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Dancing Between Two Worlds: Training Experiences of Dual Credentialed Counselors

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DANCING BETWEEN TWO WORLDS: TRAINING EXPERIENCES OF DUAL CREDENTIALED COUNSELORS

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ABSTRACT

DANCING BETWEEN TWO WORLDS: TRAINING EXPERIENCES OF DUAL CREDENTIALED COUNSELORS

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Several challenges exist in the implementation of integrated care given that SUD/Addiction treatment has historically been segregated from the broader health care system (Office of the Surgeon General, 2016). One expression of the gap that persists is that for counselors who want to administer SUD/Addiction and mental health counseling, or co-occurring services, in Washington State they are required to satisfy state requirements for two separate credentials. The purpose of this study was to conduct an in-depth exploration into the training experiences of Dual Credentialed Counselors (DCCs) in Washington State where two separate credentials are required to administer co-occurring counseling. In this Interpretive Phenomenological Analysis, six participants agreed to share their training experiences. Two semi-structured interviews were conducted with each participant. Research study findings illuminated themes that reflected how participants made sense of their training experience given the segregation, features, and conditions that were part of the ecosystem within which they trained, and elucidated how they navigated the divisions that persist between SUD/Addiction and mental health counseling. Ultimately, the study revealed that there are several opportunities to develop training resources. The dearth of supervision models which specifically address the nuances and complexity of administering co-occurring counseling is a conspicuous gap to fill. Further research studies focused on the development of resources and supervision models, which address the training needs of DCCs, could contribute to the implementation of integrated care. This dissertation is

available in open access at AURA (https://aura.antioch.edu) and OhioLINK ETD Center (https://etd.ohiolink.edu).

Keywords: co-occurring counseling, dual credentialed counselor, integrated care, SUD/Addiction counseling supervision, co-occurring counseling supervision

Dedication

This work is dedicated to the memory of my dear friend and brother in recovery, David. I promise to continue my efforts towards helping people find their way out. Also, to my brother Nicholas, who entered SUD/Addiction treatment for the first time as I was finishing this dissertation. I will cherish every day that we are sober together. Finally, and most importantly to my husband, David Rudduck, thank you from the bottom of my heart for your unwavering love and support. I could not have done this without you. Your dedication to working on the frontlines of addiction recovery for over the last two decades continues to inspire me.

Also, I dedicate this work to my participants who generously shared their stories and experiences. I am honored by your willingness to be a part of this study and without you I could not have realized the vision I had for this inquiry which was to bring more awareness to the ways we can support counselors doing co-occurring counseling. Your dedication to the field and perserverence to become DCCs are inspiring to me. I am so proud and grateful to be among you.

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CHAPTER I: INTRODUCTION

Background of the Problem

The U.S. Department of Health and Human Services Substance Abuse and Mental Health Services Administration (SAMHSA) 2020 National Survey on Drug Use and Health (NSDUH) reported that "40.3 million people aged 12 or older" met the American Psychiatric Association's (2013) *Diagnostic and Statistical Manual of Mental Disorders* (5th ed.; *DSM-5*) criteria for substance use disorder (SAMHSA, 2021, p.3). The 2020 SAMHSA report also showed that of the "644,000 adolescents aged 12 to 17 in 2020" who presented with a Substance Use Disorder (SUD) and a major depressive episode (MDE), "69 % received either substance use treatment at a specialty facility or mental health services in the past year," "66.8% received only mental health services," and "0.9% received both substance use treatment at a specialty facility and mental health services" (SAMHSA, 2021, p. 5). In 2020, there were "17 million adults aged 18 years or older in 2020" that presented with a SUD and any mental illness (AMI) (SAMHSA, 2021, p. 5). Of those 17 million people, "50.5% received either substance use treatment at a specialty facility or mental health services," "42.3% who received only mental health services," "2.5% who received only substance use treatment at a specialty facility," "and 5.7% who received both substance use treatment at a specialty facility and mental health services" (SAMHSA, 2021, p. 5). As the 2020 SAMHSA report demonstrates, not all people in need of co-occurring counseling are receiving services for both SUD and mental health issues.

A recent Surgeon General's report (Office of the Surgeon General, 2016) on the state of substance use disorders and addiction in the United States highlights the importance of increasing the integration of substance use disorder (SUD) treatment with other medical and behavioral health service provision. For decades, the SUD/Addiction treatment field has been

segregated from the broader health care system for a variety of sociopolitical reasons (Office of the Surgeon General, 2016; White, 1998). The result of SUD/Addiction treatment being siloed from other health care settings has meant that individuals in need of co-occurring services have been underdiagnosed, misdiagnosed, and sometimes left to progress into later stages of addiction (Office of the Surgeon General, 2016; Priester et al., 2016; SAMHSA, 2020).

The 2016 Surgeon General's Report (Office of the Surgeon General, 2016) highlighted the current shortage of behavioral health and medical personnel with adequate training to administer integrated services. Federal and State legislative agendas have been put in motion to integrate SUD/Addiction treatment into health care service complexes (Governor Inslee's Communications Office, 2017, 2018; Office of the Surgeon General, 2016). Aligned with national trends, the shift to more integrated health care services has occurred over the past several years at the state level. The movement towards integrated care in Washington State has involved reform or reorganization of individual credentialing, organizational designations, and broader systemic changes to support integration between SUD/Addiction and behavioral health services (Governor Inslee's Communications Office, 2017, 2018). The essential goal of integrated care with respect to SUD/Addiction is to intervene earlier, more effectively address mental health issues that accompany SUD/addiction, and prevent more acute, fatal medical issues, ultimately saving money and lives (Office of the Surgeon General, 2016).

Statement of Problem

Counselors pursuing the two credentials required to administer SUD/Addiction and Mental Health (MH) services simultaneously are referred to in this study as Dual Credential Counselors (DCCs). In the State of Washington, these professionals complete education requirements and supervised work experience hours to obtain the credentials of Substance Use

Disorder Professional (SUDP) and Licensed Mental Health Counselor (LMHC). Due to the segregation of the SUD/Addiction treatment field from mental health counseling which has historical underpinnings (White, 1998), DCCs obtain their training experience in the context of two clinical worlds that in many ways may operate independently of one another. Supervision models and their applications are well documented in the mental health counseling field (ACA, 2014; Bernard & Goodyear, 2019; Stoltenberg & McNeill, 2010). Likewise, there is literature devoted to best practices for supervision of SUD/Addiction treatment professionals and the inherent nuanced dynamics (Culbreth, 1999; Powell & Brodsky, 2004; Rothrauff-Laschover et al., 2013; SAMHSA, 2014; Schmidt, 2012; Schmidt et al., 2013). However, there appears to be a gap in scholarly works devoted to integrated training and supervision for counselors pursuing dual credentialing to provide co-occurring services.

Counselors dedicated to meeting qualifications necessary to provide effective counseling services to clients with co-occurring SUD/Addiction and mental health issues are required to assimilate messages, feedback, models, styles, cultures, and diagnostic tools. Research conducted to understand the professional development and supervisory needs of DCCs may prove to be an important building block towards supporting counselors who are administering co-occurring counseling services.

