reported that she "didn't last [at the agency] very long because I burnt down very quickly . . . [I stayed from] July to November."

The Professionalization of addiction counseling as a therapeutic specialty has created sometimes territorial rifts between those who prioritize the tradition of the profession arising from personal recovery and those who prioritize having graduate-school–trained therapists to do the work. Participant 17 reported, "Because I wasn't a recovering person [this therapist] really went for the jugular." Participant 7 shared that she faced "a certain amount of struggle about being taken seriously by people in recovery."

Wearing multiple hats. Participants in this study talked about the necessity of juggling their multiple working roles. Participant 18 shared how important it is for her to "know which hat I'm wearing any given time. Sometimes it's hard." Participant 7 asked rhetorically, "Don't we all have two jobs? Or three?" Participant 8 was particularly forthcoming on this issue: "I think we all have to be octopuses . . . . I always say, 'Just tell me which priority you want me to prioritize.' Managing all of that is pretty complicated."

As defined earlier, clinical supervisors by job description play multiple roles, tasked with supervising direct staff administratively and clinically while carrying a caseload of clients. Participant 11 reported, "You have to wear a lot of different hats every day. . . . I'm added on as a supplemental counselor. . . . If counselors are out, their clients come to me on those days." Participant 8 said, "The carrot on the stick is a lower productivity requirement."

Still, there are reported benefits to juggling many roles. Participant 16 shared, “I always have enough things on my plate that if this part of the thing is stuck in the sludge for a little while, there’s work to do on the other thing.” Participant 11 related, “I have ADHD, so I really need to keep the stimulation on many cylinders going at the same time.”

Expectations of external stakeholders. Therapists specializing in addiction are not only called on as clinical supervisors to cover multiple roles, but also to meet expectations and conditions from nontherapeutic stakeholders. There are pressures to manage the expectations of corrections and child protective services; however, the primary role remains supporting clients, many of whom are mandated to treatment by agencies with the power to punish therapeutic missteps. These expectations may be fundamentally opposed to the context necessary for supportive treatment and it is difficult to balance priorities and maintain a focus on the therapeutic relationship under legal pressure. Many therapists specializing in addiction are literally working within the prison walls and their roles may be misunderstood by those in the legal system who work with mandated clients from the perspective of the corrections system (Holleran, 2006). Therapists may provide services in prison or jail, in drug courts, and with and for probation and parole offices. Participant 1 said of one of her previous supervisors, “She was more on the law side and that just didn’t work for me . . . There was always this, I don’t want to say fight, between the treatment side of the house and the law side of the house.”

Participant 14 reported coming to an eventual understanding:

> Prisons have essentially one logic, and that is to make jail totally secure, and so they apply that to whatever problem arises. Their understanding of drugs in the prison was as a security concern. . . . Prisoners with addiction were put in the cell block into which the prison would introduce new inmates. Because they knew that the drugs were coming in inside the women . . . they knew that the drugs were

> coming in that way, and so I guess they just figured that they're all "fucking druggies" anyway, so just put them all in there together and let them burn themselves up. . . . The treatment of the addiction was just—it's practically barbaric, to be honest.

Participant 14 had since stopped working within the prison and gone into private practice, although she maintained "an advocacy attitude for them." Researchers have characterized this dilemma as an attempt to "straddle the high wire of therapeutic relationship, behavior monitor and reporter to the judge" (Fahy, 2007, p. 200).

Other participants spoke about the difficulties of working with or for child protective services in a therapeutic capacity. Participant 19 said:

> If they're going to say, "Go see [that therapist] for an assessment," aren't [the clients] going to assume that I'm working with CPS [Child Protective Services]? If CPS makes them sign a release to talk to me, then it's a setup. Because should they relapse, what would motivate them to want to share that with me, knowing that there's a release where CPS wants to hear it all?

She reported that CPS also seems to be somewhat confused about the therapist's role with a mandated client involved with protective services, saying, "They must have this assumption that everyone who comes here is active[ly using]." Participant 19 said she used to work regularly with children who are under the care of CPS for concerns other than addiction in the family, "and the hoops that people who have substance use issues have to jump through are far greater than other parents whose children are being assessed for risk." Regarding working with corrections, Participant 14 shared her strategy for managing external stakeholders: "I'm really not taking clients right now that have issues with CPS."

The process of learning to balance these competing priorities and expectations takes a considerable amount of finesse and is learned through experience and, unfortunately, by trial and

error. Therapists can, and do, err on the side of maintaining public-facing relationships to the detriment of their therapeutic relationships. They can also become fierce advocates of the privacy and primacy of the therapeutic relationship in a way that ultimately does not serve the clients' societal needs and is perhaps nice, but not ultimately kind. This process is delicate, indeed.

Primary Dimension 3: Struggling

The primary dimension of struggling is most apparent through the conditions of feeling out of balance and the baggage individuals carry, and the process necessary for these conditions is meeting challenges. The impact of learning how to struggle productively with these challenges develops the skills necessary to create valued working environments. Table 4.6 presents the conditions, process, and impacts of the primary dimension of struggling.

Table 4.6

Primary Dimension 3: Struggling

Primary dimension	Conditions	Processes	Impacts
Struggling	• Feeling out of balance • The baggage we carry	• Meeting challenges	• Developing the skills necessary to create valued working environments

Participants spoke about the unrealistic expectations regarding the competing responsibilities they were expected to manage in their highly pressurized, sometimes actively hostile, isolated, and isolating work environments.

Feeling out of balance. Participants mentioned several pressure points helping to keep them out of balance. This lack of a balanced core in their work increased their struggle dramatically. They talked about unrealistic workload expectations, unsupportive or hostile work

environments, feeling interpersonally out of balance, and the struggles related to working in private practice and rural settings.

Many participants discussed the pressure they faced to meet unrealistic productivity expectations placed on their time by their agencies and their licensing boards. Participant 1 reported that, in an attempt to mitigate her high no-show rate and make her productivity quota while working primarily with clients who have addictions, she scheduled "I booked over 40 [hours] in a week—like I don't know, 47 [clients] in 1 week—[and] they all showed up. I was mush because I was just overworked." Speaking from the perspective of her first job, Participant 6 said, "We will ask of you the impossible."

One of Participant 13's early jobs was as a one-person IOP. The definition of an IOP is 9 to 12 hours of treatment weekly, including individual and group sessions and case management. In practice, unless there is more than one clinician available, the individual sessions are scheduled either before or after the regular intensive outpatient program (IOP) hours, so the clients (and the therapist) do not miss their groups. This was also the expectation placed on Participant 18 when she was a newly graduated, unlicensed clinician at a community mental health center. She shared:

> The whole experience was really tough because I was running the Spoke [outpatient medically assisted treatment] program as newly graduated individual. Then they had me also running nighttime IOP, so I was doing four people's jobs—literally. Really, a one-person intensive outpatient program. I had these same people in group 4 nights a week—whatever, 4 afternoons, 4 nights and I had to do the program. I didn't last there very long because I burnt down very quickly: July to November, which is burnt out very quick.

A Spoke program in Vermont is one aspect of medically assisted treatment (MAT) for opioid use disorders, prescribing agonists and antagonists against opioids, and offering

individual and group treatment. Although Participant 18, like the other talented therapists interviewed for this study, is a highly capable and motivated professional with a great deal of skill, it is worth highlighting that she was expected to run an intensive outpatient program and a Spoke program within months of graduating from her Master's program. She described this situation as being "a lot of paperwork," and that she was "just drowning in paperwork." Participant 18 was able to meet this unrealistic expectation without support for 4 months. "It felt like a lot of pressure," she added, a true understatement.

Participants reported that their agencies were chronically understaffed and under resourced. Participant 11 shared her experience as "You have just a few individuals dealing with tons of clients." Participant 13 reported, "You get as many clients as you can more than imagine . . . the highest caseload in this agency. My baptism by fire, as I call it." Participant 8 charitably phrased the problem as "you might be supported to have an unmanageable caseload. . . . Nietzsche said, 'Many a hard night can be gone through with the thought of suicide.'" For Participant 9, the already-severe pressure intensified when her colleague in an inpatient residential program "blew out. That's why I had the 16 women. I think I was the only counselor there for about a year. I stayed and I paid for his [addiction] problem."

Lack of resources. Participant 12 took a systemic view of the shifting foundation created by scarce resources as trickle-down financial stress from the agencies, which are largely struggling to survive punishingly low reimbursement rates. She shared, "The results of this is really, really high productivity in direct service requirements." Participant 6 reiterated this systemic perspective: "We don't have the money to hire staff to do this." In trying to provide care and keep the lights on, agencies have had to shift some of the financial risk onto individual

clinicians through fee-for-service models and high productivity requirements (Hatchett & Coaston, 2018). Rather than receiving a salary with benefits, many clinicians can now only find work in fee-for-service positions, which means they receive a percentage of the proceeds from their billable hours. Participant 1 explained, “The agency takes 40% of what we earn.” There is no pay for missed appointments (estimated at 37% for clients with addiction), sick days, or holidays (Hatchett & Coaston, 2018; Molfenter, 2013). Typically, there is no access to health insurance, as the clinicians are not employees, but independent contractors. The effect for clinicians was summarized by Participant 13, saying “Agencies like to say they want you to take care of yourself and they give lip service to that . . . [but] that wasn’t always supported.”

Participant 1 explained that, with her specialization, she was “in an uncomfortable zone for the agency.” She shared, “If we’re not sitting with a client, we’re not earning any money.” With high productivity expectations, clients who are perceived to be a high risk for not attending their appointments (often, clients with addiction) are less likely to receive individual appointments, as they are “productivity liabilities” (Hatchett & Coaston, 2018, p. 203). Participant 19 explained: “When you’re in private practice and you have no-shows, there is no pay. No-show, no pay.”

Many participants spoke about working in unsupportive or even hostile work environments. Participant 18 recalled the first day at her first post-graduate job: **“**I walked in. I didn’t even know how to log in the computer and they’re like, ‘You have a client in half an hour.’ When I started [with] the agency, I started with a 60-client caseload and a full schedule.” This was well before orientation, as she related, “They do orientation and training months later.” Having graduated several months prior, she was “the second most experienced person in the

building. . . . They had a very high turnover rate, *believe it or not* [emphasis hers]. I was only making a dollar more than the receptionist an hour."

Participant 9 reported feeling shocked when she came back to work after the first weekend off she allowed herself in a long time: "I'm just really open and that sense of dysfunction just took my breath away. . . . I don't know why I didn't fight this, but I was in a room with no windows . . . no sunlight . . . doors were shut." She reported that she worked in isolation from her colleagues, from the rest of the world, eating lunch at her desk in order to get her work done. "I go from March, 'You're a superstar', to now it's 'I'm going to wait till first of July [to quit].'"

Participant 4 shared a different perspective on how being out of balance interpersonally affected her ability to continue working as a therapist specializing in addiction:

> It's a difficult balance of . . . meeting other people's needs and having your need . . . met with a reimbursement check, but not emotionally. . . . It's hard to maintain the balance between how much I'm giving and how much I really . . . get back. . . . I'm still running a negative balance. . . . My sense is I'm kind of bumping up against almost kind of a lifetime limit.

This sense of being isolated and out of balance interpersonally also affected participants who had been promoted to supervisory positions. Being a supervisor takes a therapist out of the collegial community built among direct staff, because it is no longer appropriate for the supervisor to remain one of her peers. This is perhaps especially true of clinical supervisors, who are still doing the work alongside their direct staff, but are separate, isolated, and outside because of their administrative work. The sense of isolation also parallels the problem of those therapists who are also in recovery, a part of, but separate from, their recovery peers. Participant 11, a highly ethical and committed supervisor, explained the barrier: "I can't go to one of my

supervisees about one of my other supervisees. . . . [Work's] not a safe place to bring up struggles."

Some participants talked about the isolation they inadvertently created when they chose to work in private practice. Participant 6 warned hypothetical others: "Be prepared. You're going to have to walk into this with a really good cohort of other professionals that are doing the same work who love and know you so that you stay sane." A rural therapist may be the only addiction specialist in the area (Cohn & Hastings, 2013; Kee, Johnson, & Hunt, 2002). This limitation on building a community of support for the therapist can lead to burnout due to "limited social integration and peer attachment" (Cohn & Hastings, 2013, p. 230). Participant 10 warned, "Private practice can be very isolating." Participant 13 spoke about the importance of being with "like-minded people"—but what happens to therapists specializing in addiction who go into private practice or administration and leave behind their collegial safety net? According to Participant 18:

> It's like a bunch of independent contractor practice clinicians and we do group consultation every 2 weeks. There's a new group of people who I don't really know and they don't come to group consult. I'm the only LADC, only addiction person in the group. . . . I don't think they understand addiction at all, to be honest. I always joke that the upstairs is this other dimension because I never see people come out. I know they exist—I think—but I don't see them.

Many participants spoke about the specific challenges of working in a rural setting. This pressure has been named "role strain," defined as "when competing roles overlap" (Cohn & Hastings, 2013, p. 230). Participant 4 shared:

> If I see my clients out in public, it's kind of like uncomfortable all around. I've shown up at a yoga class where a client was there and when he came back next time and said, "I was so pissed off because you didn't say hi to me," I'm like, "I kind of can't. I knew you were with your wife and you said hi to me and I said a

> quick "hi." But if I start talking to you, she says, "Who is this [person] who's talking to you?" I don't know where your confidentiality is. I don't know whose friends are here. I'm not going to say, "Hey, it's my client, hey." I can't do that.

Rural, as opposed to urban, therapists have reported difficulties leading to burnout exacerbated by office politics and low occupational prestige (Oser et al., 2013). Burnout in rural contexts is perhaps related to an increased tension between self-in-community and self-as-professional where the therapist is known in the community as both (Cohn & Hastings, 2013). Of course, the problem is significantly greater for therapists who are both in private practice and practicing in rural areas. Participant 4 continued:

> For me, for someone in private practice, I find it a very lonely profession. Outside of supervision groups, I can't really talk about my work. It's Vermont. It's a small town. I can't really go home to my wife and say, "Yeah, I saw this great client today. He's a runner. His wife even does yoga." She's going to go, "Oh, I know them. I know them. She takes my class."

The baggage we carry. Several themes emerged from the interviews around the things therapists carry with them. These feelings and stories have often become heavy and unwieldy. These themes overall were death and dying, financial pressures, feeling disrespected, feeling punished, Stigma-by-Association, and gender-based discrimination.

Participants spoke about struggling with clients' death and dying. Participant 3 reported her feelings of being responsible in what is perhaps not a reasonable expectation of the scope of practice of a human therapist, saying, "At the end of the day, I want to make sure nobody's going to die overnight. That's the bottom line." Such a guarantee is perhaps unrealistic in the context of what Rudd, Aleshire, Zibbell, and Gladden (2016) named an opioid epidemic, in which an increasing number of people every year are dying of drug overdoses (p. 1323). According to Rudd et al., the rate of overdose deaths from all drugs has increased by 137%, with the rate of

opioid-related overdose deaths having increased by 200% (p. 1323). As of 2016, the opioid epidemic was growing steadily more lethal, despite our (medical, clinical, peer, legal, community, religious, and familial) best efforts.

Therapists specializing in addiction are on the front lines of this epidemic. Participant 11 shared the meaning she has made out of this process:

> It [client death] doesn't even faze me at this point . . . I think it's because it's expected. There are some clients [for whom] it's sadder, because maybe you feel like they've really got it, but it's the nature of the work. We had a counselor leave because she couldn't tolerate that. She went to work in prevention because she couldn't tolerate it. . . . I compartmentalize really well. I don't allow it to hit me deep. I think a reason that death hits people deep is that they take some level of responsibility for the death like, "I should have been able to do something different." I'm not responsible for my clients dying. They were going to die and we, at least, helped them figure out a way to have more time on this planet. . . . We are all going to die. Who am I to say that this individual is supposed to die at 55 or 62 or 83? This individual unfortunately died at 24 and I wish they had gotten more years, but that unfortunately is where their journey ended. . . . We don't know how many of those clients that overdose [were] truly accidental or how many of those were a choice in their addiction that they at that moment didn't feel like they could go on and they intentionally used more than they should have.

Although Participant 11 had clearly spent a good deal of self-reflection time developing her insight into the death and dying burden, this meaning making could straddle an admittedly narrow gap between existential philosophy and the depersonalization that is a cardinal symptom of burnout.

Participants talked about the financial pressures of specializing in addiction. Participant 16 reported that, financially, "Just being a straight counselor was not sustainable for where I was in my life." Participant 7 shared disparagingly, "By the time I left, I got more than the MHWs

[mental health workers].” For Participant 6, being a therapist specializing in addiction meant accepting that:

> The pay was abusive. Getting paid, essentially, minimum wage with Master’s degree. . . . I chose to be living at poverty line for a good part of my career. . . . [The attitude was] “We will not pay you what you’re worth and we will ask of you the impossible.

Meeting challenges. Participants developed strategies to survive on too-little reimbursement. Participant 19 reported her method, echoing other therapists who had made the same attempt: “I have to book more clients to make sure that I get enough, that feels like enough, to make it work financially.” Participant 1 shared that, when she went into private practice, “My first paycheck for the month was $36.” Reflecting on her strategy for staying ahead of her “lifetime limit” of empathy, Participant 4 reported thinking, “‘OK, maybe I’ll just roll up my sleeves and work hard and make more money and retire sooner,’ and I kind of can’t.” She noted the inequality in pay for medical specialists (e.g., orthopedists or dermatologists) and the mental health, saying, “I don’t think there’s parity along those lines of recognizing people in the field who have a real specialty beyond kind of a general practitioner.”

The financial burden was even more prominent when the agency experienced financial problems and the stress trickled down to the therapist level, as Participant 8 recalled working “in the context of community mental health, which you could frame as underresourced.” Participant 6 shared that she came to feel low pay was a sign that she was not valued by her agency, as an external signal of the respect they had for her: “They definitely did not value us . . . . The state made it very clear that we were not valued.”

Participants reported struggling because of feeling disrespected, both within their workplaces and among colleagues not working in addictions. Participant 13 characterized this felt sense as "still considered 'not quite' . . . 'they're just addictions counseling' . . . not as professional. . . . Not quite professional enough. We were the step-step-children of the world"; and Participant 7 named the sense as feeling "less than, in a big way." Participant 6 suggested this lack of respect may arise from the history of the profession as peer recovery–based, a subject that undergoes further exploration in Chapter V. Said Participant 6, "[The] mental health profession, I think, has always been a profession. It wasn't people with chronic mental health issues helping other people. . . . My own licensing board was treating me like I didn't know what I was talking about."

In the pressurized world of therapists specializing in addiction, where community and collegial support can mean the difference between burnout and being able to continue working in a healthy way, it can be particularly toxic to cope with the negative perceptions from therapists who are not addiction specialists. Participants reported microaggressions, overheard or felt, yet still wounding. Participant 10 remembered feeling, "Your expertise is limited; your range of wisdom [is limited]." Participant 8 shared that, when there was pressure to get a more-general license alongside the alcohol and drug counselor license, "I thought LADCs were perceived as less professional, less valuable, maybe even less skilled than you can say [social workers]." Along similar lines, Participant 13 stated, "I remember social workers and other types of therapists are saying, 'We could do this work.'" Participant 6 perhaps best identified the attitudes and their antidote when she shared:

> Just the attitudes of other professionals in the room, like "You're just a substance abuse counselor. You are ignorant. You are coming from the old-fashioned AA model, clearly," and so that's like— Oh my God, it was unbelievable some of the attitudes I would encounter from licensed professionals. Then the attitude, aside from "You're uneducated, you couldn't get a better job, and why would you work with that population? I would never do that." That would be the attitude I would get frequently, unless I was at a specific-to–substance abuse counseling training. Then obviously, we would all get together and bitch about low pay, overwork— the usual suspects.

Many female therapists specializing in addiction reported having experienced gender-based discrimination (explored as a meso, or organizational-level manifestation of discrimination in Chapter V). Two of the women who had been working in addiction in the 1980s and 1990s reported being called, to their faces, a "grant whore" and the "red-headed bitch on heels." Unfortunately, this was not an issue left safely behind in an earlier era. Another female participant reported that within the past 2 years, she had lost a job due in part to her new direct supervisor's discomfort with working in a supervisory capacity over a woman with more experience than he had:

> [He] was not licensed at the time. Maybe [it was about] being a female. . . . What nerve do I have challenging a supervisor and his intellectual decision making or abilities? I think he is still part of the good old boys' club.

She shared that, despite being rehired by the agency and moved into another supervisory position, she has no knowledge of any consequences that supervisor received for his attitude and actions. She reported feeling "disheartened" because her supervisor was unqualified: "It was about ego for him . . . because I was in the field maybe longer. I think it was even more disheartening because that was an organization [where] I worked for almost a decade."

Participants also reported feeling punished for prioritizing their own safety. Participant 13 shared that she was signed up for a 3-day training session 40 miles away, in February, in New

England. She remembered there being a day she was unable to make the drive due to a snowstorm, saying, “I was scared to death driving over there.” When she returned to the training, her punishment was that she:

> Would have to wear a yellow vest and go do kitchen duty. That was because I did something wrong or I was “holding guilt.” They said, “You have to stand up and you have to give a song.” At that point, I am so done.

At the time of this incident, Participant 13 had 25 years of experience as a therapist specializing in addiction, and she was nearing the end of her career and her tolerance for these micro and systemic aggressions.

This surreal experience was in parallel with the therapists’ expected behavior toward the clients. The experience was also perhaps influenced by Stigma-by-Association, due to therapists working with the complex or difficult clients others choose not to work with. Participant 1 wondered whether Stigma-by-Association was a strategy employed by other professionals to distance themselves from a liability issue during the opioid crisis. Speaking as someone who has worked on both sides of the aisle, Participant 10 shared that, for her, “I think [the stigma] extends to people that work with people in addiction. . . . It’s much easier to walk through the doors of a mental health facility than it is to walk through the doors of a substance abuse facility. That’s the front line.” Participant 1 said the double standard was “because my specialty population is women with substance use issues, trauma and personality disorder. It’s like the trifecta, which all go together.” She reported that this intersection as an “uncomfortable zone for the agency.”

Therapists who work with clients who have addictions need to be prepared to work in marginalized areas. Participant 8 reported:

> My first job in the field [was] in Hudson County, New Jersey. I had a CADC [certification in alcohol and drug counseling, an as-yet-unlicensed clinician]. The facility is under the Pulaski Skyway and across from a bus terminal in front of a train track. There was nothing around this place. It was almost bizarre. Jersey City, New Jersey. Who knew there was an *under* the Pulaski Skyway? I worked there.

Therapists must ultimately learn how to reconcile and meet these challenges in order to continue in their work. This is not about grit: therapists who specialize in addiction are, at least initially, willing to engage in struggle in service of valued work. With enough supports and resources, they are able to reach a place of thriving, for themselves and for their clients; Without, the struggle can erode their ability, leading to burnout and job turnover.