Purpose of the Study

The purpose of this qualitative study is to discover more about the experiences and perspectives of counselors who have completed the process of becoming a DCC in the State of Washington. The study was designed to identify themes that reflected the meaning making processes, features, conditions, perspectives, needs, and challenges connected to the lived experience of DCCs in the State of Washington.

Research Question

This study was designed to locate experiences which may foster important information about the training and development of DCCs in the State of Washington. The research question was, *How have dual credentialed counselors in the State of Washington made sense of their training experience when navigating the division between the SUD/Addiction treatment and mental health counseling fields?* The question was aimed at collecting pertinent data that would offer an in-depth look at the lived experience of professionals that have become DCCs. A great deal of consideration was given to the construction of the research question so that it reflected the multidimensional experience of DCC training. The research question was focused on the lived experience of DCCs which included their internal processes as well as their interactions with the conditions that comprised the ecosystem within which they received their training.

Significance of the Study

Federal and state legislative agendas have mobilized towards a more integrated approach to treating clients with co-occurring SUD/Addiction and mental issues (Governor Inslee's Communications Office, 2017, 2018; Office of the Surgeon General, 2016). The complexities inherent to the intertwining of these professions is one of the trials in the movement towards more integrated care for clients with co-occurring issues. Reports have demonstrated the impacts to individuals and society that result from a lack of access to co-occurring services (Office of the Surgeon General, 2016; SAMHSA, 2009, 2020). In Washington State, there is a shortage of DCCs which contributes to the barriers to implementing more integrated co-occurring services (O'Connor et al., 2019). This study explores the training experiences of counselors who have completed requirements to be a DCC in Washington State, which is a starting point for increasing understanding about training needs, barriers, challenges, and sources of support.

Definition of Key Terms

This research study required the use of terms specific to the field of SUD/Addiction treatment and co-occurring work. Furthermore, several specific credentials are used throughout, which warrant definition. First, "Substance Use Disorder/s" (SUD/SUDs) is the language used by the *DSM-5* to diagnose clients with use patterns that warrant assistance (American Psychiatric Association, 2013). "Addiction" is not used as a diagnostic category in the *DSM-5*, but is a term used in many behavioral and medical disciplines to indicate more severe SUDs (National Institute on Drug Abuse [NIDA], 2018). Distinctions between *substance abuse*, *misuse*, and *addiction* are also important regarding understanding relevant statistics.

> *Drug use* refers to any scope of illegal drugs: heroin use, cocaine use, tobacco use. (NIDA, 2018, p. 2)

> *Drug misuse* is used to distinguish improper or unhealthy use from use of medication as prescribed or alcohol in moderation. These include the repeated use of drugs to produce pleasure, alleviate stress, and/or alter or avoid reality. (NIDA, 2018, p. 2)

> NIDA uses the term *misuse*, as it is roughly equivalent to the term *abuse*. Substance abuse is a diagnostic term that is increasingly avoided by professionals because it can be shaming, and adds to the stigma that often keeps people from asking or help. (NIDA, 2018, p. 3)

> Addiction is defined as a chronic, relapsing disorder characterized by compulsive drug seeking, continued use despite harmful consequences, and long-lasting changes in the brain. It is considered both a complex brain disorder and a mental illness. Addiction is the most severe form of a full spectrum of substance use disorders, and is a medical illness caused by repeated misuse of a substance or substances. (NIDA, 2018, p. 1)

> *Addiction is a treatable, chronic, medical disease involving complex interactions among brain circuits, genetics, the environment, and an individual's life experiences. People with addiction use substances or engage in behaviors that become compulsive and often continue despite harmful consequences. Prevention efforts and treatment approaches for addiction are generally as successful as those for other chronic diseases*. (American Society of Addiction Medicine, 2019)

The Surgeon General's Report (2016) describes the term *Recovery*:

> For some people with substance use disorders, especially those whose problems are not severe, remission is the end of a chapter in their life that they rarely think about later, if at all. But for others, particularly those with more severe substance use disorders, remission

> is a component of a broader change in their behavior, outlook, and identity. That change process becomes an ongoing part of how they think about themselves and their experience with substances. Such people describe themselves as being "in recovery." (Surgeon General, 2016, p. 5-3)

For the purposes of this research proposal, *SUD/Addiction* will be used as it respects the current diagnostic language used in the *DSM-5*, and includes the term, *Addiction*, which is used in behavioral health organizations, government agencies, reports and the addiction treatment field. Furthermore, the term *Addiction* denotes the condition that is classified as a medical disease by the American Medical Association (Bettinardi-Angres & Angres, 2010; White, 1998) and the American Society of Addiction Medicine (2019).

It is important for readers to have working definitions for *co-occurring* or *dual diagnosis treatment* and *integrated treatment*. Descriptions offered by the U.S. Department of Health and Human Services Substance Abuse and Mental Health Services Administration (SAMHSA, 2009) are as follows:

> *Dual diagnosis* [emphasis added] treatments combine or integrate mental health and substance abuse interventions at the level of the clinical intervention. (SAMHSA, 2009, p. 470)

> Hence *Integrated treatment* [emphasis added] means that the same clinicians or teams of clinicians, working in one setting, provide appropriate mental health and substance abuse interventions in a coordinated fashion. In other words, the caregivers take responsibility for combining the interventions into one coherent package. (SAMHSA, 2009, p. 470)

Finally, the term *Dually Credentialed Counselor* (DCC) will be used throughout this proposal. A DCC is a master's level counselor in the State of Washington who obtained credentials governed by the Washington State Department of Health. One credential is the *Substance Use Disorder Professional* (SUDP), which is a credential, not a license, that is required in order to administer any SUD/Addiction services. The other is the *Licensed Mental*

Health Counselor (LMHC), which is a license corresponding with the national mental health counseling profession and identity.

Limitations

This study was limited to DCCs in Washington State. The inclusion criteria were that participants be both a Washington State Licensed Mental Health Counselor (LMHC) and a Substance Use Disorder Professional (SUDP). Since participants were already fully licensed in the State of Washington, that precluded counselors currently working towards licensure from being in the study. Due to the scope of the study being limited to Washington State and the requirement for participation to be fully licensed as a DCC, some perspectives were not represented in this study.

Conclusion

The purpose of this study was to examine the lived experiences of DCCs and to discover more about how they made sense of their training straddling the SUD/Addiction treatment and mental health counseling worlds. While research shows that the integration of SUD/Addiction treatment with other health care disciplines would increase access and quality of care to stakeholders, several challenges exist when it comes to implementation (Office of the Surgeon General, 2016). One aspect of implementation that is represented in the focus of this research study is the training experiences of counselors pursuing credentialing necessary to administer co-occurring counseling. The overarching intention of this study is to contribute to the integration of SUD/Addiction treatment and mental health counseling by increasing awareness about the training experiences of DCCs in Washington State to produce a better estimation of their needs.

CHAPTER II: REVIEW OF LITERATURE

Introduction

The research question for this study was, *How have dual credentialed providers in the State of Washington made sense of their training experience when navigating the division between Substance Use Disorder (SUD)/Addiction treatment and mental health counseling fields?* The literature review examined scholarly works focused on topic areas germane to DCC training, including research focused on the composite training experience of DCCs. A review of the literature revealed three broad topic areas that are covered in this section: *Relevant Historical Context, Nuances of SUD/Addiction Counselor Training,* and *Training Experiences of DCCs.* A search for scholarly works provided ample resources focused on features related to the historical context of the segregation of SUD/Addiction treatment from other disciplines and the nuances inherent to co-occurring counseling. However, a gap was revealed related to scholarly works focused on the composite experience of clinicians who developed their identity and skill set in the contexts of SUD/Addiction treatment and professional counseling. One aspect of this gap is expressed in the lack of supervision models that integrate features and nuances of SUD/Addiction treatment and mental health counseling into a cohesive framework.

Literature Review Search

The literature reviewed identified articles related to a wide range of topics using Wiley Online Library, Antioch University Databases, ProQuest Psychology Database, PsycINFO, and ERIC. Initially, search topics included phrases that described the focus of the study such as "training experiences of dual credentialed providers," "professional development of substance use disorder professionals and mental health counselors," "supervision of dual credentialed SUD and mental health counselors," and "supervision of co-occurring mental health and substance use

disorder counseling." Multiple terms are used to represent SUD/Addiction. Several variations of terms were used such as "substance use," "substance misuse," "substance use disorder," "chemical dependence," and "addiction" to conduct a thorough search. The results of multiple searches produced scholarly works that fit into three domains: historical context, nuances of the SUD/Addiction treatment counseling world, and topics that related to training experiences of DCCs. Examination of the literature was furthered on Google Scholar by utilizing search phrases related to the identified topic domains and collating non-redundant sources.

Additionally, the literature review included an examination of government reports, SUD/Addiction research institute publications, and journals. Reports created by the National Institute on Drug Abuse (NIDA) and the Substance Abuse and Mental Health Services Administration (SAMHSA) were studied to provide crucial historical and contemporary contexts. The 2016 Surgeon General's Report, *Facing Addiction in America* (Office of the Surgeon General, 2016), was thoroughly analyzed. As with other research studies included in this literature review, the reference lists were surveyed to identify additional sources and to consult primary works referenced. Journals germane to the inquiry such as the *Journal of Substance Abuse Treatment*, *Journal of Addictions & Offender Counseling*, *Journal of Addiction Therapy and Research*, and *Journal of Counseling & Development* were explored and produced some articles that described various aspects of the lived experience of DCCs.

The literature review conducted for this study included textbooks and training manuals related to SUD/Addiction treatment that might be used in bachelor's level or master's level education courses. An analysis of content included in textbooks provided additional resource lists of research and discussion. Textbook citations were used to further unpack topic domains and substantiate assertions. Additionally, SAMHSA's Treatment Improvement Protocol (TIP)

manuals and their Technical Assistance Publication (TAP) series were used to examine current standards established in the SUD/Addiction treatment industry. The resources cited in this literature review were organized into subtopics of the three larger domains identified: relevant historical context, nuances of SUD/Addiction counselor training, and training experiences of DCCs.

Theoretical Framework

The purpose of this study is to explore the lived experiences of DCCs in the State of Washington and how they have made sense of their training experience in the context of the SUD/Addiction treatment and mental health counseling segregation. Constructivist principles contribute to the backbone of this study. Constructivism is predicated on the idea that individuals learn and create meaning as they dance with their environment, times, culture, ecosystem, and other people or influences (McAuliffe & Eriksen, 2011; Mogashoa, 2014). Therefore, the literature review topic areas represent salient elements that comprise the atmosphere in which DCCs experienced the phenomenon being studied. Additionally, the inquiry is intended to offer insight to the learning and professional development processes experienced by the participants while undergoing training as DCCs.

Constructivism centers on the view that learning and meaning making are the result of a dynamic relational process between an individual's internal paradigms and the environmental context within which they are learning (Mogashoa, 2014). Participants in this study were asked to reflect and consider the ways their learning and development progressed within the specific context of two clinical disciplines that in many respects are not integrated. The scholarly works reviewed revealed features of the clinical ecosystem within which DCCs received training. The

literature review exhibited critical elements of the environment that participants interacted with as they trained to be DCCs.

Relevant Historical Context

Reports and training manuals (Office of the Surgeon General, 2016; SAMHSA, 2009, 2014, 2015, 2018, 2020) outlined research, statistics, and trends related to the historical context of the evolution of the SUD/Addiction treatment field evolving apart from other medical and behavioral health disciplines. The sociopolitical influences that rendered SUD/Addiction treatment a separate profession and industry are important to consider in terms of describing the current clinical contexts in which DCCs are trained. As the 2016 Surgeon General's report stated, "the separation of substance use disorder treatment from general health care also created unintended and enduring impediments to the quality and range of care options available to patients in both systems" (Office of the Surgeon General, 2016, p. 6-6). The historical context of the evolution of SUD/Addiction treatment has informed a path that continues to influence the current landscape of co-occurring service delivery. The evolution of treatment for SUD/Addiction is complex because it involves sociological, political, and legislative dimensions (Office of the Surgeon General, 2016; White, 1998), thereby creating varied and nuanced aspects of training counselors within these systems. Therefore, it is crucial to understand the training experiences of DCCs to better inform the future trajectory of co-occurring counseling. The following section will include three subtopic areas with historical roots to elucidate conditions pertinent to the training experience of DCCs in Washington State.

Evolution of SUD/Addiction Treatment as an Industry

In the early part of the Twentieth Century, SUD/Addiction was seen through a more of a moral lens than as a public health issue (Henninger & Sung, 2014; White, 1998). Before the

creation of Alcoholics Anonymous (AA), before the American Medical Association designation of addiction as a disease in 1950, and before legislation such as the Comprehensive Alcoholism Prevention and Treatment Act (The Hughes Act) in 1970, individuals with SUD/Addiction were often managed within the criminal justice system or sanitariums (Henninger & Sung, 2014; White, 1998). An examination of the medical and psychology fields during the early and mid-century revealed a lack of knowledge about how to treat as well as a lack of access to services available to help people presenting with SUD/Addiction (Office of the Surgeon General, 2016; White, 1998).

In the late 1930s and 1940s, Alcoholics Anonymous (AA) was started by Bill Wilson and Bob Smith (Alcoholics Anonymous [AA], 2002). Around the same time, Minnesota Model of treatment was in its inception (Henninger & Sung, 2014; White, 1998). The Minnesota Model provided a residential setting for individuals with SUD/Addiction to abstain from use, to receive medical attention for withdrawals, and to connect with others in process groups (Henninger & Sung, 2014; Huebner & Kantor, 2011; White, 1998). The creation of AA and Minnesota Model treatment offered services centered around viewing SUD/Addiction as a medical issue and assisted clients in the goal of abstinence from substances (Henninger & Sung, 2014; White, 1998). The creation of AA and Minnesota Model treatment provided care, support and services to a individuals with SUD/Addiction. However, as the Surgeon General's Report (2016) states in reference to the historical evolution of SUD/Addiction treatment, "Despite the compelling national need for treatment, the existing health care system was neither trained to care for, nor especially eager to accept, patients with substance use disorders" (p. 6-5). A workforce was needed to provide services in the facilities administering SUD/Addiction treatment.