Core dimension: Thriving

When successfully navigated and eventually integrated, the primary dimensions of tending and pruning, juggling, and struggling, and the pressures and supports contained within them, lead to an ability to maintain a valued career over the long term. As mentioned previously, some of the participants in this study worked well past the Social Security–designated age of retirement as a result, and not in spite of, the pressures under which they were able to thrive. The conditions necessary for this longevity are community, being patient-centered, efficacy, feeling valued and respected, being a mentor, and loving the work. Table 4.7 presents the conditions, processes, and impacts of the core dimension of thriving.

Table 4.7

Core Dimension: Thriving

Core dimension	Conditions	Processes	Impacts
Thriving	• Community • Feeling effective • Having autonomy	• Having the skills necessary to maintain a valued career	The skills and flexibility to:

	• Feeling valued and respected • Being a mentor • Loving the work	• Tend to the career as a garden • Balance competing priorities and expectations • Meet challenges

I had the privilege of speaking with several participants who had been working during the earliest stages of Professionalization, a macro or societal-level process explored in Chapter V. These therapists weathered the major educational and career changes required of them to keep working in this profession. Although they reported thriving at times and at many developmental stages in their careers, it was most clearly illustrated by the participants who were over 65 years old and at or above 30 years in their careers.

Community. Participants identified the supportive impact of having a community of like-minded colleagues as crucial to continuing in the field and a foundational condition of thriving. Participant 18 reported that she was very careful "to be supportive of the other clinicians because, to me, that was the savior; [it] was the other people that I was working with." Participant 8 shared that she now understands not to look outside of the community of her colleagues working in addiction for validation, saying, "If I was going to get self-esteem or value, it would have been from other peers in the same field." Participant 3 identified for herself that "I need a community of like-minded people who are learners and people who want to talk about interesting stuff." She has taken steps to secure that community and to create it when it has not been readily available. Participant 6 reported, "You could work in a really toxic environment, but if you have the right cohort, you can move through that. . . . Having a community is, without a doubt, the most essential, most critical, quality." She warned: "Be prepared. You're going to

have to walk into this with a really good cohort of other professionals that are doing the same work that love and know you so that you stay sane." Participant 13 reported candidly that there is "safety in numbers."

Maintaining a patient-centered perspective. Participants also talked about the protective, simplifying focus of maintaining a patient-centered perspective, despite pressures to focus on the needs of the agency or of external stakeholders, as a condition necessary for thriving. Participant 8 shared her view of her role as simply: "The relationship. Most important." Participant 15 argued, as she perhaps has had to do many times in the past with a less-sympathetic listener, it needs to be about patient care. . . . We always need to do what's best for "Ithe patients and not [necessarily] what we want to do." In a parallel process with the important skill of creating a community, Participant 11 shared, "I have created good relationships" with clients and colleagues over time.

Feeling effective as a therapist. Participants mentioned the vital importance of feeling effective as a therapist to their ability to thrive, perhaps especially during the current opioid epidemic and in the context of relationship-centered work. This is echoed in the work of multiple researchers, including Baldwin-White (2016) who reported that "a lack of therapeutic success was found to be the most stressful aspect of [therapists'] occupation" (p. 30). Feeling effective appears to be protective against burning out. Participant 8 shared, somewhat playfully, "Maybe to some small extent to be, at least, on face value, an expert in a crisis that's occurring is a good thing career-wise?" Participant 13 remembered feeling, at several different points in her career: "No, we're doing OK here. We know a lot about helping people and recovery and what to do. . . . That was successful for a long time."

Feeling valued and respected. According to Schaufeli, Leiter, and Maslach (2009), burnout can be fueled by a reduction in this individual feeling, and perhaps the professional reflection, of being effective. Participants talked about the importance of feeling valued and respected as a professional as supportive for longevity. In fact, Cynthia D. Fisher (2010) prioritized what she considered perhaps an "idealistic" suggestion that organizations invest in creating "a healthy, respectful, and supportive organizational culture" (p. 398). She defines including respectful and dignified treatment as fundamental factor in creating a "happy and enthusiastic workforce" (p. 394). Participant 8 said, "I have soft data that suggests that if our organization went belly up, then I'd be able to find something else. . . . I don't think I had the opportunity to be denigrated that other people might enjoy." Participant 13 reported that she noticed a significant change over time, "Sort of as [we're] not looked at or viewed as the step-children any longer . . . just as needed and just as professional as, say, the other therapists, the social workers." Participant 11 also noticed a change: "I would hope that the view of addiction work has changed compared to the way it used to be . . . that they would provide me with the same level of respect that I give them for their work."

Being a mentor. Participants placed much emphasis on the importance of being a mentor, not just having or being a supervisor, but also as another way of supporting clients. Participant 11 said:

> I always knew that, for some reason, supervising others was something that I really loved. . . . I've gone to countless clinical supervisor trainings just because I think it's super important. . . . I think it's my greatest skill. [Clients are] getting better and better treatment because I'm doing a good job training my counselors to do a better and better job.

Participant 18, who is interested in earning a doctorate in clinical supervision, reported, "If you take care of your clinicians or take care of people, then they're not going to want to leave." Participant 3 shared her recipe for longevity as a combination that has to include good supervision:

> I continue to do a lot of reading in the field and a lot of meeting with other groups, doing supervision of counselors. All of those things, I think, add to keeping my passion there. . . . You want people to be healthy and enjoy their work.

Loving the work. Participants identified how much they loved working as a therapist specializing in addiction, despite—and maybe because of—learning how to survive and thrive with the challenges involved. Participant 11 shared her delight in her current job, which she has carefully tended and crafted through multiple tweaks and changes: "My position right now is almost, almost, my dream position . . . . The job I'm doing right now really is exactly what I want." Participant 15 reported that "there was this energy about [the job]" that attracted her and kept her working despite difficulties. After a moment's pause to reflect, Participant 8 responded, "While there are other things I might not mind doing, I didn't come up with a thing that I want to do more *or I'd be doing it."* This confidence to change jobs as needed points back to the skills arising in the first dimension of willingness to move on in service of the larger career, even if it means leaving a specific work environment. Participant 9 shared, in an uncharacteristically hushed tones, "It's sacred work. I think that made it very spiritual for me." Participant 6 identified the importance of the work, both for the clients and therapists: "I think that working with substance abuse, you really are right in that razor's edge of how precarious the circumstances are, regardless if you have an addiction or not." Participant 7 summed up her

30-plus–year career with classic understatement: “It ended up being really interesting.” Participant 18 said she continues to do this work because “There’s just such a need. It’s just such a hurting place and I just love being right in the hurt and helping people.”

The participants who generously agreed to reflect and share their insights about the processes that make it possible for them to thrive as therapists specializing in addiction provided information to resolve perhaps a small part of the problem. Their words have revealed some of the pressures affecting therapists specializing in addiction from the societal and organizational levels. The difficulties inherent in doing the work create the environment and hone the skills necessary to come to a place of thriving as a therapist. Without the challenges, the skills would not have had to be sharpened. Not all, and perhaps not even many, therapists who start out specializing in addiction make it through the challenges laid out here as primary dimensions, but those who do are able to continue their valued work from a place of self-respect, effectiveness, community support, mentorship, and valued service.

The situational analysis that follows in Chapter V centers on the systemic and organizational issues revealed in the grounded theory research arising from these interviews. I will discuss the context and culture that affect the lives of therapists who specialize in addiction. Through situational analysis, it will be possible to identify silent and more visible actors, human and nonhuman, and their relationships to one another, pressuring and supporting these individual and organizational processes. Chapter V is a move from the words of the individuals to the broader forces at work—and the relationships between them—that their words have revealed.

Chapter V: The Situational Analysis

Therapists who specialize in addiction navigate a complexly intertwined environment of supports and challenges, expectations and stereotypes. In the grounded theory analysis of the previous chapter, I identified major dimensions generated by the interviews that correlated with nonlinear developmental stages in therapists' careers: Tending and Pruning, Juggling, and Struggling. Successful integration of the challenges of these stages allowed some therapists, often in the latter years of their careers, to access the core dimension of Thriving. This is, as revealed in Chapter IV, a hard-won achievement: Some therapists find it only briefly before societal and organization pressures exile them. Not all therapists, despite high levels of grit and dedication, will reach this oasis due to nearly insurmountable gaps between social and organizational pressures and available supports.

The social arenas and organizational issues in this situational analysis received introduction in the dimensional analysis. In most situational analyses, many creative versions of messy maps evolve into ordered maps, and then project maps. What I found in this case is that messy maps, for lack of a better description, stayed messy. They are a part of this chapter, because they do not factor into the discussion that follows. One version of the project map, for instance, was a depiction of the social arenas and organizational landscape and the intersectionality between actors and ended up as indistinguishable "bubbles" directly inside of or on top of one another. Without three-dimensional modeling, interpretation is not possible. These maps comprise a complicated landscape, with nearly every arena (social or organizational) so enmeshed as to be nearly impossible to extricate for separate viewing. Therefore, Figure 4.1 presents the final categories arising from the interviews as our messy map.

During the dimensional analysis, I began to see a pattern of recurring supports and challenges on the societal and organizational levels. Attempting to group them into social arenas renewed my conviction that these are too enmeshed to be separable into enlightening geographical points. The same cultural, political, and societal issues thwarting progress in Professionalization also arrest progress toward mitigating the current Opioid Epidemic and problems with gaining Licensure and Insurance Parity. Not only do some of the elements overlap, they all overlap. In Table 5.1, I present a simple two-column project map of the complexly intertwined factors that I will explore more fully in the situational analysis that follows. Organizational issues will appear as actors within multiple social arenas and will be emphasized within text by use of capitalization. The overarching social, or macro, arena of Professionalization is identified in bold in the project map below (Table 5.1), and the major organizational, or meso, arena of Stigma-by-Association is also in bold and will be discussed in more depth than other meso arenas. These two important concepts will also hold pride of place as bold headings in the discussion to come, with dependent macro arenas presented as bold paragraph headings and dependent meso arenas presented as bold italic paragraph headings.

Table 5.1

Project Map

Social Arenas (Macro Arenas)	Organizational Issues (Meso Arenas)
Professionalization	Discrimination
Education	Stigma
History of the Profession	**Stigma-by-Association**
Opioid Epidemic	Stereotyping/Prejudice
Accreditation	Clinical Supervision
Licensure	Continuing Education
Insurance Parity	Scope of Practice
	Pay Rates

A visual that did emerge, and that I believe can be helpful as a map into some of this landscape, is a basic hierarchical chart. At the beginning of the section for each of the social arenas presented in the situational analysis to follow, I offer a chart for the discussion to follow. As a further key to this landscape, the social and organizational arenas explored will also be capitalized in text. They will become familiar to the reader through repetition, as they became familiar to me through their frequent appearance in the interviews.

Professionalization

From the grounded theory interviews, a clear picture emerged of a trend toward Professionalization that changed the addiction care workforce from counselors promoted from

the ranks of successful graduates of recovery programs to professional, educated therapists specializing in addiction. Therapists interviewed for this study who are at (or beyond) retirement age reported being part of several waves of change in their 30-plus years of work. Their words figure heavily in the exploration that follows.

I will also draw heavily from the work of William White in this section, as will no doubt be clear when reviewing citations. It would perhaps be surprising that his contribution to this research is so extensive, without the context that over the past 30 years he has authored and co-authored 20 books and more than 400 articles on addiction-related topics, all during the time of Professionalization tracked herein (White, 2019). Other sources used for this exploration include relevant websites, research and newspaper articles, and governmental or organizational surveys and reports.

Throughout the text that follows I will use the term counselor to denote unlicensed persons working in addictions and the term therapist to identify licensed, credentialed, or license-eligible persons working in addictions. I will explore each of the social arenas in turn as they either support the momentum of Professionalization or a turn toward De-professionalization. I will also explore the salient organizational issues related to systemic and individual pressures working against therapists specializing in addiction, including how the assumption of a personal recovery history and the associated Stereotypes and Stigma that have been used against addiction professionals are major roadblocks stalling or reversing the momentum of Professionalization. All of the social arenas identified and explored here interact with and are subsumed within the cycle of Professionalization and De-professionalization.

In this section, I define social and organizational factors to attempt to explain how the Professionalization momentum stalled. As recently as 2010, researchers reported that "the addiction counseling field is leaning toward requiring that counselors have a master's degree, as well as affirming the need for all counselors to acknowledge the prevalence of addiction in their clinical work" (G. Miller et al., 2010, p. 51). Since the process began in the 1970s and 1980s, one would perhaps have thought there would be more momentum than would be characterized as a "lean." What forces were working to block the momentum of this by then 30-year process? In the section that follows, I will explore the arenas of education,

Education. This section and the two that follow address the three layers of professional approval necessary to work independently as a therapist (Education, Accreditation, and Licensure), with special emphasis on the specific pressures put on therapists specializing in addiction. In our first social process arena, I will explore the apprenticeship model, the early licensing movement, and the impact of dual diagnosis on the perceived need to educate counselors.

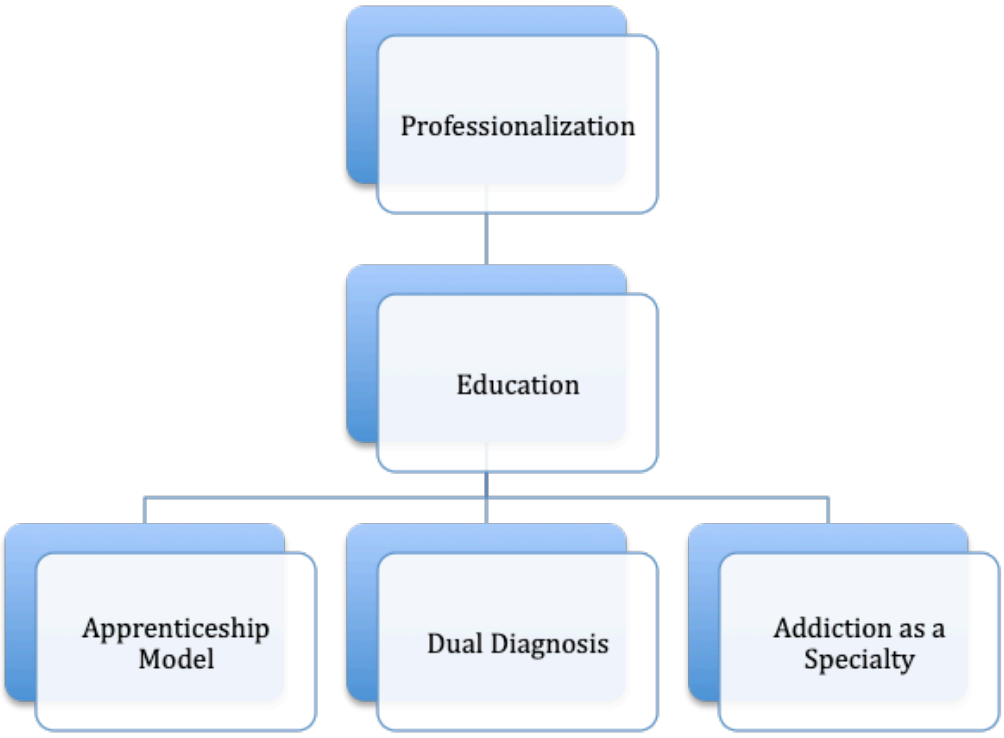

Figure 5.1. Societal factors impacting Professionalization through Education.

Apprenticeship model. Between 1980 and the early 2000s, counselors were required to become therapists, moving away from the nonprofessional context that Participant 3 characterized as "almost like a grassroots kind of indoctrination type of counseling that was going on that was based solely on a 12 Step model." This movement toward education caught Participant 7 mid-career: "[the] second half of my career there was more acceptance that you needed to be getting your master's. . . . It was so good for me. . . . As people got more educated . . . there really was an increase in our value."

Prior to Professionalization, "[t]hose individuals who emerged to address [addiction] did not initially matriculate from graduate programs in the helping professions" (Hagedorn et al.,

2012, p. 125). Roy and Miller (2012) identified this pressure to grow and develop into professional therapists as:

> the challenge for the addiction counselors working [in nonclinical services] is to allow themselves to undergo whatever professional transformation may be required of them to comfortably work side-by-side with physicians and nurses, and to adopt pharmacotherapy services for addiction patients offered in an integrated way with psychosocial services. (p. 114)

The old experiential approach to training could not keep up with the need for a credentialed and fully licensable clinical team: "The 'apprentice model' of training substance abuse counselors has built-in limitations" (Amodeo, 2006, p. 170). A national turn toward having an educated and accredited pool of therapists:

> forced many recovered alcoholics and ex-addicts to redefine the assets they brought to the helping process. It also spurred the need for new knowledge and skill development for counselors who quickly realized that they needed much more than their personal story of recovery to operate effectively as an addictions counselor. (White, 2000, p. 8)

Participant 13 remembers in the late 1990s: "The state was moving into a different level beyond the [certified alcohol and drug counselor] CADC. It was more to a licensed alcohol and drug counselor and there was a master's degree expectation that you would have." She was told: "You have to get a master's degree if you want to keep doing this."

By the first decade of new millennium, policy makers supported taking steps to "Encourage states to require that the minimum educational degree be comparable for substance abuse and mental health counselors" (Amodeo, 2006, p. 169). Licensing bodies and academic institutions "collectively tried to move addiction counseling from a folk art to a professional discipline by defining the knowledge and skill components of addiction counseling and

recommending approaches to the training and credentialing of addiction counselors" (White, 2000, p. 9).

Dual diagnosis. A deeper understanding of dual diagnosis and the complex interplay between addiction and other mental health issues emerged as a major factor raising the pressure on substance abuse counselors to become proficient in general mental health treatment. Clients who have co-occurring mental health and addiction issues are "dually diagnosed." Presumably, there had always been a strong correlation between people who had mental health issues and who were "self-medicating," but until the advent of medicinal supports to address mental health issues, this was probably a moot point. By 2012, researchers were reporting that "the advent of more pharmacological therapies is making the care of some patients with addiction look more like the care persons receive for other medical illnesses" (Roy & Miller, 2012, p. 107).

Participant 11 noted the difference as "[h]aving master's level clinicians that think more mental health" and are better prepared to work with those clients with diagnoses in multiple areas of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM 5). According to a National Survey on Drug Abuse and Health, in 2014 a combination of mental health and substance use disorders affected 7.9 million people in the United States (Center for Behavioral Health Statistics and Quality, 2015). According to Amodeo, writing in 2006, "[t]raining and credentialing are especially timely issues as the substance abuse field grapples with the challenges of responding to dually diagnosed clients, incorporating empirically supported practices, and preparing for the implementation of results-oriented management" (p. 169). Participant 10 expressed her concern that "We've made a huge demarcation between people who

work with mental health and people who work with addiction. I think it's erroneous because I think it just splits the mind-body . . . it's a way that keeps stigma alive." According to White:

> There was a debate during this period regarding whether alcoholism and drug abuse counselors should become a "new profession" or whether they should be trained as specialists within such existing professional disciplines as psychology, social work, and counseling. Strong advocacy for the former eventually tipped the scales toward creating a new professional specialty of addiction counseling. (2000, p. 9)

To respond to this newly acknowledged need for therapists who could conceptualize treatment holistically, "[f]ormalized training programs were created . . . in the 1970s to create a group of professionals to work with addicted clients using the disease concept . . . as the primary treatment approach" (White, 2000, p. 9). Previously, counselors were taught that their role was singularly to focus on alcohol (and maybe other drug) issues. Participant 13 recalls that the "focus was stay sober from alcohol or the drugs a little bit and then work on the other things." Participant 2 shared: "The perception is that [counselors will] talk about just drug and alcohol, not deep things, mostly case management." Especially when it came to trauma work, she was told "Don't open that can of worms, get them out of here first." As a nurse who trained to be a licensed clinical mental health counselor (LCMHC), she reported that the division between issues within the same client and between therapists was "confusing," and she ultimately decided not to pursue a license in alcohol and drug counseling because she believed it would be limiting for her as a professional. This division found fertile ground among colleagues who did not acknowledge the change in Professionalization from counselors to therapists, from professionalized peer counselors to fully credentialed colleagues.

Researchers acknowledged the need-driven development of a clinical workforce who were trained specifically to deal with addiction and its co-occurring mental health disorders, as "researchers have found that effective counseling with addicted clients requires specialized training and that professional counselors trained in academic graduate programs are more effective than their less educated counterparts" (Hagedorn et al., 2012, p. 126). Those therapists trained generally in mental health have an invisible educational content gap "in the training on substance abuse knowledge/skills for mental health counselors and on psychopathology, screening, and assessment for substance abuse counselors" (Amodeo, 2006, p. 170). As Participant 19 reported: "I think a lot of therapists choose to believe that they can treat addictions."

Training programs struggled to keep up with the demand for therapists capable of working with co-occurring disorders. This demand was made by third-party reimbursement (insurance company) sources, along with others: "Third party reimbursement requirements add a third reason for the lean toward graduate-level addiction counselors. Whereas state-based addiction counseling certification boards do not require a graduate degree, insurance companies *have* moved to such a requirement" (Hagedorn et al., 2012, p. 126, italics in original).

As examples, two agencies, one at the state and one at the federal level, have attempted to support forward momentum in the field of educating a professional workforce. They have attempted this through training in both addiction and mental health issues as they co-occur in real life clients. They are the New Hampshire Department of Health and Human Services, Bureau of Drug and Alcohol Services and the Health Resources and Services Administration (HRSA).

The website for the Bureau of Drug and Alcohol Services of the state of New Hampshire lists Education supports including a six-hour introductory training in addiction and a three-hour workshop on families and addiction at no cost to participants. Also provided on the website is a link to the New Hampshire Training Institute on Addictive Disorders (NHTIAD) which offers "quality, affordable, monthly training events" and one to access the New Hampshire State Loan Repayment Program that "provides funds to health care professionals working in areas of the State designated as being medically underserved and who are willing to commit and contract with the State for a minimum of three years (or two if part-time)." The website offers links to technical assistance and regional and national training resources (New Hampshire Department of Health and Human Services, 2016).

> The Health Resources & Services Administration awards grants designed to:
>
> > increase access to quality opioid use disorder (OUD) and other substance use disorder (SUD) treatment by increasing the number of professionals and paraprofessionals trained to deliver behavioral health and primary care services as part of integrated, interprofessional teams in HRSA-supported health centers. (Health Resources & Services Administration, 2018)

These and related HRSA grants offer funds to behavioral health sites meeting criteria as serving underserved populations and also to the professionals who are willing to commit to working at one of the designated sites, in some cases reducing the repayment of student loans with a generous waiver, or reducing the term from a 10- to 30-year process to six years.

As of 2010, the National Association for Alcoholism and Drug Abuse Counselors (NAADAC) was "working to standardize the certification process for addiction counselors nationwide, beginning at the college education level, so that all addiction counselors have the same educational and experiential background" (G. Miller et al., 2010, p. 51). Hagedorn et al.

(2012) found that "many who sought such initial training through a graduate program in the helping professions found that the majority of such programs were woefully unprepared to deliver the necessary addiction-related content they required" (p. 127). Participant 8 shared about her graduate school experience: "it was a program that was sort of cobbled together that one person sort of spearheaded."