In the middle of the 20th century, the industry of SUD/Addiction treatment began to evolve to address treatment through a health care lens versus a moral or criminal justice lens (Henninger & Sung, 2014; White, 1998). The budding SUD/Addiction treatment industry needed a workforce (Doukas & Cullen, 2011; White, 1998). Early treatment centers recruited people who had been through SUD/Addiction treatment and had accumulated sober time (White, 1998, 2010). Many of these individuals were involved in AA, also commonly referred to as a "Twelve Step program" (White, 1998, 2010). The growing and evolving SUD/Addiction treatment workforce consisted of paraprofessionals and individuals sometimes whose only qualifications were sobriety and involvement in Twelve Step recovery. In an effort to establish oversight on the new workforce, standards and state credentials for SUD/Addiction treatment professionals were eventually established (White, 1998). Many states designated or established these new credentials separately from other behavioral and medical professional credentials.

The workforce that emerged in the early 20th century to provide care and treatment to individuals with SUD/Addiction continues to exist today. Currently many states have a separate credential, or multiple credentials, designated to administer SUD/Addiction treatment (Office of the Assistant Secretary for Planning and Education [ASPE], 2019). Washington State has the Substance Use Disorder Professional (SUDP) which is the credential necessary to obtain in order to administer SUD/Addiction treatment services. One aspect of the segregation between SUD/Addiction treatment and behavioral health care disciplines is operational and expressed in credentialing.

While the evolution of services centered on providing respectful and effective care to individuals with SUD/Addiction was an important movement, it was also established apart from other health care spheres (Office of the Surgeon General, 2016). "This meant that with the

exception of withdrawal management in hospitals (detoxification) virtually all substance use disorder treatment was delivered by programs that were geographically, financially, culturally, and organizationally separate from mainstream health care" (Office of the Surgeon General, 2016, p. 6-5). The separation continues today in the form of service delivery, funding streams, and state credentialing. Understanding the sociopolitical historical context of the separation between SUD/Addiction treatment and mainstream health care system is crucial to comprehending the clinical training landscape in which DCCs receive their training.

Harm Reduction and Abstinence-Based Approaches

Counselors seeking dual credentialing may be trained in a variety of settings with a range of approaches to SUD/Addiction treatment. Clinical settings may adopt an abstinence-based approach, a harm reduction approach, medication assisted treatment, or an amalgamation of milieus. When it comes to service delivery, there are treatment approaches more informed by the abstinence-based model, approaches informed by harm reduction strategies, and others that are more of a hybrid. The approach employed by an agency contributes to the clinical context within which trainees learn, thereby proving an important factor to understand when exploring the training experiences of DCCs.

Harm reduction as an approach to SUD/Addiction treatment has roots in the history of HIV/AIDS as a public health issue (Des Jarlais, 2017; Logan & Marlatt, 2010; Roe, 2005). Harm reduction methods include needle exchange programs, use of medications, and engaging in outreach (Marlatt et al., 2001; White, 1998). Fundamentally, harm reduction seeks to reduce the harmful impact of substance use on individuals and the community (Logan & Marlatt, 2010; Marlatt et al., 2001). The approach does not require abstinence to receive services, but abstinence can be a goal for an individual. Essentially, assessment of client progress is determined if

interventions are reducing harm in a client's life or the community regardless of their use patterns (Marlatt et al., 2001). Motivational interviewing, unconditional positive regard, and meeting the client at their given stage in the change process are some features that are associated with harm reduction (Marlatt et al., 2001). Counselors who received supervised work experience hours at a clinic that employed harm reduction principles acquire their training through this lens or orientation.

Abstinence-based, or medical model treatment is predicated on SUD/Addiction being a medical condition, or disease involving the central nervous system (Stevens & R. L. Smith, 2018). Clients who meet criteria for SUD/Addiction based on the *DSM-5* (American Psychiatric Association, 2013) symptoms and level of severity are assessed for the appropriate level of care, in many cases by utilizing the American Society of Addiction Medicine (2019) criteria for placement (Inaba & Cohen, 2014; Morgen, 2017). Types of facilities or levels of care include hospital detoxification, residential treatment, or intensive outpatient treatment (Inaba & Cohen, 2014). The components of abstinence-based treatment include psychoeducation about the effects of alcohol and drugs on the nervous system, process groups, individual sessions, and care coordination with other service providers or recovery supports (Inaba & Cohen, 2014; Morgen, 2017). Additionally, many programs offer family or significant other support groups. Some abstinence-based programs incorporate medication assisted treatment into their services to assist with withdrawal complications and discomfort. Trainees who completed work experience hours in an abstinence-based program learned to treat addiction and the recovery process through a lens that views addiction as a treatable medical condition.

Some treatment programs may employ a hybrid or combination of principles from both the abstinence-based approach and the harm reduction approach. The purpose of this section of

the literature review was to introduce treatment approach as an important component in examining the training experiences of DCCs. Abstinence-based, or medical model and harm reduction have been long-standing approaches utilized in SUD/Addiction treatment, and continue to be to this day (Inaba & Cohen, 2014; White, 1998). Thus, the takeaway is that the approach or lens used by a treatment center is a contributing factor to the training experiences of DCCs.

Movement Toward Integrated Care

Research shows that early prevention and referrals to appropriate levels of care for people with co-occurring issues increases access to care (Office of the Surgeon General, 2016; SAMHSA, 2020). Additionally, research shows that adequately training health care workers on effective screening, referral, and ongoing care management creates a more integrated system capable of connecting more people with help (Office of the Surgeon General, 2016; SAMHSA, 2020). The 2016 Surgeon General's Report stated, "The existing health care workforce is already understaffed and often lacks the necessary training and education to address substance use disorders" (p. 6-27). Some movement has been made toward integrated care, but there is still more progress to be made toward this effort. The change process that is currently underway contributes to conditions within which DCCs are receiving their training.

Nuances of SUD/Addiction Counselor Training

Stigma Associated with SUD/Addiction

SUDs/Addictions have social, relational, occupational, health, and economic consequences. Individuals who struggle with SUD/Addiction often incur criminal charges, experience relational challenges, and are unable to sustain day-to-day responsibilities as their condition progresses. Even though SUD/Addiction has been classified as an illness by the

American Medical Association since the 1950s (Bettinardi-Angres & Angres, 2010), negative stigmas persist (Crapanzano et al., 2019; Greenbaum, 2019; National Academies of Sciences Engineering, & Medicine, 2016; Volkow, 2020). Stigma and negative stereotypes related to SUD/Addiction contribute to the problem of individuals not receiving adequate care (Office of the Surgeon General, 2016; Volkow; 2020). Although the stigmas associated with SUD/Addiction treatment are well documented, additional research focused on the role stigmas play in collegial relationships involving recovering and non-recovering counselors, supervisory dyads, and counselor education programs could produce valuable insight.

Some research indicates that stigma plays a role in counselors' attitudes and approach to treatment. Chasek et al. (2012) conducted a study to examine the connection between attitudes toward SUD/Addiction influenced by stereotypical associations and positive expectations in treatment outcomes. The study findings concluded that non-stereotypical attitudes toward SUD/Addiction contributed to optimism about treatment outcomes. Additionally, the investigation demonstrated the importance of counselor education programs adequately addressing students' biases and assumptions about people with SUD/Addiction. Supervisors and counselor educators in relationships with counselors in training who identify as being in recovery need to be aware of their biases, prejudices, and stigmas related to individuals with a history of SUD/Addiction.

Recovery Status

Since the inception of the SUD/Addiction treatment field, a large swath of the workforce has consisted of people identified as being "in recovery" from SUD/Addiction (White, 1998). Scholarly works have examined various aspects of recovery status amongst counselors (Culbreth, 1999, 2000; Culbreth & Borders, 1999; Curtis & de Tormes Eby, 2010; Doukas & Cullen, 2011;

K. Doyle, 1997). In the early years of SUD/Addiction treatment, people in recovery were recruited to comprise the needed workforce, as there was a great need to be filled (Office of the Surgeon General, 2016; White, 1998). These paraprofessionals relied on recovery experience as their main tool for helping others in withdrawals and early stages of addiction recovery. Many of the paraprofessionals were involved in Twelve Step recovery programs. For the purposes of this section, it is important to establish a definition for recovery.

The 2016 Surgeon General's report defined *recovery* in the following way:

> For some people with substance use disorders, especially those whose problems are not severe, remission is the end of a chapter in their life that they rarely think about later, if at all. But for others, particularly those with more severe substance use disorders, remission is a component of a broader change in their behavior, outlook, and identity. That change process becomes an ongoing part of how they think about themselves and their experience with substances. Such people describe themselves as being "in recovery." (p. 5-3)

A literature review (Culbreth, 2000) was conducted to collate research that examined how recovery status influenced counselors. Sixteen research studies published between 1973 and 1996 explored variations between recovering and non-recovering. Ultimately, the literature review revealed that there were notable differences between the groups, but that the differences were not related to clinical efficacy. Rather, the variations had more to do with perspectives and approaches to clinical work. Culbreth (2000) pointed out that additional inquiries could reveal important information related to the training process for counselors.

Recovery status has been shown to be an influencing factor on clinical approach. Crabb and Linton (2007) conducted a qualitative research study to explore belief systems held by counselors identifying as in recovery and those held by counselors not in recovery. It showed a range of belief systems with one end aligned toward what was considered to be the more "traditional" and included, disease model/Twelve Step-based approach, and the other end alternative approaches, considered to be "nontraditional" (Crabb & Linton, 2007, p. 11). Crabb

and Linton (2007) discovered that recovery status was not necessarily a predictor of where individuals would fall on the continuum. However, the study (Crab & Linton, 2007) identified a potential bias related to forming assumptions that counselors in recovery might lean more towards certain approaches. Additionally, the study eluded to an opportunity for further research concerning recovery status and how biases might be expressed in collegial relationships.

A study conducted by Curtis and de Tormes Eby (2010) highlighted recovery status a factor that is connected to motivation to administer SUD/Addiction counseling. The research findings suggested that there is a relationship between recovery status and dedication to the work of being an SUD/Addiction counselor. Based on the findings, the Curtis and de Tormes Eby (2010) seemed to indicate that recovery status is an important component to consider and linked recovery status to motivation and devotion to the work of providing SUD/Addiction counseling services.

Recovery status of counselors is a feature of SUD/Addiction treatment counseling in that some counselors self-disclose their recovery status to clients (Berton, 2014). It is not uncommon for clients and SUD/Addiction treatment group members to inquire about a counselor's recovery status. In fact, counselor recovery status is a topic in several SUD/Addiction treatment textbooks used in counseling education programs (Berton, 2014; Morgen, 2017; Stevens & R. L. Smith, 2018). Several challenges may arise for counselors regarding recovery status. Non-recovering counselors need to address how they will disclose their status to recovering clients and groups, and may be in a position to need to process what that disclosure means to clients. If counselors choose not to disclose their status, counselors might need support on how to process their boundary with clients. Counselors who identify as in recovery must contend with potential issues regarding dual relationships. Some may use Twelve Step meetings as part of their self-care,

running the risk of seeing clients in meetings, which requires boundary and dual relationship issue navigation (K. Doyle, 1997). The literature examined shows that recovery status is an essential component to address. Additionally, disclosing recovery status is a part of the application process for credentialing in Washington State.

Individuals who identify as being in recovery that are applying to be an SUDP in WA State must report their medical history. In the State of Washington, the Department of Health SUDP application packet contains a form entitled "Attestation of Recovery" (Washington State Department of Health, n.d.-b). Counselors who identify as being in recovery must declare the date that they entered recovery and sign the form. The Revised Code of Washington (RCW) 18.205.020 (n.d.) defines recovery as "a process of change through which individuals improve their health and wellness, live self-directed lives, and strive to reach their full potential. Recovery often involves achieving remission from active substance use disorder" (RCW 18.205.020, n.d.). The definition was sourced back to SAMHSA (2012).

As a result of the requirement to report recovery status to the Washington State DOH, there are implications for agencies who are employing counselors in recovery and supervisors providing supervision to counselors in recovery. Relapse into active addiction is another germane factor concerning the training experience of DCCs (Doukas & Cullen, 2011; Kinney, 1983). Kinney (1983) pointed out that a counselor's recovery status is not entirely a personal issue, especially for counselors whose sobriety influences their counseling approach. If a counselor relapses into active addiction, impairment could follow as well as the potential to negatively impact clients. This becomes an issue for both the counselor in relapse as well as any team member or supervisor aware of the relapse. The Washington State DOH has a monitoring program for counselors who relapse into active SUD/Addiction. Like other professional

monitoring programs for nurses, doctors, pilots, or attorneys, the purpose is to monitor their progress toward remission and protect stakeholders. Application packets for both the SUDP and LMHC require individuals to complete a medical history which includes drug addiction and alcoholism in its list of conditions (Washington State Department of Health, n.d.-a, n.d.-b). The application packets require individuals to report criminal history and provide an explanation and court documents. In terms of supervision for counselors in recovery, the application process brings up several considerations regarding oversight, relationship building, and potentially complicated interpersonal dynamics.

Another study (Culbreth & Borders, 1999) explored the connection between recovery status and contentment within the supervisory relationship. The study results indicated that recovering and non-recovering supervisees seemed equally and relatively gratified with supervisory relationships, and similar regarding various features affiliated with supervision relationships. Additionally the study (Culbreth & Borders, 1999) highlighted the potential relevance of the pairing up of recovering supervisees and supervisors as well as non-recovering supervisors and supervisees. Ultimately, recovery status is a factor that is worthy of consideration regarding training and supervisory relationships.

Training Experiences of DCCs

Educational Experiences

One of the unique features of the SUD/Addiction treatment field is that its workforce is comprised of a range of education levels (ASPE, 2019; SAMHSA, 2014). Additionally, in many states there are multiple credentials for working in SUD/Addiction treatment that include roles such as technician, paraprofessional, and associate counselor (ASPE, 2019). In Washington State, one does not have to have a masters degree to obtain a SUDP credential. There are

multiple pathways to becoming a DCC in the State of Washington. The trajectory of education and training is part of understanding the training experience of DCCs. Some DCCs may start out in the SUD/Addiction treatment field where they are not required to have a master's degree. In this case, the DCC may possess terminal educational credentials of a high school diploma to a bachelor's degree, likely combined with the Washington State SUDP education requirements at a community college program. In Washington State, there are several community colleges that provide the Washington State DOH required coursework to become an SUDP. This group of DCCs may then proceed to a counselor education program to complete their master's degree and the Washington State requirements to be an LMHC. In some ways this can be viewed as a more natural educational scaffolding beginning with AA or BA level community college courses, and then graduating to master's level coursework.