Addiction as a specialty. There were still no uniform national curriculum standards in the United States as of 2008 (G. Miller et al., 2010). Participant 1 shared: "substance use disorders are in the DSM, technically speaking, we're all qualified to treat whatever's in there" with a clinical degree, without a specialty. Participant 10 shared her concern that "I think that there's an illusion out there that you can treat somebody in a mental health setting without having to treat their addiction." About social workers, nurses and other medical staff, and therapists with no training in addiction, Participant 1 shared "I don't think they understand addiction at all, to be honest . . . try getting a psychodynamic privileged white older man to understand" that he is not sufficiently trained by a general social work, medical, or psychology program to understand and work with addiction. She explored this general clinical Education and experience gap further:

> But that would just be like me trying to treat somebody on the [Autism] spectrum. I know nothing about it. I'm not trained. And so it's practicing outside of their scope. It's not a reason that is spoken a whole lot, but I think that it underlies a lot of the decision-making. It's like that feeling you get when you know you're outside your scope of practice when you're like, "I got to refer this person."

For those who are licensed therapists, there is an ethical expectation to stay within one's training and Education as a Scope of Practice. As stated in the ethics document of the American

Counseling Association (ACA) section C.2 under Professional Responsibility, Boundaries of Competence:

> Counselors practice only within the boundaries of their competence, based on their education, training, supervised experience, state and national professional credentials, and appropriate professional experience. (American Counseling Association, 2014)

Morgen et al. (2012) contend:

> If the practice of addiction counseling really is a part of counseling . . . then the time has come to *recalibrate* the rest of the counseling profession to better fit an inclusive and unifying professional counseling identity that *includes addiction counseling*. (p. 58, italics in original)

The "professional counseling identity," however, may not be the only recalibration needed. If, as Hagedorn et al. reported as late as 2012, psychologists are not being trained in addiction, the Education of psychologists will need an upgrade. They report that:

> practice areas described for professional psychologists include clinical psychology, counseling psychology, school psychology, and other areas of professional psychology, with no mention of an addiction practice area. . . . Whereas the Accreditation Council for Graduate Medical Education (ACGME) does have specific training standards for psychiatrists working with addicted patients, (a) all of those standards are specific to those programs that train addiction specialists (i.e., they are not for the general training of psychiatrists who see addicted clients in a variety of treatment settings). (Hagedorn et al., 2012, p. 27)

Morgen et al. (2012) went further, identifying the lack of specialty training a clear risk:

> the danger is that well-intentioned, well-trained counselors will enter the field *technically* qualified to counsel individuals, but *philosophically* lacking the integration of theory and practice necessary for treating addiction. (p. 60, italics in original)

Participants in the grounded theory interviews presented in Chapter IV reported their own struggles with whether they would seek additional training in addiction counseling, either during

their graduate schooling or after, at the cost of extra time and expense (see the exploration of Licensure later in this chapter). Participant 13 shared: "even though you were licensed or whatever level you were at, there was a certain amount of education you were expected to get every two years to be eligible" to renew licensure [see the section below on Continuing Education]. Participant 11 shared that she initially did not want to work in addictions: "I was very naïve growing up to substances . . . I wasn't interested in them . . . I was never around them . . . I knew my brother had a problem with substances. But that didn't even come out until he was older." Even here, we can glimpse the underlying Stigma that only people in recovery would specialize in addictions, and if a student did not see themselves in that Stereotype, they might think they would not fit in to the role.

As Participant 7 reported about the late 1980s and early 1990s:

> I'm a social worker. I got [a master's in social work] MSW. I got my license, MSW before I got a license for an alcohol and drug counselor. It's kind of interesting. The field over the 30-odd years slowly, probably in the last maybe five to ten years, decided to go education based. I would say, the second half of my career there was more acceptance that you needed to be getting your master's, this is part of growth and recovery, no matter where you were on that recovery line.

As Participant 10 shared: "you work with *those* people. . . . I think there is a stigma in our profession . . . there's such a stigma around addiction [that] I think it extends to people that work with people in addiction." There remains a strong "belief that addictions, and the problems they cause, are the treatment responsibility of those who have traditionally been prepared to address them," in other words, peer counselors who are themselves in recovery and owe their credibility to experience rather than clinical training (Hagedorn et al., 2012, p. 128). If most people believe

that therapists specializing in addiction are in recovery themselves, the Stigma radiates across therapist and client alike in a phenomenon known as Stigma-by-Association.

Education has exerted significant pressure on participants at all stages of their careers. For those who were mid-career during the transition, the struggle point was whether or not it would be to their benefit to, as Participant 13 shared, make the move from "a gut full of instinct" to a "head full of theory." No matter what stage of work life participants were in at the time of the interview, they reported feeling misrepresented, undervalued, and misunderstood as clinical, professional colleagues.

While the National Association for Alcoholism and Drug Abuse Counselors (NAADAC) and the Substance Abuse and Mental Health Services Administration (SAMHSA) continue to provide information supporting the reality of Professionalization of therapists who specialize in addiction, the silent (and not-so-silent) actors of Stigma, Stigma-by-Association, Stereotyping, and Discrimination continue to thwart full parity in word and fact. Discursive othering continues both implicitly and explicitly. Many participants reported a strong felt sense of being perceived as an "other" among medical and clinical professionals.

Accreditation. Certification and credentialing compose a second layer of Professionalization that supported the movement from counselors to therapists specializing in addiction. The difference between Certification and credentialing is defined best as:

> *Certification,* which is often voluntary, is established by professional groups monitoring the professional behavior of their counselors . . . *credentialing* is a process handled at the state level. (G. Miller et al., 2010, p. 51, italics in original)

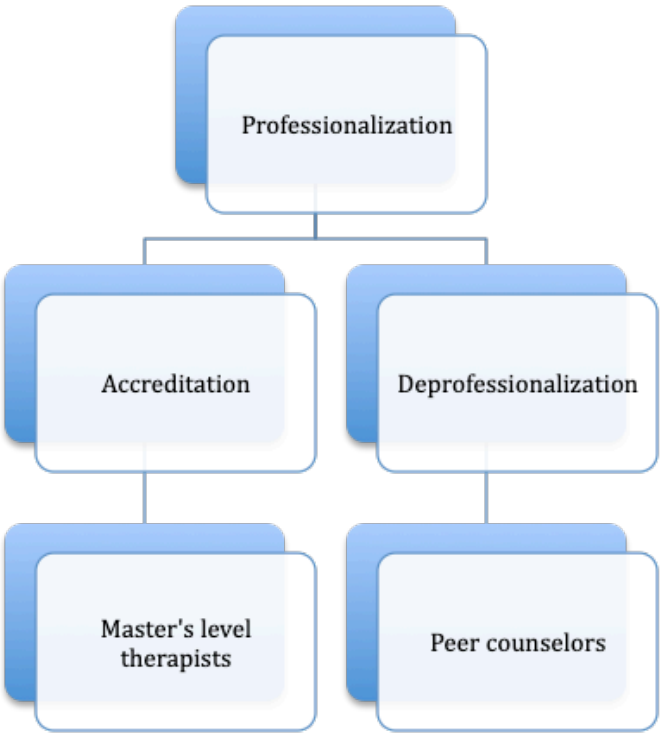

Figure 5.2. Societal factors impacting Professionalization through Accreditation.

The National Board for Certified Counselors (NBCC) was founded in 1984 and offers board certification exams for those students who complete a graduate degree in a Council for Accreditation of Counseling and Related Educational Programs (CACREP) accredited counseling program, and just to confuse the definition just provided, that have since become part of the licensing (credentialing) requirement for many states. Clinical mental health programs took the lead in accepting accreditation standards and training a workforce of therapists prepared to deal with co-occurring issues. As Hagedorn et al. reported:

> CACREP has made efforts at establishing minimal educational standards related to addiction counseling . . . these were traditionally relegated to those graduate programs with a more clinical focus (e.g., mental health counselors) . . . students matriculating from other specialties (e.g., school counseling, marriage and family counseling, etc.) have continued to be unprepared. (p. 127)

According to White, “In the early 1970s, the federal government acted to both expand and organize alcoholism and addiction treatment services. . . . The second milestone of Professionalization involved the development of professional associations and credentialing processes for addiction counselors” (White, 2000, p. 9). Two of the professional groups involved in certifying professional therapists at the general level will be explored as they relate to therapists who specialize in addictions: CACREP and the American Mental Health Counseling Association (AMHCA).

The Council for Accreditation of Counseling and Related Educational Programs was established in 1981 and is most involved in creating consistent standards for education of therapists at the graduate level. The 2009 CACREP standards promoted the “creation and inclusion of a set of specialty standards related to addiction counseling” (Hagedorn et al., 2012, p. 124). From 2008 “all future CACREP-educated counselors would be exposed to information regarding the impacts of addictions and addictive behaviors, as well as the necessary prevention, intervention, and treatment methods” (Hagedorn et al., 2012, p. 129):

> CACREP became the first accrediting body to formally establish a set of national educational standards related to addiction counseling. Whereas psychiatry may have a specialty in addiction medicine, the fact that social work and psychology have no such specialty puts counseling at the forefront of providing direct care to the millions impacted by addictive disorders. (Hagedorn et al., 2012, p. 130)

Master’s level therapists. Many therapists who graduate from clinical mental health programs continue to affiliate with the ACA, which was the parent professional organization of AMHCA (Goodman, 2019). AMHCA is now the specific professional organization for clinical mental health professionals, who are trained in the specialty area of addiction counseling as part of their graduate school’s CACREP certification standards. AMHCA:

> has taken a strong position on the need for high counselor preparation standards in the establishment of licensure, credentialing, and reimbursement for services by third parties such as federal and private health insurance companies. . . . AMHCA has sought rigorous standards for CMHCs because it believed that strong preparation standards would result in the profession being compared favorably with other clinical mental health professions such as clinical social work and clinical psychology. (Field, 2017, pp. 9–10)

Other professional associations include the National Association for Addiction Professionals (NAADAC), state and local associations such as the Vermont Addiction Professionals' Association (VAPA), the American Association for the Treatment of Opioid Dependence (AATOD), and the National Association of Addiction Treatment Providers (NAATP), among many others. These professional associations, with their codes of ethics and educational standards, provide momentum for Professionalization. Codes of ethics are introduced at the education, licensing, and credentialing levels. They describe expected and prohibited behaviors, both proscriptive and aspirational, and are a fundamental difference between counselors and therapists who embrace (White, 2019).

De-professionalization. While Professionalization was changing not just the idea of who was most capable of (and appropriate for) providing care for clients with addiction, but creating momentum away from "the concept of addiction care as a social service, to address a social problem, not a health problem" (Roy & Miller, 2012, p. 109). This echoes the literature review presented in Chapter II on the origins of the addiction field. In 2006, even as researchers were "Encourag[ing] all states to require the credentialing of both substance abuse and mental health counselors," there was also a parallel De-professionalization movement (Amodeo, 2006, p. 169). In the second decade of the 2000s work began to shepherd lay counselors into a form of credentialing that did not require a master's degree, so their valuable experience would not be

lost to their colleagues and clients: “to provide a mechanism to grandfather into the profession those addiction counselors who had long worked in the field and provided outstanding services” (Morgen et al., 2012, p. 59).

The pressure against Professionalization is maintained by cultural Stigma against people who have addiction and the therapists who work with them. Stigma-by-Association has “led to the phenomenon labeled by Googins (1984) as [the mental health and medical professions’] ‘avoidance of the alcoholic [and drug-addicted] client’” (Googins, 1984, p. 161; Whitley, 2010, p. 354). White opined that Stigma is exactly what left the field open for a new specialty, in the gap between increasing urgency of need and those skilled helping professionals who were unwilling to meet it:

> the nation was declaring war on alcohol and other drug problems in the 1970s, but the nation had no troops prepared to wage this war . . . a “new profession” [licensed alcohol and drug counselors] was born. New agencies and a new profession to treat alcoholics and addicts emerged to fill a void created by the contempt with which alcoholics and addicts were regarded by traditional helping professionals. (White, 2000, p. 5)

Peer counselors. Due to factors limiting access to equal clinical treatment, identified as including difficulties recruiting and retaining qualified therapists, inadequate compensation for those therapists (see discussion on Pay Rates to come), and lack of Insurance Parity for prospective clients and the people who treat them alike, there is a national interest in reviving peer counseling specifically through peer recovery coaching (L. Kaplan, 2012, p. 5). Creating and enhancing roles for peer counselors is a return to previous practice-as-usual, not a new phenomenon. The salient point for this discussion is that therapists specializing in addiction who became Educated, Credentialed, and Licensed in response to the Professionalization movement,

are now themselves seen as broken gears thwarting adequate response to the current Opioid Epidemic. Therapists who have not been able to survive the social and organizational pressures against them, and have de-specialized because of them, have left a treatment gap again being filled by "professional helpers":

> The use of recovered people as professional helpers has been continually rediscovered over the past two centuries. The ascension of this practice has often involved recovered people filling a void within a stigmatized arena that attracted only a small number of professionals. (White, 2000, p. 15)

Whether the field of professionals attracted to this Stigmatized arena was small or large, it was untenable.

The pressure on lay counselors working in addiction can be intense. "A.A. members invited to work as alcoholism counselors with no qualifications for counseling other than their AA membership often discovered that they were unable to cope with the demands and stresses of a job for which they were ill-prepared" (White, 2000, p. 7). Counselors and peers in the 1980s were known to "work . . . an unconscionable number of hours per week at rates of pay that would be incomprehensible by today's standards" (see discussion of Pay Rates to come; White, 2000, p. 6).

By 2000, "[t]he percentage of those with a recovery background who work as addiction counselors has been reported as low as 7% in community mental health centers and 14% in inpatient [Veterans Administration] VA programs; as ranging from 35–40% in methadone and outpatient drug free programs; and as high as 70–75% in private inpatient programs, detoxification programs, and halfway houses" (White, 2000, p. 18; Humphreys, Noke, & Moos, 1996; Mulligan, McCarty, Potter, & Krakow, 1989; Aiken, LoSciuto, & Ausetts, 1985). Note the

discrepancy in percentages, with a higher percentage of counselors finding work in jobs being available in "methadone programs," "detoxification programs," and "halfway houses." And yet, "Over half of certified addictions counselors surveyed nationally acknowledge recovery status" (White, 2000, p. 18; Birch & Davis Associates, 1984, 57%; McGovern & Armstrong, 1987, 70%; NAADAC Education and Research Foundation, 1993, 63%; NAADAC Education and Research Foundation, 1995, 58%; Roman & Blum, 1997, 62%; Roman et al., 2004, 47%). The difference appears to be, as Participant 6 recognized it: "Whereas [the] mental health profession, I think, has always been a profession. It wasn't people with chronic mental health issues helping other people."

Recently, the momentum has reversed toward providing a role for peer counselors. Peer recovery coaching is currently enjoying the support of the Substance Abuse and Mental Health Services Administration (SAMHSA). In SAMHSA's 2009 publication exploring and explaining Peer Recovery Support Services, the administration detailed four types of support peer supports can provide: "emotional, informational, instrumental, and affiliational" (SAMHSA, 2009, p. 6). Peer coaching "refer(s) to a one-on-one relationship in which a peer leader with more recovery experience than the person served encourages, motivates, and supports a peer" (p. 7). This relationship is envisioned as "highly supportive, rather than directive" (p. 7). Peer leaders are expected to run support, educational, recovery-oriented, and activity groups and may be paid for these services. In thinking about this retrenchment toward
De-professionalization, Participant 13 shared that, in her opinion: "they want to create more recovery coaches. It's light work."

The transition to a professional, clinical work force seemed as if it would be accomplished as a practical fact in the first decade of the 2000s and it is interesting to see a resurgence of, and reactions to, a peer recovery workforce. This workforce runs parallel with case management and clinical social work teams in the hospitals and jails and, at least at one Turning Point Recovery Center, has a parallel training and supervision process in place.

Where the nonclinical overlaps with the clinical could be most clearly seen in a Turning Point Recovery Center program that places peer recovery coaches in emergency rooms to sit with and care for people who are experiencing withdrawal and trying to figure out where to turn for help after the acute crisis has passed. This practice echoes back to a time when AA peers would provide amateur "nursing" care for people withdrawing from alcohol in hospitals where these patients were too often unwelcome and highly Stigmatized. These recovery coaches are reimbursed for their time in the hospital and receive more than just the one-week training for those working in nonclinical environments. Recovery coaches are expected to bridge a semi-sponsorship role and the clinical world so that they can work alongside medical and mental health staffers in a stressful setting.

While some of the concerns voiced by therapists about counselors may seem like professional jealousy, the parallel peer recovery movement has stalled the Professionalization momentum in significant ways. Speaking about nonclinical peers doing semi-clinical work, Participant 19 shared her concerns about a current client working as a recovery coach:

> I do not feel that she in any way has the skill set, the stability, or the capacity to do this. She's on disability. People on disability are allowed to make a certain amount of money and here's a way where she can make a lot of money. She's going to get mileage to go to people's houses. She's already referring to them as

> her clients, which I don't think that's the language maybe that they're taught. I don't know, because I haven't seen the training. That's not a peer-to-peer word.

Recovery coaches are not subject to a Professional code of ethics and in most states as of this writing are not mandated reporters. Therapists who witness or suspect that a client might be at imminent risk of harming themselves or others, or abuse or neglect of a vulnerable adult or minor child, are required by law and ethical code to report that concern within 24 hours. Recovery coaches have no such mandate, except as general adult persons are mandated to report child abuse in Arizona and California. Therapists are also often named in releases of information from external stakeholders, such as child protective services and probation and parole offices. Recovery coaches, as nonprofessional private citizens, are under no such mandate. It seems likely that some people, out of anxiety about what might be shared and the delicacy of accountability in these situations, might avoid professional help.

Turning to counselors to fill a therapist gap that has been created by social and organizational pressures that lead to burnout and job turnover among professionals is only a band-aid measure and may, by itself, be enough to reverse the momentum of Professionalization. The current supports for Education and Accreditation have been fortified because of the increased need for therapists during the current Opioid Epidemic. If states turn toward a nonprofessional workforce, the danger is clear: the most vulnerable populations will be once again left to the undoubtedly committed care of those who are not educated about co-occurring disorders, are not working from a code of ethics, and do not have a responsibility to work within their narrow Scope of Practice or under the support of Clinical Supervision to know where those boundaries lie.

Licensure. People interested in becoming therapists specializing in addiction need an accredited graduate Education to become licensed now that "counseling has become recognized as a regulated profession in all 50 states" (Field, 2017, p. 4). To begin this exploration, it is perhaps a good time to borrow a clarifying definition of the terms: "*Licensure* means that counselors cannot practice or identify themselves professionally without having passed required exams and meeting certain criteria" at the state level (G. Miller et al., 2010, p. 51, italics in original). In service of Professionalization of an addiction workforce, Licensing requirements were established on a state-by-state basis "similar to professional counseling via mandated supervised practice hours and education across a subscribed addiction curriculum" (Morgen et al., 2012, p. 59). The minimal requirements for most states are as follows (G. Miller et al., 2010, p. 53):

Table 5.2

Minimal Requirements for Licensure in Most States

Level I (unlicensed) [herein designated as a counselor]	Levels II and III (licensed) [herein designated as a therapist]
Work experience	Work experience
Volunteer experience	Work experience with a bachelor's degree
High school diploma or general equivalency diploma	Work experience with a master's degree
Associates degree (for some states)	Education/training/classes
Supervision	Supervision
Ethics	Ethics
Written and/or oral exam (for some states)	Written and/or oral exam
Recertification	Recertification

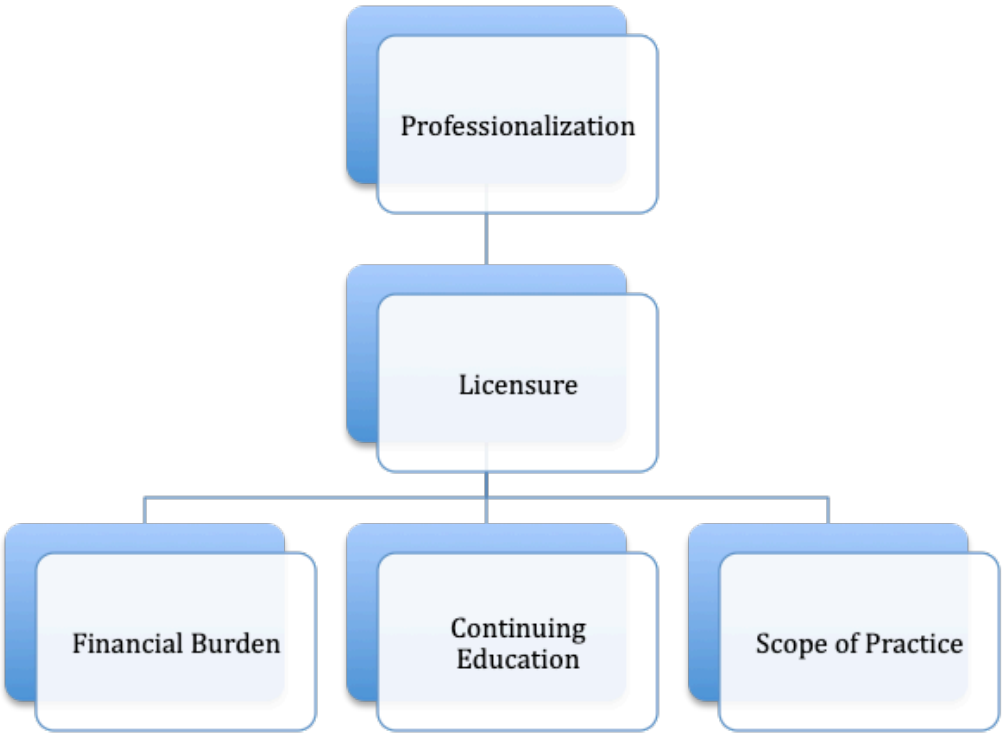

Figure 5.3. Societal factors impacting Professionalization through Licensure.

Most diagnoses in the *Diagnostic and Statistical Manual of Mental Disorders* (DSM 5) do not require their own specialty Licensure in order to present oneself as qualified to work with clients who have those disorders. Therapists specializing in addiction, however, may be required to carry the extra expense and effort of an additional license, additional Certifications and credentials, additional requirements to receive and maintain Licensure once earned, and additional focused Continuing Education. As Participant 18 reported: "There's also not a lot of specialty degrees. There's no 'borderline licensure' or something. There's like an autism certificate that you can get, but [licensed alcohol and drug counselor] LADC is kind of like a unique thing." According to Participant 2, "Licensure started out about protecting people,"

clients and therapists alike, but now "it's a game." Participant 6 found the process to be discriminatory, in a way that:

> undermines your experience as a professional. When I got my MLADC, it felt like a huge accomplishment in so many ways. Then I got my LCMHCA a few years after that. The interesting piece in New Hampshire is those are two separate boards . . . it felt like you had to prove yourself to the board that you were an ethical professional.