Other trainees may be introduced to the SUD/Addiction treatment field during their master's in mental health counseling programs. In this case, there are two educationally based features pertinent to their training experience. First, graduate programs address SUD/Addiction treatment in a variety of ways. In 2009, the Council for the Accreditation of Counseling and Related Education Programs (CACREP) revised standards related to include SUD/Addiction as a specialty area in counselor education programs (Hagedorn et al., 2012; Lee, 2014). However, according to CACREP's website (www.cacrep.org) list of schools with CACREP accredited addiction counseling programs, only 14 exist in the United States, with zero in Washington State (CACREP, n.d.). Scholarly works have explored a variety topics related to coverage of SUD/Addiction counseling in counselor education programs as well as other health care professional education programs, and some identify opportunities for further development (Chasek et al., 2015; Hagedorn et al., 2012; Lee, 2014; Martin et al., 2016; Salyers et al., 2005).

Counselors frequently interface with clients with SUD/Addiction issues, but they may not be receiving adequate education and training (Salyers et al., 2005). Lee (2014) conducted an inquiry focused on SUD/addiction coverage and learning experiences within CACREP accredited counselor education programs. The Lee (2014) study summarized the progress that has been made in terms of increasing attention on SUD/Addiction treatment as a topic area in counselor education programs as well as highlighted areas to be addressed going forward. Ultimately, there are additional opportunities for counselor education programs to infuse curriculum with learning experiences germane to increasing competency when it comes to SUD/Addiction counseling.

The second educationally based issue experienced by graduates of master's in mental health counseling programs pursuing an SUDP is that they may be required to go to community college or have to find an alternative program to their counselor education track to complete the education requirements. If their graduate program does not have coursework which satisfies the Washington State Department of Health SUDP education requirements, they will have to seek out the required coursework elsewhere. Developmentally, the trajectory of finishing a master's degree in counseling and then obtaining SUD/Addiction coursework at a community college, AA or BA level, poses two challenges. First, the coursework is presented as separate and compartmentalized from the rest of their counselor education program. Since coursework offered by community college programs is at the AA or BA level and open to a range of professions, it potentially requires DCCs to independently assimilate SUD/Addiction specific coursework with their counseling professional identity, theoretical orientation, and skill level. Second, while the education that is received about SUD/Addiction treatment may be valuable, it does not include

learning experiences that facilitate integration of their master's in mental health counseling education or professional identity.

Supervised Work Experience Hours for DCCs

In Washington State, the credential for administering SUD/Addiction treatment is a Substance Use Disorder Professional (SUDP), and there are two distinct pathways to obtain the credential. The first is the "Traditional Training" pathway, which requires applicants with AA and BA level education to complete 45 education credits in SUD/Addiction topic specified coursework as well as supervised work experience hours (Washington State Department of Health, n.d.-b). For DCCs who obtained their SUDP through this traditional pathway, who then went on to be admitted to a master's in counseling program, and completed the requirements to become an LMHC, they may have benefitted from a more natural progression in professional development.

A second pathway to obtain an SUDP was created and put into effect in order to increase the number of SUDPs in health care settings. In Washington State, the "Alternative Training" option for obtaining an SUDP, has authorized selected professional credentials, including licensed mental health counselors, to pursue the alternative training pathway which has reduced the education requirements from 45 to 15 credits as well as reduced the supervised work experience hours (Washington Administrative code [WAC] 246-811-076, n.d.). However, for the professions approved to obtain an SUDP through this alternative pathway, the supervised work experience mandate retained those candidates could receive their supervision from a supervisor who obtained their SUDP through the traditional pathway (i.e., following achievement of a terminal high school diploma, AA degree, or BA degree). Effectively, a counselor who has completed a graduate degree in counseling and is pursuing their LMHC in Washington State may

be receiving supervision from an SUDP with BA, AA, or high school diploma-level education.

When scenarios like this play out, the supervisor is likely not apprised of the counselor professional identity, not necessarily trained to view their clinical work through a social justice and multicultural lens, and not proficient in the intersection of SUD/Addiction and accompanying mental health issues. Complicating matters further, counselors who are pursuing their LMHC and hold associate status are required to have their clinical work supervised by a counselor who meets the Washington Department of Health requirements. This supervisor may or may not have any experience or formal education and training in SUD/Addiction treatment. If this is the case, the counselor concurrently pursuing their LMHC and SUDP is likely left to independently assimilate feedback, theoretical orientations, skill acquisition in different clinical contexts, and knowledge specific to co-occurring issues. Future DCCs may very well have two different supervisors, one for the SUDP hours and one for the LMHC hours, who may or may not have the same educational level, approach, values, professional identity, or ability to address the issue of recovery status of the supervisee.

Supervision Models Specific to DCCs' Training Needs

Supervision in mental health counseling is well researched, and several established models serve as a basis for guiding the supervisory alliance (Bernard & Goodyear, 2019; Stoltenberg & McNeill, 2010). Mental health counseling supervisors have access to reputable models in which to ground their supervision approach, provide ethical consult, and increase intentionality with supervisees. There appears to be a gap in the literature when it comes to integrated supervision models that account for the nuances and features that are necessary for comprehensive training of DCCs. To date, I was not able to locate a supervision model specific to SUD/Addiction treatment and mental health counseling produced by the mental health

counseling profession, nor has it adapted an existing model to include the nuances of SUD/Addiction counseling. For example, Morgen's (2017) Counseling and Professional Identity Series text, *Substance Use Disorders and Addiction*, included a statement to open the chapter on supervision: "I tried to choose models that seemed most applicable to the addiction counseling and supervision process" (p. 241). Morgen (2017) emphasized the importance of addressing the nuanced dynamics associated with SUD/Addiction counseling and ethical considerations related to supervision.

The SUD/Addiction treatment field has attempted to establish principles for supervision using models that exist in mental health counseling (SAMHSA, 2014). Powell and Brodsky's (2004) *Clinical Supervision in Alcohol and Drug Abuse Counseling* is one text devoted to supervision practices applied to SUD/Addiction treatment and is cited frequently, but was published in 2004. The SAMHSA TIP 52 (2014) provided standards for clinical supervision of SUD/Addiction treatment service delivery. A review of *TIP 52* revealed that various constructs from reputable models such as Bernard and Goodyear's (2019) Discrimination Model and Stoltenberg and McNeill's (2010) Integrated Developmental Model (IDM) were hemmed together to provide structure and guidance to supervisors. *TIP 52* frequently referenced the work of Powell and Brodsky (2004), as does other literature focused on the topic of supervision in SUD/Addiction treatment. To date, Powell and Brodsky's (2004) *Clinical Supervision in Alcohol and Drug Abuse Counseling* was the only text or model located that was designed specifically to encompass the distinct features and needs of providing supervision to SUD/Addiction treatment providers. Powell and Brodsky (2004) included several different approaches to supervision before describing the "blended model" of clinical supervision for the alcoholism and drug abuse field (Powell & Brodsky, 2004, p. 142). The title "blended model" was selected because "like

alcoholism and drug abuse treatment itself, the supervisor process blends insight-orientated with skills-orientated approaches" (Powell & Brodsky, 2004, p. 142). While this has been an important contribution to the field, it is written in the context of SUD/Addiction treatment, not in the context of providing clinical supervision to a DCC or integrated with the mental health counseling identity. Much has been written about various topics relate to supervision in the SUD/Addiction treatment field (Culbreth, 1999; Laschober et al., 2012; Ramsey et al., 2017; Roche et al., 2007; Rothrauff-Laschober et al., 2013; SAMHSA, 2014; West & Hamm, 2012). A thorough review of the literature pointed to a lack of training resources including supervision models that address the needs of DCCs in a comprehensive manner.