Financial burden. As presented in Chapter IV, Participant 6 shared her concern that she "had to do two separate renewal applications. I had to pay two separate fees. . . . That's a big chunk of money." Continuing to use the state of Vermont as an example, and as reported earlier in Chapter IV, licensed alcohol and drug counselors pay $270.00 for biennial renewals, whereas clinical mental health counselors pay $150.00. The combination adds up to a hefty $420.00 and does not include malpractice insurance and similarly bifurcated (state and national, mental health and addiction) professional dues or fees to maintain specialty certifications such as the master addiction counselor (MAC) national credential. Participant 16 shared her ongoing concerns about the difficulties she anticipates in earning her license as an alcohol and drug abuse counselor: "The whole thing pisses me off a little bit just because it's a lot of effort and a lot of documentation for not a lot of reimbursement." In both community mental health and not-for-profit agencies, the typical reimbursement is a one-dollar-an-hour increase for the first, but not successive, licenses. Therapists who specialize in addiction are now *more* credentialed than general mental health counselors and continue to suffer Stigma, Discrimination, and unequal Pay Rates. Participant 6, who eventually "decided to drop [her master licensed New Hampshire alcohol and drug counselor] MLADC" credential, reported:

> there were only certain number of trainings that I could use for both so then it was extra investment in trainings. Even the peer collaboration, I found that I had to argue that it was acceptable to meet with an [licensed social worker] LICSW or an [licensed clinical mental health counselor] LCMHC to count towards my MLADC hours. It's like, *okay.* Headache after headache . . . doing it and trying to twist myself into a pretzel figuring out [Continuing Education hours] CEUs and peer collaboration and documenting everything and having all the proper paperwork. (italics added to capture her emphasis)

Due to the inconsistent training available in different graduate schools with widely variant curricula, "some providers feel that they are being forced by private payers to get two licenses for their staff—one for mental health, and one for substance abuse" (Knopf, 2009, p. 4).

As reported in *Alcoholism & Drug Abuse Weekly,* "It's actually harder to get a LADC than a mental health counselor license" (Knopf, 2009, p. 5). Participant 3 agreed:

> They made it difficult, too, having your LADC. There was more paperwork involved. They were paranoid. They would check everything. You had to send in all the paperwork, all the [documents related to Continuing Education credits] CEUs, and if they weren't signed right, they would send them back.

She eventually relinquished her separate alcohol and drug license (De-specialization). Participant 7 remembered the process with a verbal wince: "It took me three times to get my license. That was back when we had orals. The first time I took it, I failed because if you miss one question you fail. By then, I probably was in the field ten years and people knew that I did good work." Add to this pressure the new Interlock devices that act as an added silent De-professionalization trend away from requiring that clients who have earned driving while impaired charge see a licensed alcohol and drug counselor to certify that they have received and successfully completed specialized, or indeed any, treatment. Interlock devices are breathalyzers wired into a car's electrical system that require a breath sample at random intervals while the driver is operating the vehicle. If alcohol is detected, or if the operator refuses to comply, the device shuts

off the car in an attention-getting manner [car disabled, lights flashing, horn blaring]. It is much less expensive, to the client and to the insurance companies, if the Interlock device mechanically polices their sobriety while driving, rather than requiring treatment to change the behavior.

Continuing education. Using the state of Vermont as an example, licensed alcohol and drug counselors participate in 20 hours of Continuing Education in order to renew their licenses every two years. The philosophy behind requiring Continuing Education is solid and admirable. One study reported that, among other benefits, therapists who participate in Continuing Education showed a 76 percent greater ability to deal with difficult clients (Jameson, Stadter, & Poulton, 2007). Continuing education provides a bridge between what was state of the art during the therapist's graduate education and new developments, between research and practice, in alignment with the Continuing Educational requirements of other health professions (Felch & Scanlon, 1997). Many options, both virtual and bricks-and-mortar, for Continuing Education workshops are offered for therapists. Most agencies will offer education supports including paying for the accredited conferences, paying the day's salary as if the therapist were at work (notably, not a benefit available for fee-for-service workers), or even hosting workshops and conferences on site. Workshops vary from an hour to half-day (usually three-and-a-half contact hours) to day-long (usually six contact hours), to multiple days at a time (especially for those conferences offering credentialing). There is an expectation, and even often a requirement, that therapists attend at least six contact hours of ethics training each licensure period (usually two years). These conferences offer a chance to be part of a community of therapists interested in the same theories and modalities and a break from day-to-day responsibilities. They are a chance to explore new ideas and ways of working without making a full commitment to a specific practice,

a great benefit for life-long learners and their clients. For some, however, this "dabbling" has become unsatisfying: As Participant 6 reported, she no longer attends "day-long workshops. I don't do those anymore. I've made the decision that they're not worth my time. They don't do anything for me. I'm like now I'm going to invest in one big training hopefully every year."

For therapists specializing in addiction, there are specific requirements to maintain Licensure in the specialty. As mentioned earlier, there is a general requirement for six hours of ethics training, but for those licensed in alcohol and drug counseling, the requirement is specifically six hours of ethics related directly to substance abuse treatment. In rural areas, this could mean that, especially as renewal time approaches, access to specific ethics trainings may be limited. While the umbrella license (social work, clinical mental health, psychology) will almost certainly accept substance abuse-related conferences, the reverse is not always true. For Participant 6, this is the exact broken gear that convinced her to give up her license as an alcohol and drug specialist. She reported not having the money or the time off available to attend both her "one big training" a year and "day-long workshops" on other topics. Her licensing board did not accept the intensive training she had done, even though her Education in that field certainly was a support for her co-occurring clients and for her own development.

Scope of practice. Despite Education in general mental health, Credentialing, and Licensing, therapists who specialize in addiction are often burdened with a limited and limiting Scope of Practice. On the other side of this pressure is the reality that general mental health therapists and social workers may also be limited in their ability to work in addictions without specialized training.

Before the era of Professionalization, people who were interested in serving those suffering from addiction "worked as counselors, 'aides,' 'psychiatric technicians,' and 'house managers.'" (White, 2000, p. 6). Rather than Licensure and Credentialing, "Graduate of [Rutgers Summer School of Alcohol Studies] was about the highest qualification you could get" (White, 2000, p. 6, quoting a personal interview with Schulstad, 1998). It is interesting that some of the now-retired participants in this study attended Rutgers Summer School of Alcohol Studies at the end of its life as a two-week intensive training program.

In the early days of the profession, counselors and fully qualified therapists working in addiction-focused departments were encouraged to refer clients with mental health issues to other therapists. As recently as 10 years ago, Knopf (2010) could report that "the days of referring to someone else are fading, with 'no wrong door' now the prevailing philosophy" (p. 5).

For those therapists specializing in addiction who were in practice before the advent of the 21st century, there remain questions and concerns about taking on the responsibilities of a therapist. This culture arises from the training received at places like the Rutgers Summer School, where therapists were socialized to call themselves counselors. In working across semi-permeable boundaries between disciplines, it can be surprising when encountering "an often unrecognized cultural divide" (Whitley, 2010, p. 343). Whitley (2010) reports: "[b]ecause they have markedly different histories, social work and addiction counseling professions have distinct cultures" (p. 344).

Far from continuing the historical limits on Scope of Practice, therapists specializing in addiction who are trained in CACREP-accredited graduate programs can look forward to joining

their medical colleagues as behavioral health interventionists who might "work in primary care medical clinics offering direct counseling services, and in many cases, helping the other members of the medical team to understand addiction" (Roy & Miller, 2012, p. 113). According to Knopf (2010), expanding the Scope of Practice is essential "[i]f the addiction world is going to compete in the marketplace with social workers and psychologists, we have to have a scope of practice that is competitive." As recently as 2009, whether trained in addiction as a specialty or not, "[i]f someone has a mental health license, they can also treat substance abuse—but not vice versa" (Knopf, 2010, p. 4). This limitation is still in effect in many agencies today, where licensed drug and alcohol counselors are expected to avoid diagnosing, let alone working with, mental health issues.

Looking back toward the early days of trained professionals working with clients who had addictions, Whitley recounts that social workers were generally inadequately trained for the work: "the mainly female social work professionals were unprepared to treat the predominantly male alcohol- and drug-addicted population" (Whitley, 2010, p. 344). Morgen et al. reported in 2012 that, given the currently consistent requirements for certification and credentialing "a separate licensure/credentialing process for addiction counseling seems antiquated" (p. 59):

> the additional supervisory and training hours required for addiction licensure/credentialing (in addition to the supervisory and training hours required for licensure as a professional counselor) *implies* that addiction content falls *outside* the professional counseling scope of practice. . . . Unfortunately, a system also was established that over 30 years reinforced the notion that addiction falls outside the scope of practice for professional counseling (i.e., the presence of a separate licensure and certification processes focused on *addiction* counseling). (Morgen et al., 2012, p. 59, italics in original)

And, as we heard from the participants interviewed for the grounded theory presented in Chapter IV, the financial burden of maintaining dual licensure, credentialing, and education is punitive given the lack of equity in Pay Rates.

By 2010, writers were identifying the need for nationally consistent guidelines for Scope of Practice:

> a national scope of practice document for counselors has been developed . . . by NAADAC . . . and is expected to help give the position of addiction counselor more clout with insurance companies. . . . There are four [proposed] scopes: 1) addiction professional in training (including faith-based); 2) first level (two years of education with addiction-specific coursework); 3) second level (bachelor's degree possibly including some clinical supervision as the field progresses); and 4) top level (Master's or Ph.D.), which also qualifies for clinical supervisor or administrator positions. (Knopf, 2010)

There is significant intersectionality between Scope of Practice and equitable reimbursement by third party payors, as highlighted by Knopf (2010): "It's essential to have a national scope of practice standard so counselors can get paid by insurance companies." Even with a national Scope of Practice, therapists specializing in addiction do not receive equitable reimbursement, and their clients do not have Insurance Parity for their services.

A therapist specializing in addiction often has such a limited, and limiting, Scope of Practice that Participant 2 decided not to take her board exams for Licensure as an alcohol and drug counselor because she was told during a pre-exam training that she would not be able to work with or diagnose mental health conditions. It is worth mentioning here that Participant 2 is both a nurse and a licensed mental health counselor who, presumably and demonstrably, has the training to work with co-occurring medical, mental health, and substance-related disorders. While the Professionalization movement promoted clear guidelines for Scope of Practice, it

stalled on the broken gear created by Stereotype and Stigma of therapists as *counselors* arising from the History of the Profession. Therapists specializing in addiction may themselves be under the false impression that they are not expected or allowed to diagnose, consider, or work with co-occurring mental health issues, despite their holistic training.

Federal parity laws. Whether insurance companies are willing to reimburse for services, and how little they are willing to pay, are conditions that put a great deal of pressure on therapists specializing in addiction. In this section, I will explore how failing to reimburse for addiction treatment has been an ongoing social justice issue; how the federal Parity laws, designed to require equal treatment of mental health issues, still failed in many cases to include payment for addiction counseling and the therapists specializing in addiction; and how Medicare continues to refuse equal standing for licensed clinical mental health counselors (LCMHCs) and licensed alcohol and drug counselors (LADCs) working at most outpatient sites (Centers for Medicare and Medicaid Services, 2019). The American Mental Health Counselors Association (AMHCA) has been working, with its parent organization, the American Counseling Association (ACA), for the past 25 years to gain equal standing without success at the date of this writing. It is perhaps important to reiterate here that CACREP-accredited graduate schools for clinical mental health counselors are the only master's level schools consistently including addiction training in their general educational requirements for conferment of the degree. This is still not true of graduate schools for social work, psychology, or medical schools (nursing or physician).

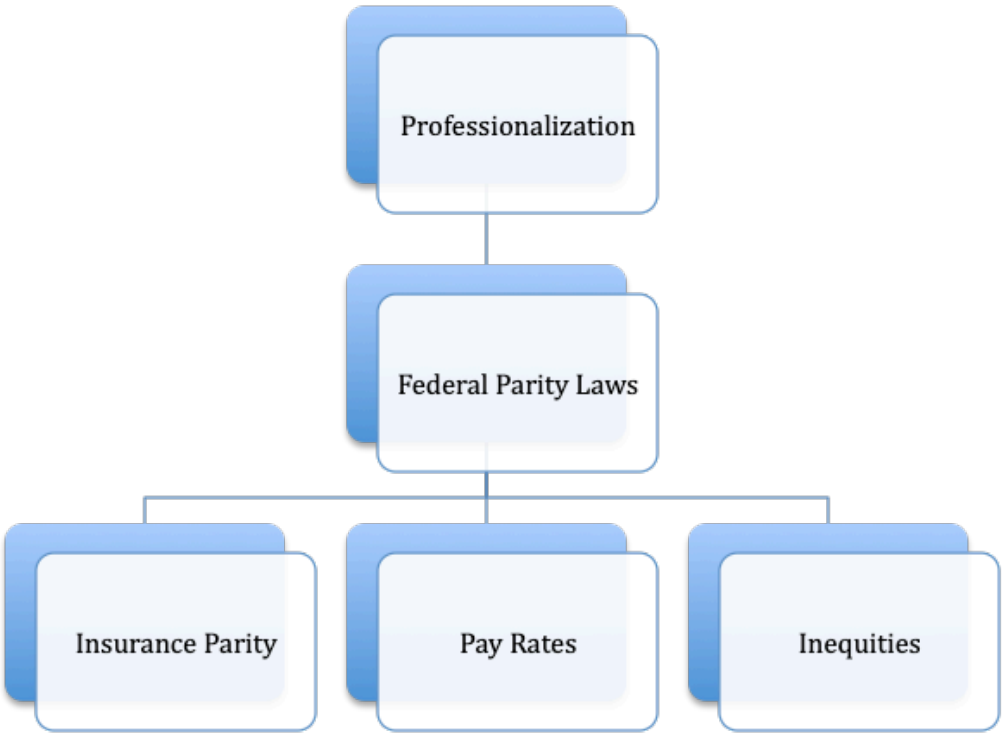

Figure 5.4. Societal factors impacting Professionalization through Federal parity laws.

Insurance parity. From the beginning of Professionalization in the mid-eighteenth century, when individuals with addiction were not even allowed into hospitals for the potentially lethal medical problem of withdrawal, reimbursement for addiction treatment has been a social justice concern (White, 2014). Very little reimbursement was available even up to relatively recently: "[i]n the 1990s, private insurance dollars paid for less than 10% of addiction care" (Roy & Miller, 2012, p. 109). In the latter part of the twentieth century:

> very few persons with addiction received any professional treatment; those that did received it in specialty outpatient or inpatient settings geographically separate from general medical clinics or hospitals; and those who received treatment had the costs of their treatment covered in almost 80% of the cases by public-sector funding mechanisms. (Roy & Miller, 2012, p. 109; Mark, Levit, Vandivort-Warren, Buck, & Coffey, 2011)

This is a perhaps a trend that will re-emerge in the context of De-professionalization. However, "[t]he growing trend by insurance companies to reimburse treatment for alcoholism led to the rapid growth of hospital-based and private for-profit addiction treatment units" (White, 2000, p. 5). In 2012, Roy and Miller warned (optimistically, as it turns out) of the imminent need for:

> addiction counselors and addiction medicine physicians (along with nurses, psychologists, physician assistants and clinical social workers who specialize in the care of addiction) [to] prepare themselves as addiction treatment moves from a social model and a criminal justice model of intervention and from a public-sector funded model of payment for services to a private sector, medical model of identifying and intervening with addiction and other substance-related health conditions, using payment systems that are like payment for other illnesses, and that may be very different from the predominant funding mechanisms of the past half-century . . . addiction treatment in America is becoming integrated into general medical care. (p. 108)

In the early days of health care reform, there were many concerns that including mental health and addiction treatment in reimbursement expenses would be unaffordable, and several researchers worked to puzzle out Parity's impact on the overall medical spending budget. Busch et al. (2014) found that "[i]nclusion of substance use disorder services in the federal parity law did not result in substantial increases in health plan spending" (p. 76).

Willful refusal of Parity creates a barrier to services between those who could pay for treatment out of pocket and those who could not: "People of means continued to support a self-pay intensive treatment model that was often in an attractive location and not supported by third party payers" (Roy & Miller, 2012, p. 110). Compare this concept of an "attractive location" to the locations of care photographs included in this study in Chapter IV. As is too often the case with medical care, "working class individuals had the greatest barriers to access to care, while impoverished people, criminal justice subjects and those well-to-do individuals in the

self-pay segment had the easiest access to care" (Roy & Miller, 2012, p. 110). This continues to be true today: in the state of Vermont, for example, Medicaid offers excellent insurance based on fair ability to pay and this provides access to treatment for vulnerable and marginalized populations as well as functionally working-class families. Unfortunately, not reimbursing therapists at comparable rates to those with private insurance. Therapists in general, and those who specialize in addiction, cannot make a career out of Medicaid reimbursement.

Many of our most vulnerable citizens have access to Medicare and Medicaid reimbursement for medical services, but for those with addiction, Medicare continues to reject billing from LCMHCs or LADCs as of this writing, although AMHCA continues to lobby for parity (Field, 2017). It is worth reiterating here that therapists trained as LCMHCs from CACREP-accredited universities are the only professionals routinely trained to address addiction. Not only therapists, but also "[p]hysicians working in usual medical treatment settings and paid by Medicare, Medicaid, or private insurance generally were not part of the addiction service delivery and financing structures that covered addiction treatment" (Roy & Miller, 2012, p. 109). According to several researchers, "Although a majority of states had previously enacted laws requiring parity for coverage of mental health disorders, many fewer states included [substance use disorders] SUDS in the conditions covered under their parity laws" (Busch et al., 2014, p. 76). The parity barrier runs counter to other humanitarian efforts during the current opioid epidemic.

Mental health treatment has fought its own battle to win semi-equal treatment from third-party reimbursement sources. In 2009, Knopf warned that any credible program should

"have licensed mental health counselors who, in terms of insurance, are on 'the same level' as a social worker" (p. 4). According to Field (2017):

> The counseling profession has attempted to gain recognition by Federal agencies as core providers of mental health services for more than 25 years. Both AMHCA and ACA have focused their legislative agendas on achieving the authority for licensed counselors to independently bill for reimbursable services without having another medical practitioner sign off on the insurance claims within the military healthcare system known as TRICARE [formerly known as the Civilian Health and Medical Program of the Uniformed Services], the Veterans Affairs system, and the Medicare system. (pp. 4–5)

As of 2012, in considering progress toward Health Reform, there appeared to be some hope that:

> Health Reform holds the promise that mental health and addiction care truly will be integrated into the mainstream of medical care . . . addiction professionals will have access to the mainstream systems of health care financing that fund primary care today. . . . Addiction will be viewed as an important health problem and addiction services valued as a means to reduce the incidence of . . . complications. (Roy & Miller, 2012, p. 115)

As of the fall of 2019, this hope has not yet been fully realized.

The National Association for Alcoholism and Drug Abuse Counselors (NAADAC) director Cynthia Moreno Tuohy was quoted in 2010, advocating for expanding education in order to compete with other professionals "[f]or third-party payers, you can't have someone with a two-year degree—you're going to have to be Master's level to compete for third-party payment. Lower level counselors would have to work under supervision" (Knopf, 2009).

While the momentum of Professionalization has presumably met Tuohy's (2010) bar for competition, as of this writing the struggle for true parity and equal access to treatment continues. An average salary, reported on Indeed in September 2019, remains under $17 an hour, a number that has remained stable over the past three years (Indeed.com, 2019). This number represents a small increase in pay, most likely due to cost-of-living increases. Interestingly, the

website also reports that the typical tenure is only one to three years, in alignment with the extreme job turnover rates reported in Chapter II and elsewhere. The perceived need for other health professionals to receive specialized training in addiction, rather than assuming competence without that training, has not shifted issues of Stigma, Stigma-by-Association, or Discrimination against therapists specializing in addiction.

Pay rates. In comparison with their mental health and medical peers, therapists specializing in addiction experience inequity in pay rates that is punitive and unsustainable. While it is common practice to consider post-graduate work prior to licensure as a sort of apprenticeship, with correspondingly lower rates of pay, this condition appears to continue post-licensure. Olmstead, Johnson, Roman, and Sindelar acknowledged, perhaps tongue-in-cheek, a "widespread belief that counselor salaries are relatively low" (2005, p. 181). Curtis and Eby (2010) stated this process even more pointedly: "clinicians have high caseloads and low pay" (p. 248). Participant 6 spoke poignantly about her experience: "I was passionate about the work. I adored the clients. I loved the team I worked with. Everything about it was nourishing. *The pay was abusive.* Getting paid, essentially, minimum wage with [a] master's degree" (italics added to show her emphasis). She eventually was forced to turn her focus away from clients with addiction to be able to afford to drive a reliable car. While working at an inpatient residential, she reported: "Staff didn't get a raise for eight years, not even cost of living . . . we will not pay you what you're worth."

Participant 4 stated, when thinking about the reimbursement difference between therapists who specialize in addiction and other behavioral and medical health specialists: "I don't think there's parity along those lines of recognizing people in the field who have a real

specialty beyond kind of a general practitioner." She shared that she has lived through periods of trying to make changes to outpace her burn out, out of the sheer grit of her character, telling herself: "'Okay, maybe I'll just roll up my sleeves and work hard and make more money and retire sooner,' and I kind of can't."

Inequities. Therapists in recovery appear to experience a second layer of Pay Rate pressures with the only difference being their recovery status: "counselors not in recovery earn $2,300 more than their in-recovery counterparts" despite the fact that they both have master's degrees (Olmstead et al., 2005, p. 186). The authors continued this interesting line of research and reported two years later on their expanded findings that:

> recovering counselors earn up to 50% less than nonrecovering counselors doing comparable work. . . . Compared to nonrecovering counselors, recovering counselors receive, on average and controlling for other factors, $2,580 less per year for a college degree . . . [there is] the possibility that recovering counselors are willing to accept lower pay as a reflection of their 'calling' to this work. (Olmstead, Johnson, Roman, & Sindelar, 2007, p. 31)

This inequity is especially powerful since there is a widely held Stereotype that ALL therapists who specialize in addiction must also be in recovery. There is no widespread, intentional inequity, such that therapists are asked whether they are in recovery or not at hiring. The Stereotype functionally generalizes lower pay to all who take on this specialty.

In the first decade of the new century, at a time when Professionalization had been struggling forward for 30 years, authors were still writing about Pay Rates for nonlicensed counselors and comparing their Pay Rates with credentialed and licensed peers:

> counselors with a college degree, master's/professional degree, or an MD/PhD earn, respectively on average $1,700, $7,900, and $13,200 more than their nondegreed counterparts. . . . Licensed or certified addictions counselors earn,

> respectively on average, $3,300 and $1,900 more than their noncredentialled counterparts. (Olmstead et al., 2005, p. 186)

Participant 18 reported that early in her career, as a post-graduate with a master's degree, "There was really no positive incentive [to get licensed]. I was only making a dollar more than the receptionist an hour, who was a high school graduate," not to mention that the receptionist was presumably a nonclinical employee of the agency. If Pay Rates can be seen as a way to signify the value placed on the job and the employee, then being paid at the level of nonclinical staff speaks volumes about how the agency views therapists working in addiction.