Summary

The literature review identified critical elements inherent to the training experience of becoming a DCC in the State of Washington, providing evidence that the phenomenon of training to be a DCC exists. However, when it comes to locating scholarly works dedicated to representing a composite picture or comprehensive training trajectory, there is a gap. This review of the literature included research and discussion on a range of aspects that may impact the training experience of DCCs. Many features of the current clinical landscape DCCs navigate have been researched. However, there appears to be a dearth of knowledge addressing the lived experience of counselors being trained as DCCs. In terms of understanding how DCCs are assimilating factors that the literature substantiates as crucial to training, there is very little research available. Furthermore, the research gap is evidenced by the lack of supervision models that exist for simultaneously addressing SUD/Addiction treatment nuances, approaches, and models with mental health counseling professional identity, skill, and theoretical orientation development. SAMHSA and other organizations have made strides to establish addiction

counseling competencies (SAMHSA, 2015). Additionally, SAMHSA (2014) created *TIP 52* to offer guidance and structure for SUD/Addiction treatment supervisors. In an extensive search, I was not able to locate a supervision model or approach that clearly addressed all the components, or the composite experience represented in the various subtopic areas of this literature review focused on providing counseling to clients with co-occurring issues.

CHAPTER III: RESEARCH METHOD

Introduction

The phenomenon being studied in this Interpretive Phenomenological Analysis is the lived experience of training to become a Dual Credentialed Counselor (DCC) in the State of Washington. A comprehensive study of the literature addressed components of this phenomenon, but as compartmentalized from one another. The historical evolution of the SUD/Addiction treatment industry, including the nature of the workforce that administers SUD/Addiction treatment, was one topic area represented in the literature. Historical context provided foundational understanding for why and how SUD/Addiction treatment and mental health counseling continue to be separated operationally and professionally. Other features identified related to the clinical nuances of being a treatment provider in the SUD/Addiction treatment world were stigma, recovery status, and supervision needs. However, with regard to the phenomena of becoming a DCC in the context of the two largely segregated disciplines of SUD/Addiction treatment and mental health counseling, scant literature attended to the composite training experience or professional development trajectory. I wanted to design a research study that would facilitate an in-depth inquiry into the lived experiences of counselors who underwent the training required to be a DCC in Washington State. Additionally, I wanted to maintain an attitude of curiosity to allow for the emergence of DCC's lived experience as professionals developing while straddling these two worlds.

I selected a research method that would require me to listen with an open mind to the narrative accounts of counselors who had experienced the phenomenon. The purpose of the study was to explore in depth the participants' meaning making, reflections, descriptions of conditions, and perspectives of how they navigated their training experience to become a DCC in

Washington State. Additionally, I wanted to design and conduct a study that would preserve participant narratives as independent entities prior to identifying broader themes across the participants. The goal of my inquiry was not to test or construct a theory, but rather to understand more fully what it was like for these clinicians to navigate the gaps between these two worlds.

Research Design

Qualitative Approach

Qualitative research facilitates inquiries that aim to reveal constructs that represent complexities of a phenomenon connected to a lived experience (Creswell & Poth, 2018; Morrow, 2007). The methods used in qualitative studies are focused on exploring how people make sense of and relate to a phenomena that in some cases have not been represented, named, or discussed fully. Qualitative research approaches facilitate discovery of a complex multi-faceted phenomenon. For these reasons, I chose a qualitative design to discover more about the composite lived experience of training to be a DCC.

Being a DCC myself and meeting the criteria to be a research study participant, I entered this project with awareness of the complexity of the phenomenon. The goal of the inquiry was to explore the phenomenon of training to be a DCC. In agreement with Creswell and Poth (2018), I chose to conduct a qualitative research study "to empower individuals to share their stories, hear their voices, and minimize the power relationships that often exist between a researcher and the participants in the study" (p. 45). The decision to utilize a qualitative approach was inspired by elements of constructivism and social constructivism, allowing for a collaborative relationship between myself and each participant who generously shared their lived experience of training to be a DCC.

Constructivism Inherent to the Research Inquiry

The heart of this research study was informed by principles inherent to constructivist and social constructivist theories. Constructivist theory posits that learning occurs as we make meaning of our experiences in relationship to each other and the world around us (Heppner et al., 2016; McAuliffe & Eriksen, 2011; Mogashoa, 2014). Our ability to grow and change happens in a crucible of experiential learning through a dynamic relationship between our internal world and the complexities inherent to the environment within which we are learning. The meaning making processes involved in our learning include features of our lived experiences such as language, relationship, motivation, sensory input, and time. Our internal processes and relationship with the outside world inform the way we develop systems of meaning making. Additionally, social construcivism theorizes that meaning making occurs in the context of an environment with all its complexities, which include exchanges or relationships with other people (Creswell & Poth, 2018). The methodological choices demonstrated social constructivist principles in that the focus was to explore the complexity associated with participants' meaning making and lived experiences, while I as the researcher, composed my own understanding of the phenomenon. The learning or discovery inherent to the research inquiry, design, and procedures were co-constructed between the participants and the researcher. In that way, social constructivism was expressed as well.

The research question as well as the interview questions were designed with constructivist principles in mind and aimed to capture the multidimensional training and development process of DCCs. The focus of the study was to examine the named phenomenon as well as to include participant descriptions and interpretations of the ecosystem within which the phenomenon was experienced. Becoming a DCC in Washington State does not solely involve

knowledge and skill acquisition; there must also be account for the context of complex historical, economic, sociopolitical, cultural, societal, and professional dynamics. An expression of constructivism in this study was the explicit focus on the research inquiry itself. I wanted to understand how participants composed their learning in becoming DCCs in the context of navigating, interpreting, and making sense of the incredibly complex sociopolitical features inherent to the process of integrating SUD/Addiction treatment and mental health counseling.

Principles inherent to social constructivism were also demonstrated in this research study. As the primary researcher, I shared the criteria for being an eligible research participant while taking pains not to approach the study from a place of "knowing." I aimed for curiosity, wondering what I would learn while at the same time attending to the knowledge and experiences I brought to the investigation. I had my own training experience as a DCC, and I wanted to include that in the lens used to explore the phenomenon while stopping short of my perspective deeming anything as "true" or "known." Instead, I wanted to involve the learning that existed in me as part of the dynamic process of learning what the experience was like for others. My goal was to understand how participants constructed and made meaning of their training process, while simultaneously constructing and making meaning of the phenomenon of becoming a DCC. Therefore, social constructivism was also at the heart of design and methodological choices.