I would be remiss if I left out the general wage disparities in our culture that are based on gender and race, also, of course, putting pressure on therapists who specialize in addiction:

> Male counselors earn, on average, $1,200 more than female counselors. . . . White counselors earn, on average, $3,300 more than minority counselors. (Olmstead et al., 2005, p. 186)

Therapists who specialize in addiction have utilized strategies to ameliorate the wage gap problem. Participant 16 reported her strategy of taking on the leadership role of a "brand new department and brand new project": "I knew that just being a straight counselor was not sustainable for where I was in my life with not only one kid in college and one kid in med school." The potential efficacy of this strategy is affirmed by the research: "Counselors with an administrative role in addition to their duties as full-time counselors earn, on average, an additional $7,100" (Olmstead et al., 2005, p. 186). Many of the therapists interviewed for this research reported that they moved into a clinical supervisor role in order to make more money and reduce their caseloads. Participant 18 shared her experience of what that caseload could look

like for a post-graduate, unlicensed clinician: “when I started the agency, I started with a 60-client caseload and a full schedule.”

Taking on administrative responsibilities to make slightly more money as a strategy is the proverbial two-edged sword. Participant 8 shared: “As a supervisor, the carrot on a stick is a lower productivity requirement.” To put this in perspective, for $7,100 more in 2019 dollars, a clinical supervisor may see fewer clients, but is also responsible for supervising staff and interns, administrative tasks, and community interface while maintaining that somewhat-reduced caseload. There is rarely a one-to-one correlation between the responsibilities taken away from the supervisor and the responsibilities added, as was frequently pointed out by participants in the interviews. Participant 8 characterized this as: “the ridiculous amount of bureaucratic effectiveness we are supported to.”

Where a therapist works is also important financially, since those “working in [substance abuse treatment] SAT programs that are private for profit, accredited, and owned by a hospital earn more than their counterparts . . . that are public or private not for profit, nonaccredited, and not owned by a hospital” (Olmstead et al., 2005, p. 181). Community mental health agencies often subsidize the inadequate Pay Rates by providing Continuing Education opportunities and helping pay for licensure exams and annual or biennial renewal fees. As mentioned previously, this has become a sort of de facto apprenticeship for clinically trained newly graduated therapists, who are likely to move on once they achieve licensure. Unlicensed clinicians can, under the aegis of an agency, bill Medicaid for their services. Whether these clinicians are benefited full-time employees, or fee-for-service workers, they bear the burden of the agency’s need to pass along the low reimbursement rates available. Many newly graduated therapists will

find themselves with large caseloads made up of clients who have Medicaid. These therapists, especially those who are fee-for-service employees, have developed skills for making this work financially, if not supportive of their long-term wellness.

Often, like Participant 1, clinicians feel pressured to "book more clients to make sure that I get enough, that feels like enough, to make it work financially." This is the same participant who reported her first month's wage in a fee-for-service position was 36 dollars. Participant 18 remembered, with more than a hint of sarcasm (italics added to include her emphasis):

> it was advised to me, from the person that manages everyone . . . to have a lot of clients because then when there's a cancellation, I [still] get paid . . . 24 a week is considered full time so I was advised to schedule more like 30 to 40 [clients] a week. Which I tried but is exhausting so I had to cut back because *when they all show up it's not good*.

And, of course, as Participant 6 did after much soul-searching, many therapists give up their specialty licenses under the pressure of the untenable Pay Rates and hang up shingles as general mental health therapists or leave the profession entirely. Average yearly salaries for clinicians working in private practice have been reported as high as $150,000 (Steele, 2019). As of 2017, general mental health counselors working in community mental health made a median salary of $43,300, with a range between $55,850 and $33,960 on the lower end (*U.S. News & World Report,* 2019). If that discrepancy is not shocking enough, please remember to factor in the financial penalties for specializing in addiction treatment, gender, and race reported throughout this chapter. For Participant 6, and for many others, the wage gap proved too wide to sustain.

Stigma-by-Association

Alongside the major social arena of Professionalization is a second societal level pressure, that of Stigma-by-Association, that includes Discrimination and Stereotype of Addiction. Participant 8 reported that she recognized how much internalized Stigma she carried about her own chosen specialty and asked a salient question: "I thought LADCs were perceived as less professional, less valuable, maybe even less skilled [than] say MSWs. . . . I wonder if people who have MSWs are encouraged to get [a] LADC so they will be more marketable?" After much time and soul searching, she decided not to go back to school to meet the necessary conditions to earn a social work or general mental health license in addition to her license in alcohol and drug counseling. To be clear, Participant 8 had been trained as a therapist, but would have needed to "refresh" her education in order to qualify for an added license after many years in the field.

Stigma, a not-so-silent actor creating pressure for therapists specializing in addiction, is perhaps best defined and put in its historical context by Participant 6:

> I would say it's a shame-based system and it's very much a parallel process. I think the profession itself rose from addicts helping addicts and from that peer model, we have moved into the realm of "professional" and I think that there is this shadow of shame around it that the profession itself needs to prove, "oh no, we really are professionals."

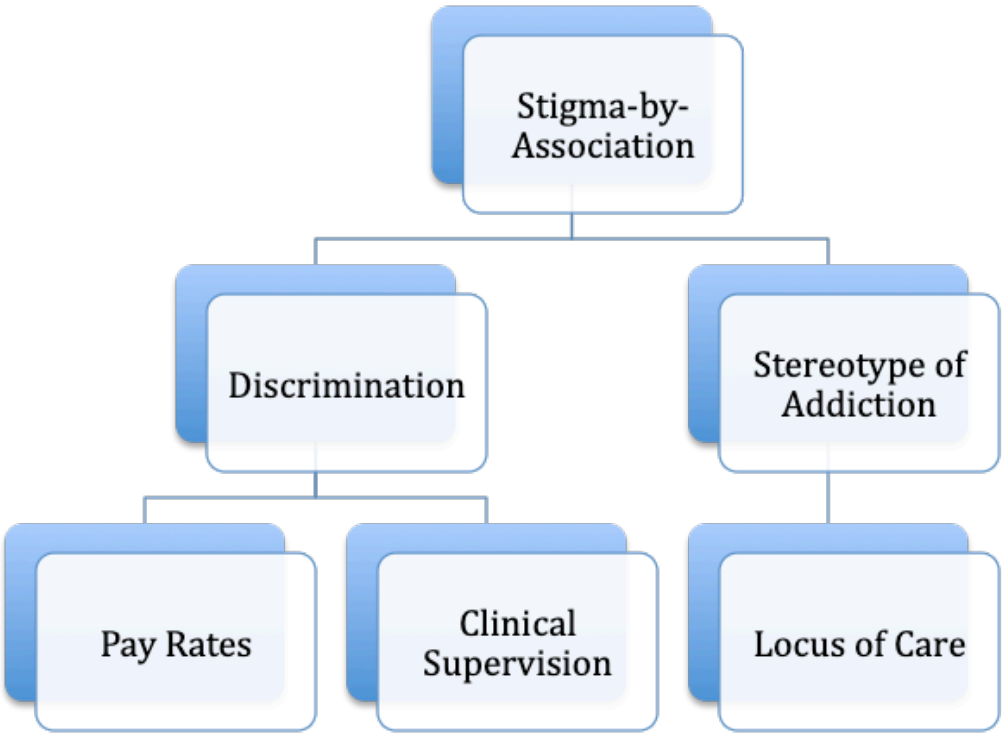

Figure 5.5. Societal factors impacting Stigma-by-Association through Discrimination and Stereotypes.

Discrimination. Participant 6 recounted her experience of Discrimination from colleagues and family members: "everybody who will enter this profession needs to prove themselves a million times over." She reported that "the attitudes of other professionals in the room" are: "you're just a substance abuse counselor"; "you are ignorant"; "you're uneducated"; "you couldn't get a better job"; "why would you work with that population?" And warned therapists considering going into the field: "They're not going to trust you. They're going to be disrespectful. They will be condescending."

Participant 13 poignantly characterized the impact of discursive othering she felt as a microaggression:

> That's how we were viewed, really. A recovery coach, certified alcohol counselor, kind of the same viewpoint, not as [a] peer . . . the mental health field looked at us as the stepchildren . . . we were perceived as not quite up-to-par. . . . Substance abuse counselors, addictions counselors, we were the "other." . . . They're *just* addictions counseling (italics added to show her emphasis)

She remembered:

> I was talking to a psychiatrist about the fact that I appreciated Anna Freud's work on the denial system and all the different levels of denial. I just started listing them and he looked at me and says, "You mean you alcohol and drug counselors know about those?" I'm like, "Uh, yeah." And he says, "And you talk about feelings in group?" And I'm like, "Yeah."

Why is there so much Discrimination and Stereotype of Addiction pressuring those who are working with clients who have addiction? According to Participant 15: "I think that other professionals are similar to people in the community. . . . I don't think that they categorize it as a specialty. . . . I still think that they sometimes clump it together with . . . I don't know, recovery coach?" Participant 6 reported: "Be grateful that there are any resources given to you because, ultimately, the people you work with are the forgotten people of our culture." She said of her value-based decision to take a job specializing in addiction, for as long as she could afford to financially and emotionally: "I felt like, in that moment, I decided to be the underclass of the underclass of a graduate degree professional." When working with the "forgotten people," therapists are tarnished by Stigma-by-Association.

Discrimination is perceived as coming from many angles. Participant 7 reported on her sense that it came "[f]rom my supervisors, from the people that . . . I work with. . . . Very critical, very negative and of course . . . there was a negativity, a sense of blame, the constant 'you're not measuring up.' . . . it's 'less than' in a big way." Participant 14 reported that she noticed Stigma coming from her nonprofessional friends: "working in addictions is perceived by my friends . . .

and acquaintances as a sort of dirty work. . . . [W]e're dealing with taboo and shadow and things people don't want to talk about."

Pay rates. I discussed how punitive rates of pay stall the momentum of Professionalization in the section presenting Federal Parity Laws. Here, I address how low pay intersects with Discrimination. I will mention here that most post-graduate therapists specializing in addiction will earn their license as an alcohol and drug counselor after 2000 direct hours of supervised work, or one full-time year, and about 18 months before being able to earn their license as a clinical mental health counselor. This is often met by agencies with a one-time, one-dollar-per-hour raise in pay and title, from an unlicensed to a licensed therapist. As Participant 18 reported, this meant that she would literally be making a dollar more an hour than the receptionist.

Clinical supervision. Supervision for therapists specializing in addiction is relatively new, highly problematic, and requires "experienced and skilled senior counselors who possess a wealth of formal knowledge and professional experience regarding substance use disorder treatment and evidence-based practices" (Eby & Laschober, 2014, p. 27). Participant 11 shared that "being a supervisor is a super passion for me" and she now invests most of her continuing education on clinical supervision trainings.

In contrast, however, as discussed earlier, many therapists specializing in addiction take on supervisory roles in order to reduce productivity requirements and pad insufficient salaries. The Center for Credentialing and Education (CCE) offers an Approved Clinical Supervisor (ACS) certification, with required training and continuing education necessary to maintain the credential, that presumably ensures supervisors have the appropriate training and experience.

According to the CCE (2019), only 15 states had adopted the ACS as a "credential of choice" for supervisors.

As noted in Chapter IV, many participants shared their difficulties with un- or under-trained supervisors, some even considered their supervisors to be a toxic influence. Participant 11 shared her concern for her site: "there's no training in master's or anything about being a Clinical Supervisor. . . . The Clinical Supervisor was awful. She was awful." Participant 18 shared her opinion that: "I think that a lot of the ingredients for a bad supervisor are also ingredients for a bad clinician, like no empathy, burnt out." She experienced actively predatory supervision in private practice: "supervisors that weren't paying me. In private practice, your supervisor gets the check from insurance companies and then you get the check from them and they wouldn't pay me and I'd have to wait." Participant 15 reported that she left her job due to the negative influence of a supervisor who was not licensed as a therapist, in an addiction specialty or otherwise, and was nevertheless hired as her clinical and administrative supervisor. At the time, she had been licensed for over 10 years.

Stereotype of addiction. Cultural stereotypes of people who have addiction and the helping professionals who work with them intersect with the History of the Profession to create a stereotype in parallel with the disdain with which many clinical and medical professionals hold people who have addiction. Therapists who specialize in addiction are often assumed to be in recovery themselves, also known as a "two-hatter," by clients, by colleagues, and by Licensing boards and Accreditation agencies (White, 2000, p. 4). Participant 6 relayed her experience of the attitude of her colleagues, with a modicum of sarcasm: "You are coming from the old-fashioned AA model clearly." This assumption arises from the reality that "[t]he history of

the wounded healer in the addiction recovery arena was until the mid-twentieth century a story almost exclusively about those recovering from alcoholism" (White, 2000, p. 1). As Participant 13 reported: "I get into this after about five years of recovery on my own." During that time period, and into the early twenty-first century, there was an opportunity for "recovered" clients to move into the role of "counselor," who could "not only acquire professional credentials, they could also specialize in work in particular settings" (White, 2000, pp. 10–11). Their earlier recovery experience was validated as a sort of apprenticeship for joining a helping profession and valued as a way to give back and came with its own baggage (Ball et al., 2002; Culbreth & Borders, 1999; Glover-Graf & Janikowski, 2001; Hser, Joshi, Maglione, Chou, & Anglin, 2001; Stoffelmayr, Mavis, Sherry, & Chiu 1999; Osborn, 1997). This tradition is probably not as visible for other helping professions, such as medical specialties, although it still no doubt plays a part in how medical professionals choose their specialty. It is certainly true of psychoanalysts and Jungian therapists, who engage in their own treatment prior to gaining certification to practice.

As late as 2007, Olmstead et al. were reporting that "recovering counselors . . . account . . . for 30–55% of all [substance abuse treatment] counselors" (p. 31) Participant 4 shared her belief that:

> People who are drawn into the addiction field, a lot of them are recovering addicts themselves who carry their own sort of burdens of shame and guilt and their own kind of wreckage from their addiction and recovery.

This History of therapists developing out of a personal recovery journey, and its accompanying expectations, puts a heavy amount of pressure on therapists with and without their own personal recovery histories. To borrow a hierarchical frame from the medical world (with

the blessing of Participant 9 who reported that "the Northeast is top-down. It's all shrink-led"), it creates pressures at the organizational level from all angles. Participant 11 reported simply that she did not feel like she fit in with counselors in recovery because she herself was not and had not acknowledged the issues her family members had with addiction. She shared that at the beginning of her career, when she did not expect to work in addictions and was more interested in other specialties: "I still viewed the field as, predominantly, individuals with past substance use problems were the ones that were into that realm."

This silent pressure is saliently visible around the issue of self-disclosure, which is a not usually a freely expressed element of a non-addiction–inclusive therapeutic relationship. There is, however, as Participant 8 shared, "a tradition of recovery counselors" sharing this personal information. This tradition is antithetical to the ethical, clinical guidelines of other healthcare professionals and is viewed with suspicion by colleagues, as a proof that the therapist must not be quite professional enough. Participant 2 suggested: "Self-disclosure is seen as naïveté," not quite the intervention of a *real* professional. "The modern debate about counselor self-disclosure suggests a movement from the personal to the professional/technical" (White, 2000, p. 14). And whether the therapist specializing in addiction actually does disclose or not, the underlying assumption that they are "two hatters," "wounded healers" and even "professional ex-addicts" leads to the next logical assumption that they *do* share too much information about their personal lives (White, 2000, p. 2). According to Participant 15: "I don't think that [colleagues] categorize it as a specialty like mental health treatment. I don't. I still think that they sometimes clump it together with maybe, even in the realm of, I don't know, recovery coach?"

The pressure can be even more intense from clients. When a client asks whether a therapist is in recovery, it is almost always a loaded question, guaranteed to alienate as often as it aligns. Those therapists without a personal recovery history reported self-disclosure as dangerous territory. As Participant 17 recounted: "because I wasn't a recovering person [the clients] really went for the jugular." Participant 7 reported a "certain amount of struggle about being taken seriously by people in recovery." This is perhaps especially problematic with the advent of a parallel treatment track. If the widespread belief is that only a therapist in recovery is qualified to treat addiction, then nonclinical peer recovery coaches will have more credibility than a professional therapist.

Those therapists who do share that they are in recovery, however, generally reported a positive reception from clients. Participant 16 shared that she utilizes self-disclosure therapeutically because she: "realized this isn't peer-to-peer recovery, but I think that it does something to help build the therapeutic relationship. If it helps somebody to hear that I've been where they've been then so be it."

Another issue that creates pressure for therapists specializing in addiction who have their own recovery history arises around the boundary crossings that occur when therapists work their program. Even though "recovering social workers have a right to meet their own needs and can serve as compelling role models to clients and colleagues in recovery" this is looked on with suspicion by colleagues (Reamer, 2003, p. 128). The artificial hierarchy, an "us versus them" again becomes visible here, as it does with self-disclosure. As Kaplan, L. (2005) reported: "A dichotomy is inherently part of these roles; one is either a professional or a client. Such dichotomy may not apply here as professionals in recovery may be said to bridge between these

two roles" (p. 84). Kaplan's findings were echoed by the lived experience of Participant 18: "you're a bridge between the recovery world and the clinical world."

The high percentage of therapists specializing in addiction who are also in recovery can also be a source of support and wellness: "recovery . . . represents an important anchor for an individual's self-identity . . . those who are in recovery will identify more with their profession, attach greater meaning to their day-to-day work tasks, and . . . experience a greater sense of meaning at work" (Curtis & Eby, 2010, p. 248). According to the same study, this effect also extends to those therapists who come to the work with a family, rather than personal, history of addiction: "counselors who are not in recovery themselves but have a close friend or family member who has struggled with an addiction may have deep-level identification with their work" (p. 253). This identification may ameliorate some of the organizational pressures that lead others toward burn out by lending them meaning as a price paid to engage in valued service. Participant 17 shared that her experience began at the very beginning of the Professionalization movement of the 1970s as a family member of a person with an alcohol use disorder when:

> Honestly, I was invited in. I had no background, whatsoever. . . . It was pretty amazing because then, I did things that when I'd go away to these conferences and trainings, people would say, "How do you do that? You can't do that." I was like, "Nobody tells me different and it works."

The transition to Professionalization moved from predominantly male counselors whose credibility and reputation arose from their recovery history to predominantly women in the behavioral health field whose credibility and reputation arose from education, credentials, and licensure. Participant 17, and others in the retirement-plus age demographic, were affected by this shift first-hand: "Oh, a new supervisor came on. He took one look at me and said, 'You're

out of here.' Small man syndrome. I was big, powerful. He didn't like it." Out of this period of whitewater emerged counselors trained to work holistically under the mantle of therapists: to go to school and jump through licensure and credentialing hoops that many found too burdensome to negotiate (Vaill, 1996).

Locus of care. One aspect of the societal and organizational challenges experienced by therapists who specialize in addiction is most clearly represented by the locations of care (see photographs in Appendix B) where they and their clients come together. How much Stigma are patients subjected to when they are seen entering a medical institution or a doctor's office? What do typical medical service locations look like from the outside? Contrast this with how much Stigma clients might feel when observed entering a methadone clinic. And what about the therapists who work there? What predictable Stereotypes prevail to inform passers-by about why clients and therapists are entering that location? Despite the widely acknowledged reality that addiction is a mental health issue, and that mental health issues are medical issues, all too often therapists and clients are relegated to available store fronts, abandoned properties, and gated industrial areas.

It will perhaps be interesting to see the places where addiction clients go to receive recovery supports, medically assisted therapy and peer recovery, and where clinicians and interns report to do their work day after day. These locations of care are a systemic manifestation of discrimination. It may be apparent that most of the photographs were taken from inside of the car: These are not walkable neighborhoods. As a visual example of the issue, I include the

photographs of the current Habit OPCO methadone clinic in Brattleboro, Vermont.

Figure 5.6. Habit OPCO, Inc., a for-profit methadone clinic, owned and operated by Tennessee-based Acadia Healthcare; copyright by author.

The front entrance has been decorated and is as welcoming as is possible. The clinic shares the building with an auto body and detailing business, behind a privacy fence.

Figure 5.7. Photographs of locations of care: Habit OPCO's surroundings; copyright by author.

Figure 5.8. Photographs of locations of care: Habit OPCO's surroundings; copyright by author.

What is perhaps most concerning about the for-profit parent company, Acadia Healthcare, is that it has reported to its investors that it expects to earn 3.15 to 3.2 billion dollars this year (Kinney, 2019). Many Habit OPCOs are located in closed retail stores in shopping plazas and in industrial parks, out of sight of the general public, with paper covering the windows for privacy.

To get a sense of the disparity in context on evidence here, one needs only compare the façade of the local hospital or a primary care doctor's office. Participants in this study identified

these locations as a clear indicator of the distancing strategy against problems others would prefer to remain invisible. Participant 5 addressed this directly, stating, "You've kind of got this 'Not in my backyard' [NIMBY] kind of thing." Although I did not often leave my car when taking these photographs, interns, clinicians, peer recovery coaches, and other helping professionals work at these sites every day.

Conclusion

I have attempted in this situational analysis, through identification and exploration of the social arenas and organizational issues that support the momentum toward Professionalization and the Deprofessionalizing impact of Stigma-by-Association, to highlight pressures at the social and organizational level that affect therapists who specialize in addiction. There are, no doubt, many other seen and unseen actors, silent and otherwise, to be found in this complexly intersectional and enmeshed context. I could have spent many pages discussing particular forms of parallel discrimination, such as ageism, ableism, and racism, that are salient to the lives of the participants in this study.

Therapists who specialize in addiction have been called on to adapt to many transitions across the history of the profession. And yet, their perception in the medical and clinical community has not kept pace with the Professionalization accomplished through education, licensure, and accreditation. Therapists continue to be seen in the same way that counselors were in the era before Professionalization. Persistent Discrimination continues a parallel process of discursive othering: *those* therapists are assumed to be in recovery themselves, because why else would someone chose to work with *those* clients? In the wake of the current opioid epidemic, nonprofessional peer recovery counselors are returning to the menu of treatment options and are

sometimes working alongside clinical professionals in hospitals and other treatment locations of care. Pay rates continue to be, as Participant 6 reported, “abusive” and unequal. And with the Stereotype of having an addiction in order to choose addiction work comes parallel Stigma and Stigma-by-Association.

Over the past 40 years, counselors have become therapists and peer helpers have been replaced in large part with highly trained clinical staff. Therapists specializing in addiction now have access to clinical training in their specialty within their graduate programs. Licensing, certification, and credentialing are recalibrating to become more consistent nationally so that each professional working in addiction has a similar range of experience and education. Insurance companies continue to deny parity in reimbursement for mental health and addiction, leading to the exclusion of many clients and to create real, if not acknowledged, barriers to therapists remaining in the field. Scope of Practice continues to be limited, as if these specialists were not fully credentialed therapists. The Stereotype of the therapists as counselors (a nonclinical, Stigmatized, and nonprofessional specialty) continues to haunt therapists specializing in addiction, despite a 30-year trend toward Professionalization. As I presented in the section on De-professionalization, there is a significant trend toward creating a parallel nonclinical workforce to meet the challenges of the current opioid epidemic.

In Chapter VI, I will move from this grounded situational analysis to propositions about what is going wrong and ideas for how society at large and organizations in particular might reverse the trend toward De-professionalization we have identified here. These theories are firmly grounded in the lived experience of the therapists who specialize in addiction and the

professional literature. I will start the chapter with a model of the current reality and offer leaders and change agents some grounded action steps.

Chapter VI: Discussion and Conclusions

In the previous two chapters, I have attempted to disentangle the dimensional, social, and organizational processes identified through this research. In this final chapter, I begin by presenting these processes holistically with the organizational assistance of a theoretical model that holds therapists, clients, and their ability to thrive at the heart of concentric levels of pressure and support. Using the model as an organizational key, I explore each cycle as it relates to the core dimension of thriving. I show how the social forces of Stigma and Stigma-by-Association impact the efforts of therapists specializing in addiction and the people who come to them for help with a social and organizational poison that leads far too many clinical professionals to stop struggling with their jobs and retreat into other roles, other agencies, and other lives. I will present some of the wellness literature to identify an action plan for leaders and change makers who work with these therapists and are in a position to enhance and support their ability to thrive.

I then present four theoretical propositions grounded in and identified by the research as salient to the wellness of therapists who specialize in addiction. I explore how the history of the profession has created a stereotype that is itself a barrier to addiction specialists becoming equally respected parts of the helping community, along with actions that organizations might be able to take to support therapist wellness. I will identify in the second proposition the regressive cycle toward De-professionalization currently threatening the status of these therapists and offer some actions that might slow or halt the cycle. In the third proposition, I show where it is best to deploy resources. Finally, in the fourth proposition, I explore how education at a societal,

organizational, and individual level could address the destructive forces of discrimination, unequal treatment, Stigma, and Stigma-by-Association.

In the final sections of Chapter VI, I identify this study's limitations and point toward implications and future opportunities for research. It is perhaps necessary here to bring forward from Chapter I the importance of this research at this point in the historical cycle, when it may still be possible to reverse the momentum toward De-professionalization could still perhaps be reversed and to revitalize the therapists who are caught in this cycle revitalized. This research is important, because therapists are burning out well before they reach the heart of thriving. These findings especially matter because, in the current opioid epidemic, society cannot afford the loss of professionals from a specialty that is best prepared to effect a cure. Finally, this research is important because a significant portion of the general population is unwell, unhappy, and dying of addiction and the people best trained and best suited to their care have in too many cases given upon trying to be available for this undervalued struggle.

The Theoretical Model

The theoretical model (see Figure 6.1) emerged from the dimensions and processes identified through interviews with therapists who specialize in addiction. The purpose of the model is to allow visualization of the complex, intertwined factors affecting therapists, who begin their careers by tending and pruning (primary dimensions) their professional opportunities through the internship and education process and arrive as Master's-level clinicians with a chosen specialty of addictions. On arrival in their agencies, they learn how to juggle (primary dimension juggling) expectations and responsibilities far in excess of financial and professional rewards. Once settled in, they too often struggle (primary dimension) against the realities of

social and organizational pressure, with no guarantee that their efforts will be successful. If the skills learned at each stage are sufficient, they might work their way up to thriving (core dimension); however, even that is not a final destination. As such, therapists may find themselves again exiled again into any of the previous dimensions. Interviews with the therapists who are now at the end of 30-year careers, and who navigated the cycle of medicalization and Professionalization, revealed alternate instances of calm and turmoil. As Participant 13 shared of this workplace ebb and flow, “That was a good spot for me to be for a while.”

In the following description, I explore and explain the separate circuits of a complex, active mandala presented whole in Figure 6.1. The societal (or macro) arenas are visible in the external ring and include medicalization, Professionalization, the opioid crisis, and De-professionalization. Organizational level (meso) arenas, shown in two cycles, include paraprofessional counselors, recovered counselors, master’s level therapists, licensure, accreditation, continuing education, De-specialization, peer recovery centers, recovery coaches, AA sponsors, community, supervisors, inequities, locations of care, and pay rates. Between the organizational cycles are the primary dimensions of struggling, pruning, juggling, and tending. And, in the heart of the mandala, as in the heart of the therapeutic relationship, are the therapist and client and their enmeshed ability to thrive. It may be best to visualize the concentric circles might best be visualized as in perpetual motion, wheels moving toward or away from Professionalization, with the heart of thriving (for therapists and clients in parallel) at the center infected by the intrusion of Stigma and Stigma-by-Association. As each actor comes into alignment with others, a new struggle or resource emerges.

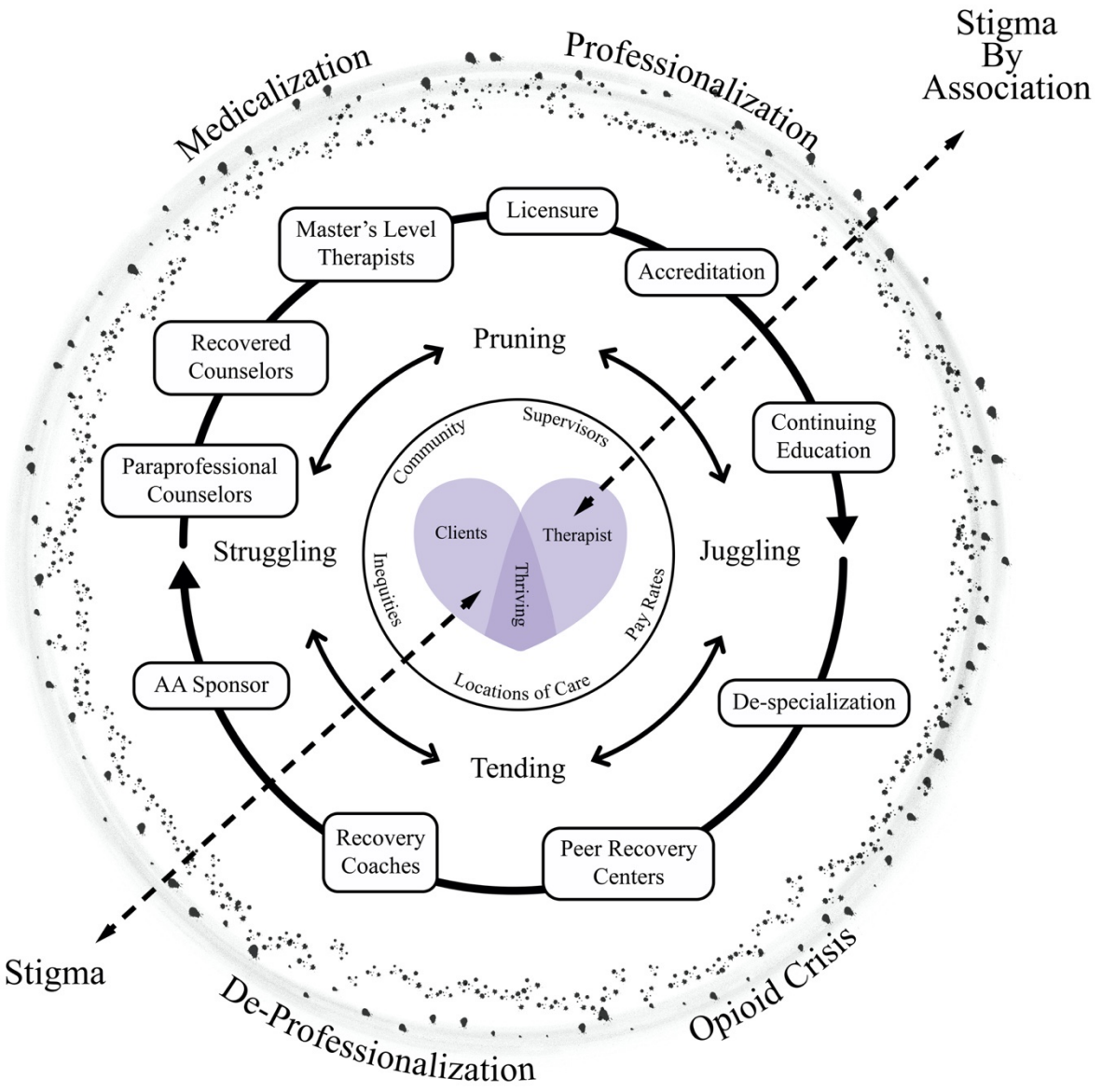

Figure 6.1. The world arenas of therapists specializing in addiction.

The heart of thriving. The inner heart of the model shows the vital connection between thriving for therapists and their clients. Thriving at work "combines feelings of vitality and energy with beliefs that one is learning, developing and making progress towards

self-actualization" (C. D. Fisher, 2010, p. 389). This sense of thriving is mirrored between therapists and clients alike, who alike need to feel energized and that their work is making a difference. As signaled in Chapter IV, thriving is an adaptive, emergent process and is the direct opposite of the pediatric medical term "failure to thrive." According to Spreitzer, Sutcliffe, Dutton, Sonenshein, and Grant (2005), thriving is essentially "socially embedded" because it arises "from connections with others" (p. 539).

Stigma, and its clinical parallel of Stigma-by-Association, are the factors weakening the heart of thriving. The difficulties are not caused, as some might think, by working with challenging clients who have a chronic devastating disease during an unrelenting epidemic of addiction. The words of the participants in this study serve as testimony to this effect. As Participant 11 said "I feel privileged to get to work in this field . . . now I can't imagine not working with the substance use population." Participant 15 shared about her work in corrections:

> The women . . . the patients. They were amazing. . .. To be able to walk through that with them and to just sit with them through that, and then for them to be able to just live and to find something to be happy about and to have hope.

Participant 18 identified, "There's just such a need. It's just such a hurting place and I just love being right in the hurt and helping people." Participant 7 shared, "We become our clients." Participant 6 reported, "I think a lot of people believe that burnout is about the clients and it is so not about the clients." Participant 8 shared her insight that, "Part of me is attracted—and I don't know if it's part of why I'm in the field, going to the dark places or so-called dark places—like, the most extreme. Getting my hands dirty, so to speak. Edgy-ish."

The heart of thriving is impacted by Stigma (aimed at people who have addiction) and Stigma-by-Association (aimed at those who work with them). This process is best defined by Participant 6, who reported:

> I would say it's a shame-based system and it's very much a parallel process. I think the profession itself rose from addicts helping addicts and from that peer model, we have moved into the realm of "professional" and I think that there is this shadow of shame around it that the profession itself needs to prove, "Oh no, we really are professionals." Whereas mental health profession, I think, has always been a profession. It wasn't [necessarily] people with chronic mental health issues helping other people. Be grateful that there are any resources given to you because, ultimately, the people you work with are the forgotten people of our culture.

As discussed in the literature review and corroborated by the grounded theory research, therapists who specialize in addiction suffer from stereotype, discrimination, and multiple inequities, leading all too often to burnout, which Freudenberger (1974) defined as "to fail, wear out, or become exhausted by making excessive demands on energy, strength, or resources" (p. 159). Other descriptions of burnout are as a "work-related mental health impairment" (Awa et al., 2010, p. 184) or as "a prolonged response to chronic emotional and interpersonal stressors on the job" (Vorkapić & Mustapić, 2012, p. 189). Burnout disproportionately affects those who are the most "dedicated and committed," as those therapists experiencing burnout become "just too tired to go through more changes" (Freudenberger, 1974, p. 161).

Once burnout strikes, the individual experiences the "unbearable fatigue of compassion" (Fahy, 2007, p. 199), and that compassion is an early casualty of the malady: "What we see happening . . . is a gradual loss of caring about the people they work with" (Maslach, 1978, p. 56). Burnout is a chronic, recurring ailment that can go into, however, in an interesting parallel with the disease model of addiction, it is not possible to ever cure burnout and experience does

not ensure immunity. Participant 8 reported that, even after 20 years as a professional and 14 years specializing in addiction, “There was a couple of months last year and [a] stretch that was as hard as I’ve ever had.” The contagion of Stigma-by-Association, and it is caused by “professional relationships with, or even being in close proximity to, stigmatized others” leading “to the devaluation of nonstigmatized targets” (Hernandez et al., 2016, p. 69).

When the illness is symptomatic, the effects can be severe and career-, if not life-, changing. According to Participant 18, “I laid in bed for a couple weeks and then [my counselor] kind of picked me up from my brokenness and helped guide me towards private practice . . . I could not go back into full-time working.” Stigma-by-Association is an infection that spreads stereotype and discrimination and excuses the social and organizational inequities that lead to the dis-ease of burnout.

Core pressures and supports. At the meso level of influence, the core organizational policies and procedures affecting therapists who specialize in addiction include supervisors, community, pay rates, general inequities, and locations of care (see Figure 6.1 containing clients and therapists and Figures 5.6 through 5.8 and Appendix B for local photographs of professional and peer locations of addiction services). In this section, I will explore core supports from the perspective of the therapists who have worked at similar sites.

Supervisors. Like good-enough parenting, good-enough supervision is a fundamental requirement for building resilience not only at the earliest stages of counselor development, but throughout their careers. Participant 11 shared that good supervision was so important to her that she continued in a difficult job because “I wanted to continue working with [named supervisor] so I stayed.” Participant 8 queried knowingly, “How much does our good work depend on good

supervision?" Participant 1 identified the importance of her peer and clinical supervision when she shared:

> The agency and my colleagues are just so incredibly supportive of each of us going to that fragile vulnerable place to be able to talk about those scary things that are just— They tell you in your ethics class, "Make sure to talk about this," but if you're in an agency that's not welcoming to that, you don't talk about it, and that's the most dangerous thing.

A positive relationship with one's supervisor can be so important, in fact, that "a high-quality *relationship with one's supervisor* may alleviate the influence of job demands . . . on burnout, because leaders' appreciation and support puts demands in another perspective" (Bakker, Demerouti, & Euwema, 2005, p. 172, italics in original).

Participants in the interviews reported an imbalance between pressure and support from their supervisors, a key predictor of burnout (Maslach et al., 2001; Vilardaga et al., 2011). Participant 7 characterized most of her supervisory experiences during her 30-year career as somewhat neglectful: "'Wow, you're doing a good job or wow, where did you come up with that idea?' That doesn't happen." Of her current administrative supervisor, Participant 11 shared, "He can't supervise me for my Clinical Supervisor because that is not his strength. He has no training in it. . . . It is not a good relationship." Participant 13 noted that some of her supervisors were not qualified in addiction treatment. She said, "They put a nurse as our supervisor who didn't even have a [license as an alcohol and drug counselor] LADC. She wasn't even an alcohol and drug counselor. She was a nurse. She was the nurse manager of the psych unit." Participant 15 reported that her supervisor "who . . . was not licensed at the time" did not support her decisions or accept her suggestions about the program, despite the fact that she had been licensed for 10 years and that "it was just an awful feeling." She identified the crux of this issue when she stated

directly, “I needed the support of a supervisor to treat the patients that I cared about so deeply.” When she did not receive that support, she stopped struggling against the pressure and quit. Participant 18 discussed her first post–graduate school job:

> The state paid for this researching team to come in and figure out what was wrong with the system at this place I worked at and the researchers said that people aren’t getting proper supervision. . . . they didn’t have a supervisor on site. I’ve had a lot of really bad supervisors in the private practice now and when I was at that agency. . . . I still haven’t had good supervision since I left [graduate school].

Many of the participants were, themselves, clinical supervisors. Participant 11 reported that being a supervisor is, in fact, one of the core ingredients of her thriving:

> Being a supervisor is a super passion for me. I love helping other counselors develop professionally and figure out how to work with this population. . . . By helping them get better at their work, I’m then treating the clients.

Participant 11 shared, “there’s no training in Master’s or anything about being a clinical supervisor,” although she dedicates much of her continuing education to supervision training. Unfortunately, because of her supervisory role within the agency, “there’s no one else who is clinical that I can go to [for her own peer supervision] that would be appropriate . . . it’s not a safe place to bring up struggles I might be having with my [staff].”

There is a national credential is available for professionals such as Participants 8 and 11, who have a passion for and have been trained in clinical supervision: the Approved Clinical Supervisor (ACS) through the National Board for Certified Counselors (NBCC). According to the NBCC, the requirements include having a Master’s degree or higher in a mental health field, status as a National Certified Counselor (NCC), license or certification as a mental health provider, proof of 45 hours of specialized training in clinical supervision, a minimum of 100 hours under supervision, and at least 5 years of post-degree experience in mental health services

(Center for Credentialing & Education, 2019). Given the importance of good-enough supervision, there should be a wider adoption of the credential for those therapists specializing in addiction who wish to provide supervision (Bono & Ilies, 2006). The majority of participant discussion around supervision involved poor, or even toxic, supervisory relationships, which pose a major challenge to the therapist (Ashforth, 1994; Baard et al., 2004; Bono & Ilies, 2006; Breevaart et al., 2014; Bride & Kintzle, 2011; Einarsen, Aasland, & Skogstad, 2007; Evans & Hohenshil, 1997; Powell, 1991; Vilardaga et al., 2011; Väänänen et al., 2003; Webster & Hackett, 1999; Yagil, 2006). In fact, for many post-graduate, unlicensed clinicians working in their first placements, their supervisors are only a few years ahead of them in experience, with few having enough training to qualify for the ACS.

Community. Having a community of colleagues has shown to be a fundamental necessity for thriving (Ducharme et al., 2008; D. K. Knight, Becan, & Flynn, 2012; Nohria, Groysberg, & Lee, 2008). This is a direct parallel with the peer recovery tenet that the cure for addiction is people. Participant 12 demonstrated her understanding of this necessity by stating, "I need a community of like-minded people who are learners, and people who want to talk about interesting stuff." Participant 11 found her part of her community through required peer supervision for licensure by becoming "part of another clinical collaborative." According to Ducharme et al. (2008), leadership plays a central role in creating a positive climate to increase job satisfaction in that "social climate is a product of management practices and policies that lead employees to perceive that they are valued and integral members of the organization" (p. 83). The reality is far from this aspirational goal, however. As Participant 13 shared: "As long as I was with a bunch of other counselors, we sort of laughed at [Stigma and Stigma-by-Association];

It didn't bother us. Safety in numbers." This period of thriving in community was not to last, as the agency "whittled us away" (D. K. Knight et al., 2012).

For many therapists, that vital collegial community is not guaranteed or even easy to find. Working in private practice, Participant 5 shared, created an environment in which "my tribe has gotten smaller." Participant 18 summarized her thoughts on the importance of community while balancing being a helper and a human being in need of support, rhetorically asking "What do shamans do then when they're stuck in the middle of these two worlds? . . . They find other shamans." Participant 19 asked "Where's the roster of all the private practice LADCs in this state? There isn't one. We couldn't all get together and have a gathering if we wanted to unless we're going to spend hours looking for each other." Participant 6, whose struggle ultimately ended with giving up her specialty in addiction in response to many pressures and inadequate supports, warned:

> Be prepared. You're going to have to walk into this with a really good cohort of other professionals that are doing the same work that love and know you so that you stay sane. . . . Having a community is, without a doubt, the most essential, most critical quality. . . . You could work in a really toxic environment, but if you have the right cohort, you can move through that.

She did not have that community, and it cost the profession a dedicated, passionate, and effective therapist.

Pay rates. Participants in the interviews identified pay rates as part of their decision to accept supervisory positions or ultimately to give up their specialty in addiction. I refer readers back to Participant 11 related that being a supervisor takes her out of the community of supervision that her staff enjoys because of her efforts and her supervisor is only qualified to work with her administratively, not clinically. About her struggles at her community mental

health agency, Participant 12 said bluntly, "[The site] sucks with base pay." Whereas community mental health agencies figure prominently in this discussion of untenable pay rates, they also figure prominently in the early development of post-graduate therapists. In a form of apprenticeship exchange, community mental health agencies are often the only ones that will accept unlicensed clinicians and supervise them to licensure. Participant 4, who has been feeling as if she is coming up on a "lifetime limit of empathy" (i.e., burnout), reported that she considered applying the strategy "'okay, maybe I'll just roll up my sleeves and work hard and make more money and retire sooner,' and I kind of can't." Working harder and working more hours cannot address the critical issue of unequal reimbursement and is thus a slippery slope for burnout (Vilardaga et al., 2011). Translated into a production strategy, individuals cannot make enough money to stay in business if they sell more widgets at less than it costs to produce them, no matter how hard they push production. As previously reported, also referring to a time when she was working in community mental health, Participant 18 shared, "There was really no positive [financial] incentive. I was only making a dollar more than the receptionist an hour, who was a high school graduate." Many therapists carry a heavy burden of student loan debt well into the middle developmental years of their careers. Participant 16 grew heated on this topic:

> The whole thing pisses me off a little bit just because it's a lot of effort and a lot of documentation for not a lot of reimbursement. I knew that just being a straight counselor was not sustainable for where I was in my life with . . . one kid in college and one kid in med school.

Anger was a common emotion among participants when discussing pay rates, perhaps because of a reasonable fear that this one factor had the power to take them out of their specialty due to practical concerns (Vilardaga et al., 2011). Participant 6 reported bluntly "The pay was

abusive. Getting paid, essentially, minimum wage with [a] Master's degree. Staff didn't get a raise for 8 years, not even cost of living." Of course, anything that affects the therapists also affects their clients. Participant 6 related a time when resources were so low that "we went to the food bank for food for the residents." Participant 19 shared her opinion that, particularly during the current opioid epidemic, "Cheap is expensive." Forcing therapists who specialize in addiction to work at or near the poverty level leads too many to abandon their specialty and seek higher remuneration in private mental health practices.

Inequities. Many participants reported unequal treatment, sometimes at the level of outright discrimination, which they had endured as therapists specializing in addiction. Participant 13 shared her opinion that "the mental health field looked at us as the step-children." Discrimination comes from family members, friends, colleagues, supervisors, and agencies. Participant 6 remembered, "The response I would get from friends probably more than family was like, 'Why the hell are you doing that?' My sister, who's a police officer, worried about my safety." Although generally unaware of that level of discrimination during graduate school, as Participant 8 shared with a touch of irony "eventually [that's] something that's presented to you." Participant 15 said, "I don't think that they categorize [addiction therapy] as a specialty like mental health treatment. I don't. I still think that they sometimes clump it together with maybe, even in the realm of, I don't know, recovery coach." Participant 14 reported that "working in addictions is perceived by my friends, for example, and acquaintances as a sort of dirty work . . . We're dealing with taboo and shadow and things people don't want to talk about." If being an addiction counselor appears parallel to, and perhaps fused with, being a sponsor or a recovery coach, then the expectation that, as Participant 2 stated, "anybody could be an

addictions counselor" is perhaps understandable. Participant 5 identified an underlying tone among other professionals as being, "Why are you helping these people that do this to themselves . . . I don't feel sorry for them." By extension, friends and family also may not empathize with therapists specializing in addiction who have in parallel "done this to themselves." The general perception is, as Participant 10 shared, "Your expertise is limited; your range of wisdom" narrow. With regard to the discussion on scope of practice in Chapter V. Participant 18 said that other professionals think of an addiction specialty as:

> A little bit like less than the LCMHC. It's kind of like the LCMHC, in where you want to be at and LADC is less. It's lesser . . . in their world, they're probably seeing the kids because the parents are struggling with substance use disorders. So then the kids are their clients so they get mad and protective of the kid and mad at the parents for using.

Participant 6 shared how she felt others perceived her when she still specialized in addiction:

> It's amazing how classist it is . . . the attitudes of other professionals in the room like "You're just a substance abuse counselor. You are ignorant. You are coming from the old-fashioned AA model clearly. You're uneducated. You couldn't get a better job. Why would you work with that population?"

During the early days of the current cycle of Professionalization, the workforce changed from mainly older White men in recovery to clinically educated women. There were perhaps expected reports of gender-based discrimination from the 1980s, but the reality is that gender discrimination and microaggressions continue to the current era, when forces are again pushing toward De-professionalization. Participant 15 reported that some of the discrimination she felt was based on "maybe being a female . . . What nerve do I have challenging a supervisor and his intellectual decision making or abilities?" While running a program and trying to keep the lights

on and the doors open, Participant 9 shared, “A friend of mine used to call me a grant whore.” It is hard to imagine a successful male grant writer given that label.

Participant 13 even remembered a time when unionization was coming to her place of work, and the social workers and nurses lobbied, successfully, to keep the therapists specializing in addiction out of the clinical union. Colleagues told her, “They’re going there and they’re testifying that you’re not professional enough.” The final verdict was that therapists specializing in addiction at her agency were unionized with the clerical and administrative staff, a situation in place to this day. She has, however, changed jobs several times and is no longer specializing in addiction. She remembered, “Maybe I can be just done fighting this now. . . . maybe I can just be done now. I stopped in 2002.”

The participants’ sense of dis-ease is echoed in the critical research on wellness. According to Cynthia D. Fisher (2010), “Three factors are critical in producing a happy and enthusiastic workforce: equity (respectful and dignified treatment, fairness, security), achievement (pride in the company, empowerment, feedback, job challenge), and camaraderie with team mates” (p. 394). The industry is not meeting this standard.

Locations of care. Where people work appears to be another significant predictor of burnout: I refer the reader back to photographs of locations of care, both clinical and nonclinical, in Chapter IV. Locations of care are among the heaviest of pressures, along with “low salaries, staff turnover, agency upheaval, and limited opportunities for career development” (Vilardaga et al., 2011, p. 323). Many participants in the interviews reported being surprised and appalled when they observed the sites where they would be doing their work, greeting their clients, and spending their working lives. Participant 8 spoke of her first addiction counseling placement

"under the Pulaski Skyway and across from a bus terminal in front of a train track. There was nothing around this place. It was almost bizarre. . . . Who knew there was an *under* the Pulaski Skyway?" (italics retained to express her emphasis).

Photographs in Appendix B reveal three different life stages of the Turning Point Recovery Center (TPRC) in Brattleboro, Vermont. The location of the middle stage, shown in Appendix B, Figures B.4 and B.5, was on the outskirts of town in an industrial and retail area, near the train tracks, without regular bus service, posing a major barrier to access to care. Participant 18 found an office space with accessibility in mind, relating, "My office is downtown, and a lot of my clients walk to my work because they don't have—there's just poverty." According to Participant 5, "You've kind of got this 'not in my backyard' kind of thing." Even given the Stigma against people who have mental health issues, Participant 10 shared her belief that "it's much easier to walk through the doors of a mental health facility than it is to walk through the doors of a substance abuse facility. . .. there's more blame and for mental illness, initially, there's more compassion. . .. It's a feeling tone that I get." For clients who have addiction, a classist system and a moral view of their disease set the stage for exclusion and exile. Participant 19 reported, "I've never been referred anybody that comes from wealth." Although that demographics of those affected has shifted during the current opioid epidemic, the locations of care have not. Participant 6 shared her:

> Personal opinion is that we live in a very classist country and we refuse to acknowledge that. And the economic disparity grows in such ways that just is offensive to my sense of being. Those who are poor, possibly homeless, [face] challenges around everywhere with social access, social resources, I think whole communities are just dying. That's what it feels like.

The dimensional factors. Beyond the core pressures affecting therapists who specialize in addiction and their clients are the shifting factors identified in the dimensional analysis of Chapter IV: tending and pruning, juggling, and struggling. Therapists move through these nonlinear developmental stages throughout their careers, sometimes finding the heart of thriving in certain agencies, with specific communities of colleagues and clients, and with enough resources to maintain wellness at work (Bakker et al., 2005; Chapter IV provided full descriptions). Thriving is a state that "combines feelings of vitality and energy with beliefs that one is learning, developing and making progress towards self-actualization" (C. D. Fisher, 2010, pp. 389–390). These dimensional factors come together to create the context necessary to achieve thriving.

Tending. Tending is perhaps one of the earliest developmental stages a new therapist goes through. Tending starts before graduation through the choice of internship sites and specialty, chosen prior to the new therapists knowing very much about what their field will look like, mainly driven by curiosity and passion. Participant 11 shared that she had no idea whether she would fit in as an addiction specialist. Once she was actually doing the work,

> That's when the passion finally hit, when I was like, "Wow, what I'm doing and my approach works really well with this population." Then the passion came. . .. I love meeting with clients, assessing them, figuring out where they're at, figuring out what they need.

At the end of a very long career, Participant 7 shared, "I got involved in a lot of different things. . . . It ended up being really interesting." Part of what made it possible for her to retire with a sense that she was thriving was her curiosity and her ability to turn her attention to different aspects of the work at different stages. Continuing in the work requires a therapist to

keep learning new skills and tools and may eventually result in times that, as Participant 8 reported of her current situation, “I’m very happy where I’m at right now.”

Pruning. Along with tending, participants talked about shaping their work lives to suit them best. After many years of figuring out what actually worked for her, Participant 11 said, “My position right now is almost, almost my dream position . . . the job I’m doing right now really is exactly what I want. That’s why I stay . . . because it really is exactly what I want.” The operant word here is “almost.” Participant 11 continued to prune away the parts of her work life that do not nurture her and to work toward creating a work environment that contained most of her favorite things. About her work life, Participant 8 shared:

> There are times I’m thinking about calling you or looking for other employment . . . . I could help others working at [a local grocery store] . . . . I’m happy now. It’s just true. Because now my caseload is manageable. . . . While there are other things I might not mind doing, I didn’t come up with a thing that I want to do more or I’d be doing it.

This participant’s words are, indeed, thriving: an inner sense that the therapist herself has the power and willingness to make changes that will support wellness and happiness at work.

Juggling. Participants emphasized a requirement to develop the skill of effectively juggling multiple work expectations from internal and external stakeholders in order to continue doing the work. Participant 12 identified that her site works under such a low reimbursement rate that there is a trickle-down effect onto the therapists: “The results of this is really, really high productivity in direct service requirements.” Agencies cannot afford to be adequately staffed. Participant 18 burned out of a job after four months, when she was expected to continue “doing four people’s jobs, literally” due to constant job turnover. Participant 7 said, “Don’t we all have two jobs? Or three or we’re in school so that we don’t have to have three jobs” eventually.

There are positives of juggling multiple priorities, as Participant 16 noted: “I always have enough things on my plate that if this part of the thing is stuck in the sludge for a little while, there’s work to do on the other thing.” Participant 8 summed it up best when she said: “I think we all have to be octopuses.” She continued, perhaps tellingly, by quoting Nietzsche: “Many a hard night can be gone through with the thought of suicide.” Juggling, sometimes with a dark sense of humor, is a hard-won skill that therapists gain through trial and error, necessary to reaching the heart of thriving.

Struggling. Many participants identified how hard they struggled to be able to maintain their work, trying to stay a little ahead of burnout and financial distress. Participant 13 characterized her struggle as “my baptism by fire, as I call it.” Participant 6 shared putting her:

> life’s heart into the work that I did and made very conscious choices about I will sacrifice my financial well-being and work long hard hours and do 50 million jobs at the same time because I really . . . believe we made a huge difference.

In parallel with her clients, she continued, “I think that working with substance abuse, you really are right in that razor’s edge of how precarious the circumstances are, regardless if you have an addiction or not.” She reported:

> I tried. . . . then was like “I have to leave. I’m killing myself here.” Literally was a lot of—it just felt really unhealthy. Spiritually, emotionally—it was physically painful to go into work. I made that very difficult decision, left [the work site], went to [another work site] which was its own nightmare situation. Stayed for about 4 months.

Cultural, economic, and professional forces. The outer wheel of Figure 6.1 encompasses the macro-level social factors affecting therapists who specialize in addiction, within the cycle of Professionalization/medicalization and De-professionalization and in the context of the current opioid crisis. The forces working to support Professionalization and

medicalization include the requirement over at least the last 30 years of a graduate-level education, accreditation, licensure, and continuing education. The forces working toward De-professionalization that have gained momentum due to the lack of trained professionals to address the opioid crisis include peer recovery centers, De-specialization, paraprofessional counselors, the Stereotype of recovered counselors, and recovery coaches.

Professionalization. The forces for Professionalization include graduate-level education, accreditation, continuing education, and licensure, each briefly explored in this section. (See Chapter V for expanded discussions on each of these topics.) As the forces for Professionalization took hold, about a decade after the last opioid epidemic, nonprofessional counselors were replaced with highly educated, Master's-level clinicians replaced nonprofessional counselors. This was a difficult transition for many, who had for the most part, come up through the apprenticeship and personal experience model. Some therapists who weathered that period of change continue to grieve their old way of working. Participant 13 shared that she had to integrate "a gut full of instinct and a head full of theory. I was a better, more intuitive counselor before I got my Master's degree." In contrast, Participant 7 reported about her graduate school experience, "Oh my God, I loved that course. It was good. It was really good, but you see it was a little radical, I guess." The forces of De-professionalization and the stereotype of a nonprofessional workforce, creep in even here. As Participant 15 reported, "My supervisor basically was just supporting this new clinician saying, 'She doesn't want to be trained, don't bother. Let her do relapse prevention' . . . Very frustrating." Participant 13 struggled "to define what I do to be more professional" in a context where there were few

therapists and many counselors, and very few therapists further ahead on the Professionalization journey available to model the path.

Not all helping professionals have the training or experience to treat clients who have addiction. Neither a Master's degree in social work, a nursing or other medical degree, or a doctorate in psychology necessarily includes training in clinical work for addiction (C. M. Fisher et al., 2014). As discussed in Chapter V, only clinical mental health counseling curricula routinely include education in addiction, although other professionals can and do qualify for this additional specialty license or certifications.

Therapists trained as clinical mental health counselors from CACREP-accredited graduate schools have received training in addiction counseling. Scope of practice, code of ethics, and curricula are standardized through accreditation. This is not yet true of every discipline or every school but generalizing addiction training to education for other professions is a major concern of Proposition 4 below. As Dr. Diane Kurinsky stated, in a general mental health graduate-level class, when encouraging students to take a specialty in addiction despite the extra time and classes required, "You can either deal with addiction and know that you're dealing with it . . . or not" (D. Kurinsky, personal communication, 2008). Accreditation has been among the most successful Professionalization and medicalization strategies over the past 30 years, aimed directly at ensuring the quality of the foundation of a therapist's education. In a commentary on the work of Kerwin et al. (2006), Amodeo (2006) proposed three targeted Professionalization and accreditation strategies to "move the field forward":

1. Encourage all states to require the credentialing of both substance abuse and mental health counselors.

2. Encourage states to require that the minimum educational degree be comparable for substance abuse and mental health counselors.
3. Consider incorporating some features of the "allied health professional model" into the training of substance abuse counselors. (pp. 169–170)

Therapists specializing in addiction must attend at least 20 hours of continuing education every licensing period (2 years) through workshops, conferences, or graduate-level courses related to their practice. At least 6 of these hours must be in ethics specific to addiction practice, and those workshops sell out relatively quickly. Continuing education can be costly. A day-long course will provide six continuing education units (CEUs) and might cost between $100 and $200, not including travel expenses. Continuing education is another successful Professionalization strategy that encourages and supports lifelong learning, which, in turn, supports therapists thriving. Far from the idea that education ends at graduation, therapists continue in their learning throughout their careers, and potentially into retirement, as an integrated part of their profession.

A separate license, often named something similar to Vermont's title of licensed alcohol and drug counselor (LADC), identifies licensees as having met specific educational and experiential milestones. As discussed in the previous section, the foundational education milestone is that of a Master's degree in counseling. Required experience includes the equivalent of at least a year of supervision in direct addiction treatment. In the state of Vermont, the renewal fee for a general mental health counselor license is significantly less than that for the specialty alcohol and drug counselor license, both billed biennially at the same time.

Stereotype and discrimination, along with the added expenses related to maintaining dual licensure and credentials, have forced more than one therapist who specializes in addiction out of their addiction specialties. Said Participant 6:

> No one at a state agency leadership level values [addiction specialty treatment]. My own licensing board was treating me like I didn't know what I was talking about, that I was trying to get one over the system. . . . You will be working for systems that treat you like you, yourself, have some kind of psychological disorder. They're not going to trust you. They're going to be disrespectful. They will be condescending.

It is worth noting that the state of New Hampshire still requires character references for those seeking licensure in alcohol and drug counseling. As discussed in Chapter IV, Participant 6 gave up her specialty license when her licensing board refused to accept her continuing education work. They refused to accept it because the modality, while evidence-based, was not specifically and narrowly titled as an addiction-related topic. She reported, "There was some grief around that because it was my first professional license and I had poured my heart and soul into the work that I did." This is clearly discrimination, a misunderstanding based on historical stereotypes of the workforce that provides addiction treatment (nontherapists, counselors, sponsors, and peer recovery coaches).

Some therapists who specialize in addiction, whether they are licensed as an alcohol and drug counselor or not, hold the credential of Master of Addiction Counseling (MAC) through the National Board for Certified Counselors (NBCC). I would submit that, if one of the rectifications might be to generalize training for addiction to all helping professions (see Proposition 4, a discussion of which follows), the MAC credential might be an excellent parallel to, or even a substitute for, the specialty license of LADC. The Professionalization movement shifted the

workforce from “counselor” to “therapist,” and was accomplished first through education and then through licensure.

Medicalization. Addiction is a medical issue, and it has always been a medical issue. Dr. Benjamin Rush, considered the father of addiction medicine, turned his attention to addiction in the late 18th and early 19th centuries. Dr. Rush was, among other notable things, the Physician-General for the Continental Army. This was at a time when there were few medications were available for the treatment of this disease. The earliest safe and effective medications were methadone, approved by the Food and Drug Administration [FDA] in 1947, and Antabuse, approved by the FDA in 1951. Now, doctors working in medication-assisted treatment (MAT) have an arsenal at hand. Alongside methadone and Antabuse, they can prescribe buprenorphine to reduce withdrawal symptoms and cravings for opioids, naltrexone and Vivitrol (a monthly injection of naltrexone) to reduce cravings, Acamprosote (or Campral) that attempts to restore chemical balance for someone in post-acute withdrawal from alcohol, and baclofen, which is thought to have some efficacy against cravings for cocaine (although still controversial).

The disease model of addiction offers a holistic medical picture of a biological, neurological, heritable, and environmental disease that, like other diseases, causes discomfort, dysfunction, and distress. As I discussed in Chapter V, co-occurring disorders are among the root problems a professionalized workforce should address. According to a Substance Abuse and Mental Health Services Administration (SAMHSA) Treatment Improvement Protocol (TIP) 42 (2005), at the beginning of the Professionalization movement, the “striking” correlation between mental health and addiction issues emerged. In traditional addiction treatment settings, “50 to 75

percent of clients had co-occurring mental health disorders" (SAMHSA, 2005), and in mental health settings, "between 20 and 50 percent of their clients had co-occurring disorders" (Sacks, Sacks, De Leon, Bernhardt, & Staines, 1997). With this new understanding of addiction as a disease process, often presenting with a co-occurring mental health disorder, addiction counselors were no longer able to focus just on the addiction. Participant 13 remembered the time before Professionalization with some nostalgia:

> The focus was stay sober from alcohol or the drugs a little bit and then work on the other things. . . . I knew when they should go see somebody that was more trained in different things. I always went by the tip of the iceberg because I know that the addiction, for many people, can be the tip of the iceberg and then what's down underneath that you have to deal with. . . . so they can manage the feelings that come up about whatever childhood trauma that is going to be there.

By the 1980s and 1990s, however, SAMHSA promoted a "no wrong door" principle:

> The healthcare delivery system, and each provider within it, has a responsibility to address the range of client needs wherever and whenever a client presents for care. . . . Every "door" in the healthcare delivery system should be the "right" door. (SAMHSA, 2005)

To meet this principle and protocol, the addiction counselors had to be professionalized—trained in co-occurring disorders as therapists with holistic experience and education (Roy & Miller, 2012). This Professionalization was widely successful at the early developmental stages of a therapist's career but met with such discrimination and Stigma-by-Association based on the historical stereotype of who and how a peer addiction counselor worked that the cycle of Professionalization stalled and regressed just before the current opioid epidemic. I will end this section with the words of Participant 13, who experienced the transition (and the stereotyping) firsthand:

> I was talking to a psychiatrist about the fact that I appreciated Anna Freud's work on the denial system and all the different levels of denial. I just started listing them and he looked at me and says, "You mean you alcohol and drug counselors know about those?" I'm like, "Uh, yeah." And he says, "And you talk about feelings and group?" And I'm like, "Yeah."

Unfortunately, scholars and agencies have not fully addressed denial as of yet. As a therapist who specializes in addiction, I recently experienced a microaggression at work when a psychiatrist I have worked with for 7 years asked, in a public-facing e-mail, if I was working with a client, then who was his therapist?

There used to be a widely held understanding that specialized treatment would be helpful in putting the disease of addiction into remission. As Participant 7 recalled "You're an addict, you need to go to 6 months to a year of counseling." The system for regaining one's driving privileges through the state of Vermont's Project CRASH generally included six to eight sessions of clinical therapy with a licensed alcohol and drug counselor for a first offense and 20 for a second or further offense. Under the current agency, the Impaired Driver Rehabilitation Program (IDRP), there is no specific mandate for clinical treatment and, if a client does qualify, their referral is for just three to four sessions.

De-professionalization during the current opioid epidemic. The therapeutic community is now moving into a cycle of De-professionalization, an invasive process well-rooted over the past 5 years, promoting peer recovery coaches and recovery centers as nonclinical parallels with an undiluted focus on addiction rather than co-occurring issues. Instead of a Master's degree in holistic mental health treatment, recovery coaches have a 1-week academy in addiction. Before the era of Professionalization, when the Rutgers Summer School of Addiction Studies was the only training available, even that was 2 weeks long. As discussed in Chapter V, scope of practice

and codes of ethical behavior do not apply to peer counselors. There is now and has always been a place for peer recovery in the wrap-around support of people with addiction. Support is not equal and, in many cases, not sufficient to meet the needs of the affected population, but it has gained credibility and popularity due to the societal demands of the current opioid epidemic. The landscape is bleak: Too many highly educated, professionally trained therapists who took on this specialty in the decades between opioid epidemic outbreaks have been lost to the profession because there were not enough supports in place to allow them to thrive.

Summary of the theoretical model. This theoretical model, seen in its entirety, depicts swirling concentric cycles of pressures and supports affecting the heart of thriving for therapists who specialize in addiction and their clients. Following is a discussion of the four theoretical propositions arising from this research, grounded in the interviews of Chapter IV and the situational analysis of Chapter V.

Theoretical Propositions

To mitigate the toxic effects of Stigma and Stigma-by-Association, and to purposively and strategically support wellness on the societal, organizational, and personal levels affecting therapists specializing in addiction, following is an exploration of the four propositions and identify ways to arrest and reverse the gathering momentum of a regressive De-professionalization cycle. The cycle of Professionalization had, over the past 30 years, crafted a well-prepared, well-educated, and dedicated cadre of therapists who chose to specialize in addiction. This workforce met, and was devastated by, stereotype, lack of financial and professional support, and Stigma-by-Association, leading to many to give up their specialties (a meso-level process termed De-specialization in Chapter VI) and disappearing into general

mental health practice. This occurred at a time when the storm of the opioid epidemic was gathering strength and these therapists could have been available to meet it.

Proposition 1: An entrenched social and organizational environment has created a context of denigration and devaluing of professional addiction treatment that prohibits therapists from becoming an equal part of the mental health treatment team. As a result of the misperception of the depth and breadth of scope of practice for therapists who specialize in addiction, general providers, without an addiction specialty, are considered interchangeable with the highly trained therapists who specialize in addiction. Thus, the addiction specialist is not regarded as having a highly specialized skill set that is essential to the overall treatment of the individual with addiction. The common view of addiction specialists—as confrontational, recovered, bitter, older White men who speak in slogans and rhetoric—is the equivalent of thinking therapy involves lying on a couch with a silent observer who has a legal pad and a goatee. Consequently, agencies often are not compelled to hire or refer to addiction specialists, but rather fill positions with providers without the requisite skills and experience in addictions, thwarting satisfaction of their intrinsic needs for "competence, autonomy, and relatedness" (Baard et al., 2004, p. 2045).

The widely held belief that addiction specialists are not quite professionals leads to a division of prestige and labor that shuffles people with addiction out of medical and mental health hospitals and into recovery centers. This leads to the appallingly separate and unequal locations of care, a "not-in-my-backyard" sensibility, and a devolution toward the historical epoch during which people with addiction were not even able to receive treatment in medical hospitals except by AA volunteers. Education could help expand the community fundamental to

therapist wellness. By creating a culture that promotes teamwork, collaboration, openness, and understanding among helping professionals, change agents could potentially leverage employee motivation and lower job turnover and burnout significantly (Nohria et al., 2008).

Based on this research, potential corrections include a public and professional information campaign designed to clarify the similarities and differences between therapists who specialize in addiction and other helping professionals, relocating the clinics where people access addiction care to clinical and professional sites, requiring actual parity for addiction and mental health treatment with other medical treatments, and equalizing pay rates. These remedies would be a clear indication of respect and validation in a capitalistic society (Broome et al., 2009; Ducharme et al. 2008; Knudsen et al., 2006, 2008; Vilardaga et al., 2011). The following are four proposals for leveraging change to promote therapists who specialize in addiction as equal members of the therapeutic team.

A public and professional information campaign. Support for therapists who specialize in addiction must start at a grass roots level with general public education (Shoptaw, Stein, & Rawson, 2000). The target audience must not only be the people who have addiction or those who care for and about them. To reach clients in need of a well-educated, professional treatment team, the medical teams, case managers, social workers, recovery coaches, and agencies that are potential referral sources must be aware of the value of this service. Dispelling historical stereotypes may require a catchphrase along the lines of the "this is your brain on drugs," perhaps reworded to "this is your brain after addiction therapy," with a return back to the shell unscrambled.

Relocation of sites of care. Relocating medication-assisted treatment sites to hospital venues—one of the six key factors of livability (Eger & Maridal, 2015)—would do much to reduce the Stigma, and Stigma-by-Association, is so clearly illustrated by the current locations of. The query of Shoptaw et al. (2000) remains relevant: How much difference is there in perceived Stigma between a client entering a medical hospital and a methadone clinic? Why are people with a diagnosable medical disorder being treated daily on the site of a car collision and detailing shop, or in an old retail store in an aging shopping mall behind papered-over windows? If people with diabetes who had to arrive every morning at a clinic for blood sugar monitoring and insulin delivery, I tend to believe it would not be behind the local fast food establishment with little or no bus service. The care and respect U.S. culture extend to its medical and professional treatment providers suffers from Stigma-by-Association when it extends to addiction professionals and the clients they serve.

Insurance parity. Medicare recognition of licensed clinical mental health counselors (LCMHCs) and licensed alcohol and drug counselors (LADCs) legitimate providers in their own right is long overdue. This is a particular concern with the prospect of "Medicare for all" becoming a reality. Clients would lose, in just 2011 numbers, access to 138,700 highly trained clinicians (Grohol, 2019). Under the current system, LCMHCs and LADCs cannot bill Medicare directly, a privilege offered psychologists, social workers, psychiatrists, and other medical professionals. Parity, although the law, remains unrealized, as "many fewer states included [substance use disorders] SUDs in the conditions covered under their parity laws" (Busch et al., 2014, p. 76). Where job demands are high and job resources are low, as is too often the case for

therapists specializing in addiction, burnout is a common result (Bakker et al., 2005; Demerouti et al., 2001).

Equalizing pay rates. As reported in Chapters IV and V, there is a tremendous wage gap between therapists who specialize in addiction and their colleagues with other professional degrees, and between those who work in community mental health and others in private practice. To provide redress for such discrimination and Stigma, pay rates and opportunities for advancement should immediately be equalized between social workers and therapists specializing in addiction, with retroactive correction beginning with the therapist's starting wage (Demerouti et al., 2001; Evans & Hohenshil, 1997; Vilardaga et al., 2011). In the current environment, the funds for this major overhaul could come in part from the settlements with the pharmaceutical companies most implicated in the current opioid epidemic. In a capitalistic society, pay rates send a powerful message about who, and what, is valued. To ensure a sufficient and sufficiently trained workforce to address the opioid epidemic, equalizing pay rates is a necessary foundation.

Proposition 2: The evolution of professionalism of addiction specialists over the last 30 years has stalled and is currently cycling back toward a nonprofessional, peer counselor model due to the pressure created when qualified professionals left the specialty during the opioid epidemic. It is worth reiterating at this point that therapists who specialize in addiction are therapists who took on extra graduate level courses, internships, certifications, and licenses in addiction as their chosen specialty. The extra training required to earn a license as an alcohol and drug counselor is more extensive than, for example, a forensic specialty at the same Master's degree level. Addiction specialists are, and have been for the past 30 years, Master's level

clinicians, on a par with social workers and other clinical mental health counselors. Their rates of personal recovery histories are not as high as the stereotypes would suggest, and certainly not as high as they were prior to Professionalization. A personal recovery history is not something to assume and, despite client preferences in either direction, not shown to be necessary for effective clinical treatment of addiction; however, recovery history does affect the salaries of these professionals (Olmstead et al., 2005, p. 186).

The current parallel process of peer recovery coaches and other nonprofessional counselors is not just separate, but unequal in scope of practice, ethical guidelines, education, training, and experience. For example, therapists in training learn how to identify, and skills to mitigate, vicarious traumatization. Peer counselors receive about a week of training, distilled down from the three years of graduate school: they clearly do not fully explore self-care and wellness topics. Although an important adjunct to treatment, recovery is not treatment itself; as such, the current momentum toward De-professionalization reduces societal commitment to redressing the adversities pushing therapists who specialize in addiction out of their specialty practices during the opioid crisis. Over 30 years of Professionalization, had society addressed these toxic elements, the therapeutic community would have been in a much more robust position to meet the current challenge. Instead, too many therapists have burned out and disappeared from the front lines.

Based on this research, the foci for change include expanding education in and understanding of the treatment of addiction for people working in other helping professions and for graduate students in all mental health professions. Policy-making organizations on the

governmental level and in the private sector also stand to benefit from these two corrections (Shoptaw et al., 2000).

Expanding clinical education in addiction treatment. It remains puzzling that the disease of addiction is not a cornerstone of the graduate education for the general medical and mental health communities. Using the model of clinical mental health counseling graduate programs, all training programs for healthcare professionals must include at least a general course in addiction treatment. Not all professionals will choose addiction work as a specialty, but all need to have a basic understanding of the disease. With an understanding of addiction as a disease will come a parallel understanding that the professionals who do choose addiction work as a specialty are, indeed, professionals and deserving of equal standing and respect (Shoptaw et al., 2000).

Expanding understanding and acknowledgement of the profession at the agency and governmental levels. To reduce symptoms related to burnout, therapists who specialize in addiction must be seen and acknowledged as equal partners in the medical and professional helping community (Ducharme et al., 2008; D. K. Knight et al., 2012; Nohria et al., 2008). Over the past 30 years, a timespan that includes the current opioid epidemic, addiction work has perhaps been the quintessential example of a high-strain job, defined as "combin[ing] high job demands with low job control" (Westman & Bakker, 2008, p. 2). This imbalance is currently becoming more pronounced. Education across the helping professions will expand understanding and acknowledgment of the role of therapists who specialize in addiction and will help reverse the De-professionalization cycle.

As discussed earlier, the momentum for De-professionalization has increased, evidenced by policies such as the Impaired Driver Rehabilitation Program (IDRP) in Vermont retreating from the previous agency's (Project CRASH's) standard of having a LADC sign off on treatment before a driver could regain driving privileges. This change may be a reflection of the widespread use of personal breathalyzer devices that disable a vehicle if the driver is alcohol impaired. It is far easier to install a device that has the potential to keep the crime from occurring at all (and shifts the cost off the insurance companies and onto the driver) than it is to provide treatment sufficient to put the disease of addiction into remission. There are, of course, enormous gaps in the effectiveness of breathalyzer devices. Drivers are not necessarily primarily or only impaired by alcohol, which is the only substance detected by current breathalyzer machines. Some states, Vermont included, that require approved breathalyzer devices to include a camera to confirm that the target individual is the same person inputting oxygen went into the device; however, this is not the standard for all states. It is at least as effective and efficient to require concomitant treatment for the root cause of the targeted behavior.

Proposition 3: Increased resources in parallel with the increased societal demand would allow parity efforts at the organizational level to redress a workforce shortage over the long term and negative perceptions in the short term to support those entering or re-entering the field (Bakker et al., 2005; Demerouti et al., 2001). As a result of the lack of equity in pay rates, therapists who specialize in addiction struggle to maintain their certifications, licensure, and continuing education and to repay their student loans. Many have reacted to the reality of lower pay and higher costs to drop the added expense of a second license, focused continuing education, and professional dues. (See discussion earlier in this section and in

Chapters IV and V on the wage gap.) Using Vermont as an example, a dually licensed LCMHC and LADC belonging to the National Association for Alcoholism and Drug Abuse Counselors (NAADAC), the Vermont Addiction Professionals Association (VAPA), the American Mental Health Counselors Association (AMHCA), and the Vermont Mental Health Counselors Association (VMHCA) owes $450 a year for membership in professional organizations and $400 for renewing both licenses every other year (NAADAC, 2019; Office of Professional Regulation, 2019; VAPA, 2019). If that same professional was held credentials as a Master Addiction Counselor (MAC), there would be a $200 fee added every other year to maintain that certification (NAADAC, 2019). During that same 2-year period, 20 hours of continuing education are necessary to renew licensure, with at least 6 hours of ethics specific to addiction treatment (Office of Professional Regulation, 2019). Some agencies reimburse or cover the costs of continuing education, but others leave it up to the individual therapist to afford the time and expense. The added pressure of repaying student loans compounds the magnitude of the problem for professionals in the early stages of their career making, by their own report, slightly more than minimum wage.

Based on this research, potential corrections include offering stipends for graduate students who choose internships at recovery sites, treating all treatment centers working with clients who have addictions as underserved and therefore deserving of extra federal and state resources on the organizational and individual levels, and offering an amnesty period for a return to licensure for those who were specialists and whose licenses have lapsed (Bakker et al., 2005; Demerouti et al., 2001).

Stipends for internship in addiction service. In general, internships are un- or minimally reimbursed educational and experiential opportunities that are invaluable training grounds for emerging therapists. In fact, supervised internship direct and indirect hours are part of the graduation requirements for CACREP-accredited clinical mental health counseling graduate programs. If a stipend were available to those students specializing in addiction, not at the expense of the internship site (which may be under resourced, especially if serving a population suffering from addiction and mental health issues), more students may be attracted to the specialty. As a recent example, for the 2017–2018 academic year, the State of New Hampshire offered a package of incentives for students specializing in addiction that included a $10,000 stipend and additional educational opportunities directly supporting the student's ability to earn an alcohol and drug counselor license after passing a board exam, leading to MLADC licensure after 3000 hours of post-Master's internship experience (C. Lounsbury, personal communication, October 6, 2019). Twenty students, who graduated between 2018 and 2019, took advantage of this opportunity and are presumably currently working as post-graduate therapists.

National Health Service Corps grant. The National Health Service Corps (NHSC) offers a student loan repayment program of up to $75,000 for 3 years of full-time work (or $37,500 for part-time work) at designated underserved sites that provide treatment for addiction (Friedman, 2019). Although a seemingly unbeatable offer, it does require that the post-graduate therapist specializing in addiction work at specified sites and organizes job fairs to match therapists with those agencies. However, the reality is that all agencies in all communities are under -resourced and -staffed to respond to the current opioid epidemic. Overtaxed staff have been shifted into care of those with opioid-related disorders, leaving those with addiction to other

substances to catch whatever time and energy is left over. The grant needs to be extended to cover all therapists specializing in addiction, perhaps funded by the anticipated settlements of pharmaceutical companies most implicated in the opioid epidemic.

Amnesty. To entice therapists back to their previously-chosen specialty who have given up their licenses and credentials in addiction treatment, I propose offering a return-to-service grace period over a designated future 6 months when all previously qualified therapists could renew their licenses as alcohol and drug counselors without the requirement of retaking the board exams or proof of continuing education credits on addiction topics. A current license in another helping profession could serve as proof of ongoing direct service hours. Society can ill afford to have side-lined educated, qualified professionals because of inequities we visited on those same professionals who are desperately needed on the front lines.

Proposition 4: Education about addiction at the graduate and medical school level will broaden the pool of trained professional helpers available to address the opioid epidemic and addiction in general and reduce the Stigma, Stigma-by-Association, and discrimination against people with addiction and those who choose to work with them. As a result of a lack of training in addiction across the helping professions, many perceive addiction as different, foreign, and perhaps even a moral rather than medical issue. Such misperception creates the sense that only people in recovery should or can help people with addiction and leads to a nonparallel system. The buffering role of Community is forestalled and unavailable to therapists who specialize in addiction, who are seen as perhaps inextricably part of the different, foreign, and immoral "other" due to the historical misunderstanding of who does this work, and why (Ducharme et al., 2008; D. K. Knight et al., 2012; Nohria et al., 2008).

Based on this research, potential corrections include educating all helping professions in addiction, offering incentives to specialize in addiction work, and expanding the Master of Addiction Counseling certification as proof of training and supervised experience to treat clients with addiction across all helping disciplines. As previously discussed, providing all helping professionals with some basic training in addiction treatment, it might go a long way toward removing the Stigma and othering directed at therapists who specialize in addiction and their clients. Adding addiction counseling to the general medical curricula for prospective doctors and nurses would promote and validate the concept that addiction is a disease. Similarly, ensuring psychologists, psychiatrists, and all therapists and social workers receive basic training in addiction treatment as part of their general graduate education would promote and validate the concept that addiction is a co-occurring mental health disorder.

It is important for all these proposed corrections to work together if any one of them will work over the long term. Apparent from the Professionalization movement over the past 30 years that forward momentum in any one area can be stalled and reversed by misperceptions and lack of education in another arena.

Study Limitations and Scope

The research included a small, purposeful sample of therapists who specialize in addiction, including social workers, clinical mental health counselors, and nursing professionals. The sample was limited to a specific geographical, three-state area, although many of the professionals interviewed had worked in and brought perspectives from their practice in other countries and regions. This regional sample was also, and perhaps stereotypically, racially homogeneous. Although geography and race are important limiting factors, the more general

research literature surveyed for this study mirrored these findings. This mirror points toward the transferability and trustworthiness of the findings but also leaves room for future exploration of other regions with other racial mixes, or indeed of a national research endeavor.

Implications of Theoretical Propositions for Leadership and Change

We are currently at an interesting space in history, when the companies who made billions of dollars on prescription pain killers are being required to pay legal settlements. Investing pharmaceutical reimbursements could support the therapists who treat those same individuals affected by the opioid crisis, in part mitigating the incredible damage done by a capitalism-driven attack on those who became addicted. As discussed in the propositions offered earlier in this chapter, money realized from the legal settlements against pharmaceutical companies could become investments, with the proceeds used to equalize pay rates, encourage students and previously-licensed and credentialed professionals to enter or return to addiction treatment, enhance and expand the NHSC loan repayment program, expand education in addiction treatment to include previously undereducated helping professions, and relocate sites of addiction care to more closely resemble locations of care for other medical complaints.

Community mental health, private not-for-profit, behavioral health, and other agencies that employ therapists specializing in addiction will need to prioritize providing good-enough supervision. One way to best accomplish prioritizing is by utilizing the ACS accreditation discussed earlier, ensuring at the very least that the supervisor has met basic experience and education requirements before being given the important responsibility of supervision of staff and interns. Supervisors will need to support their therapists who specialize in addiction to

access needed continuing education through allowing paid education time and reimbursement for continuing education workshops, conferences, and university courses.

Leaders in professional organizations and state licensure boards will need to lead the field in demanding that Medicare credential LCMHCs and LADCs and require true parity for mental health and addiction treatment among private and public insurance options. If this does not occur, the professional field will lose a substantial percentage of those best trained to work with people who have addictions if Medicare for all becomes a reality. Private insurance companies are by no means separate but equal in terms of parity for mental health and addiction treatment, an admission needed to cease the historical reality of spa-like addiction treatment for the wealthy and incarceration for the poor and addicted.

Fundamental changes and the leadership to support necessary changes are required. Policymakers at the governmental and hospital administrative levels, directors of programs, clinical managers and clinical supervisors will need to lead this change. Left on its own, the momentum for Professionalization has met with historical misunderstandings, stereotype, and Stigma and reversed direction. In addition to these proposed, and substantial, financial investments, therapists specializing in addiction treatment should be required participants and colleagues in any behavioral health, mental health, and general medical health establishment. Their input is necessary, perhaps vitally so, during the current opioid epidemic and to provide guidance for clients and colleagues alike; without such input, the U.S. may see another opioid epidemic in 20 or so years, when the children of those currently served reach adolescence and adulthood and begin working through their own mental health and addiction journeys.

It would be interesting to expand this research to interview therapists specializing in addiction in other geographical areas and of other racial and ethnic groups. This research centered on a small, regional, homogeneous sample that mirrored the national percentages; however, there is obviously an opportunity to learn more, hear more (and potentially different) wisdom, and thereby broaden the understanding gained herein. Follow-up research would also be welcome for the swings between Professionalization and, if it continues on its current arc, De-professionalization. Researchers could also give us a sense of which wellness interventions might be the most effective and efficient at supporting this specific workforce. It would also be illustrative to hear from addiction specialists with other professional designations, to find out if the Stigma and Stigma-by-Association issues identified herein are fully generalizable to all those helping professionals who work with those who have addiction.

Conclusion

This study was an attempt, through grounded theory and situational analysis, to understand the lived experience of therapists who specialize in addiction. There was no question of grit; in fact, quite the opposite. Without passion, there is no burnout; without pressure, there is no stress; and without enhanced supports, there will be no guarantee of thriving for therapists or their clients. The therapists in this study, who spent at least an hour of their scarce free time to participate in the interviews, identified several nonlinear developmental stages that led, through the situational analysis of the social arenas affecting their professional lives, directly to the focused proposals for change. America is in a time of addiction crisis; to not recreate the same barriers in the next generation, it is imperative to learn the lessons from the current opioid epidemic.

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Appendix

Appendix A. Consent Form for Research Participants

DISSERTATION PARTICIPANT CONSENT FORM

This informed consent form is for **therapists specializing in addiction** who have been invited to participate in a project titled "**Therapists who Specialize in Addiction: A Grounded Situational Analysis of a Stigmatized Profession."**

Name of Principle Investigator: Heather Humphrey-Leclaire, MA, LCMHC, LADC
Name of Organization: Antioch University, PhD in Leadership and Change Program
Name of Project: Therapists who Specialize in Addiction: A Grounded Situational Analysis of a Stigmatized Profession

You will be given a copy of the full Informed Consent Form

Introduction

I am **Heather Humphrey-Leclaire**, a PhD student enrolled in the Leadership and Change program at Antioch University. As part of this degree, I am completing a dissertation **to understand more fully the experience of therapists specializing in addiction counseling concerning how they are perceived by their colleagues and the larger mental health community.** I am going to give you information about the project and invite you to participate. You may talk to anyone you feel comfortable talking with about the project and take time to reflect on whether you want to participate or not. You may ask questions at any time.

Purpose of the Research

The purpose of this project is to **draw attention to the needs and opportunities for policy makers to mitigate the high levels of burnout, stigma, and attrition (job turnover) among addiction professionals.** This information may help me to **examine the macro, meso, and micro social processes affecting therapists specializing in addiction counseling as they manage the competing priorities of valued work with an underserved and suffering population in under-resourced and marginalized clinical environments.**

Project Activities

This project will involve your participation in a **one-on-one interview** lasting approximately 60 to 90 minutes). Interviews will be audio recorded solely for research purposes and transcribed with strict attention to confidentiality. You may be asked to participate in a follow-up interview for the purpose of clarification or verification.

Participant Selection

You are being invited to take part in this project because **I believe your experiences as a therapist specializing in addiction counseling can contribute to understanding various elements of this topic.**

Voluntary Participation

Your participation in this project is completely voluntary. You may choose not to participate. You will not be penalized for your decision not to participate or for anything involved with your contributions during the project. You may withdraw from this study at any time. **If an interview has already taken place, you may request that the information you provided not be used in this research.**

Risks

I do not anticipate that you will be harmed or distressed as a result of participating in this project. You may stop being in the project at any time if you become uncomfortable. I will be available for processing any unanticipated discomfort in person or by phone.

Benefits

There will be no direct benefit to you, but your participation may help me to learn more about **the macro, meso, and micro social processes affecting therapists specializing in addiction counseling.**

Reimbursements

You will not be provided any monetary or other incentive to take part in this research project.

Confidentiality

All information will be de-identified, so that it cannot be connected back to you. Your real name will be replaced with a pseudonym in the write-up of this project. I will be the only person with access to the list connecting your name to the pseudonym. This list, along with any digital recordings will be kept in a secure, password-secured computer. Generally speaking, I can assure you that I will keep everything you tell me or do for the study private (professional limits of confidentiality apply).

Future Publication

This project will be published as a dissertation and the results may be further published as an article or articles.

Right to Refuse or Withdraw

You do not have to take part in this research if you do not wish to do so, and you may withdraw from the study at any time without repercussions.

Who to Contact

If you have any questions, you may ask them now or later. If you have questions later, you may contact **Heather Humphrey-Leclaire, e-mail:** redacted. If you have any ethical concerns about this study, contact Lisa Kreeger, PhD, Chair, Institutional Review Board, Antioch University Ph.D. in Leadership and Change, e-mail: redacted.

DISSERTATION PARTICIPANT CONSENT FORM

Therapists who Specialize in Addiction: A Grounded Situational Analysis of a Stigmatized Profession

Name of Principle Investigator: Heather Humphrey-Leclaire, MA, LCMHC, LADC
Name of Organization: Antioch University, PhD in Leadership and Change Program
Name of Project: Therapists who Specialize in Addiction: A Grounded Situational Analysis of a Stigmatized Profession

DO YOU WISH TO PARTICIPATE IN THIS PROJECT?

I have read the foregoing information, or it has been read to me. I have had the opportunity to ask questions about it and any questions I have been asked have been answered to my satisfaction. I consent voluntarily to participate in this project.

Print Name of Participant

_____

Signature of Participant

_____

Date _____
day/month/year

DO YOU GIVE PERMISSION TO BE AUDIOTAPED AS PART OF THIS PROJECT?

I voluntarily agree to let the researcher audiotape me for this project. I agree to allow the use of my recordings as described in this form.

Print Name of Participant

_____

Signature of Participant

_____

Date _____
Day/month/year

To be filled out by the researcher or the person taking consent:

I confirm that the participant was given an opportunity to ask questions about the project and all the questions asked by the participant have been answered correctly and to the best of my ability. I confirm that the individual has not been coerced into giving consent, and the consent has been given freely and voluntarily.

A copy of this Informed Consent Form has been provided to the participant.

Print Name of Researcher/person taking the consent

_____

Signature of Researcher /person taking the consent

_____

Date _____

day/month/year

Appendix B. Locations of Care

This series of photographs show the three iterations of Turning Point Recovery Center (TPRC) in Brattleboro, Vermont. Turning Point's first location in Brattleboro was in a refurbished garage in the middle of one of the neighborhoods earliest and hardest hit by addiction, crime, and other socioeconomic stressors. Also noticeable by the view from the inside of the vehicle is that this, too, is not a walkable neighborhood.

Figure B.1. Photographs of locations of care: Turning Point's first location; copyright by author.

Figure B.2. Photographs of locations of care: Turning Point One's neighbors; copyright by author.

Figure B.3. Photographs of locations of care: Turning Point One's neighbors; copyright by author.

For many good reasons, including an unsupportably steep increase in rent, Turning Point moved out of its first location, and found a space in an industrial park between the main business route through town and just in front of the train tracks. Unfortunately, this move created a tremendous barrier to access, with inconsistent and inconvenient bus service. The main hotels available to the town's homeless population during inclement winter weather (designated as under 20°F) were also in this area, which theoretically kept the Center in the middle of the need.

During the opioid epidemic, however, this area of town developed into another hub for drug trafficking.

Figure B.4. Photographs of locations of care: Front aspect of Turning Point Two; copyright by author.

Figure B.5. Photographs of locations of care: Rear aspect of Turning Point Two; copyright by author.

Turning Point's board spent several years trying to find an affordable space downtown to address their target population's transportation and access issues. After Tropical Storm Irene, Turning Point was able to buy and rebuild practically from the foundation up a damaged property at the bottom of the hill from its first location. Again, the space has been made beautiful and welcoming. It is only when the surroundings are visible that the marginalization of the target population, and the people who choose to support them, is apparent.

Figure B.6. Photographs of locations of care: Turning Point Recovery Center 2019; copyright by author.

Figure B.7. Photographs of locations of care: Brownfield site across from current Turning Point Recovery Center; copyright by author.