Phenomenology and Interpretive Phenomenological Analysis

Theorists who hold tenets of constructivism at the core of phenomenology are likely to posit that a phenomenon being investigated lives in the participants' minds, hearts, memories, felt sense, and internal processes (van Manen, 2014). Van Manen (2014) stated "we can speak of an 'experienced' person when referring to his or her mature wisdom, as a result of life's

accumulated meaningful and reflective experiences" (p. 40). Phenomenological research studies require methods that aim to reveal the phenomenon using interviews, observations, photographs, conversations, and reflective activities (Creswell & Poth, 2018). I believed that the phenomenon being studied would be revealed in the participants' narratives if I remained faithful to the methodology serving as the tool to facilitate its emergence.

My ambition was to select and employ methodological procedures that would serve as a sound structure for extracting data connected to my research question, while at the same time preserving the voice of the participant. Constructing a methodological approach grounded in reliable practices without stripping down participant narrative to the point of losing complexity required discipline and creativity. The ability to focus and immerse myself in the participants' stories to discover and articulate salient themes and features required a great deal of reflection and contemplative consideration. In addition, it was important for me to be flexible and creative in organizing and digesting the data.

Interpretive Phenomenological Analysis (IPA) provides a methodological framework that rests on tenets of phenomenology, hermeneutics, and idiography (Pietkiewicz & J. A. Smith, 2012). IPA studies are concentrated on revealing more about the object of inquiry in all its complexity, which is the essence of a phenomenological study. Philosophies pertaining to hermeneutics address the construct of interpretation (J. A. Smith et al., 2012). IPA studies require an iterative process where the researcher interacts with the data in a variety of ways to extract meaning (J. A. Smith et al., 2012). The hermeneutic cycle "is concerned with the dynamic relationship between the part and the whole, at a series of levels" (J. A. Smith et al., 2012, p. 28). The IPA process involves two hermeneutical rings. First, the participants are making meaning of the lived experience of being a DCC, and secondly, I am simultaneously

interpreting and making meaning of their narratives. Finally, idiography "is concerned with the particular" (J. A. Smith et al., 2012, p. 29). IPA studies exhibit idiography in two distinct ways. The data collection methods are centered on culling data that honors the complexity of the phenomenon. And second, IPA studies consider the perspectives of each participant independent of one another before identifying broader relationships amongst the group. Themes pertinent to the individual narrative and accounting for the lived experience unique to each participant are represented exclusive of one another before considering how they relate to the larger group. Once super-ordinate themes specific to each case have been communicated, a reflective analysis is employed to consider more global trends and patterns among participants.

IPA was selected as the methodological frame for this research study because it most closely matched the goal of the inquiry: to uncover how DCCs made sense of, interpreted, perceived, and experienced their training experience. "The primary goal of IPA researchers is to investigate how individuals make sense of their experiences" (Pietkiewicz & J. A. Smith, 2012, p. 362). It provided a methodological framework that supported my desire to understand with depth the lived experiences of participants. Additionally, the idiographic aspect devoted to considering each participant independently aligned with my core intention: exploring with curiosity the complexity of training to become a DCC.

Research Question

The research question for this study was, *How have DCCs in the State of Washington made sense of their training experience when navigating the division between SUD/Addiction treatment and mental health counseling fields?* I viewed the research question as the North Star that, in combination with IPA, would yield the phenomenological experience I wished to explore. To that end, I considered word choice. First, I wanted my research question to

succinctly communicate the complexity of my inquiry. Second, I wanted my research question to accurately reflect the intention of my investigation, to explore the complexity of training to be a DCC. My goal was to discover how the participants experienced, lived out, or lived through the central phenomenon being studied, and I wanted to include their meaning making processes. Finally, my hope was to craft a research question that named the phenomenon being studied and reflected the depth of experience that I was seeking to garner from participants. Careful consideration was given to selecting words and phrases to compose the research question so that it would reflect the complexity and various dimensions of the phenomenon being studied.

Participants

The primary inclusion criteria for this research study were individuals who had completed requirements to be a Substance Use Disorder Professional and Licensed Mental Health Counselor in the State of Washington. Six individuals that met criteria of being a dual credentialed SUDP/LMHC, or DCC in the State of Washington agreed to participate in the study. While I knew the participants from prior professional activities, there were no identified conflicts of interest. As my proposal and IRB application stated, the dearth of DCCs in Washington State made it likely that I would know the participants either directly or indirectly since I also met criteria to be a research participant, and because I have been in the field for 20 years. Each participant was supplied an informed consent and given an opportunity to ask questions. Some demographic information was collected, and each person selected a pseudonym to protect their identity in the presentation of results. Six DCCs agreed to participate in the study and completed the required two rounds of interviews and member checks. Participants were asked to voluntarily participate in a third round of member checks after the final super-ordinate themes were identified.

Data Collection

IPA studies are aimed at collecting accounts of lived experience connected to the phenomenon being studied that capture complexity and depth (J. A. Smith et al., 2012). For this reason, I chose to conduct two 60-minute semi-structured interviews. The interviews were scheduled at participants' convenience and conducted over Zoom. I informed individuals that the interviews were being recorded. Because I knew the participants professionally, I reminded them that I would be in an interviewer role during the session, with focus on evoking their lived experiences. I asked them if they had any questions or concerns before getting started. I indicated that although I had prepared questions, they should feel free to expand on anything that felt important to share about their experience. I thanked them for their time and participation and proceeded to conduct the interview.

Interviews conducted in qualitative studies are characterized by J. A. Smith et al. (2012) as "a conversation with a purpose" (p. 57). This is the spirit in which I approached the interviews with participants. I formulated an initial schedule of questions and submitted it to participants for review before the first interview. In doing so, participants had an opportunity to review the topic areas that would be covered in the interview beforehand, and indicate if there were any questions they would prefer not to answer or address. The questions were linked to the topics that emerged in the literature review. Table 1 lists the first schedule of interview questions.

Table 1

Initial Schedule of Interview Questions

1. As you underwent training as a DCC, how did you make sense of the separation between SUD/Addiction treatment and mental health service delivery?
2. As you underwent training as a DCC, how did you make sense of the differing approaches, i.e., abstinence-based and harm reduction? Was there an approach or model that was a primary influence?
3. How did your recovery status influence your training experience?
4. Tell me about your supervision experience for SUDP and MH credentials. What was it like for you to assimilate feedback and guidance for both disciplines in your training experience?
5. As the SUD/Addiction field and MH services move towards integration, what would you like to see happen for counselors younger in their development, who are pursuing dual credentialing?

Semi-structured interviews are a way to have questions to guide the conversation while allowing the participant to share about topics or experiences important to them, expand, or provide more depth (Mannan, 2020; J. A. Smith et al., 2012). The interview schedule afforded participants the ability to review what they would be asked, while I followed their lead during interviews regarding topics on which they organically wanted to expand. The nature of the semi-structured interview allowed me to hear the unique voice of each participant; every individual had their own story that included features specific to their experiences, meaning making processes, challenges, and sources of resilience. The interview questions were aimed at understanding the lived experience of participants including their unique perspectives, observations, meaning making processes, and interpretations of the clinical landscape. I took care to collect data connected to the literature review topics and used interview skills to elicit as much depth as participants would provide. A few follow up questions were generated for each participant to deepen understanding on topics represented by the first schedule of questions, or

that had organically emerged as additional topic areas during interviews. Participants were given an opportunity to share anything they believed was pertinent or important about their experience at the end of the second interview.

Data was stored on a password protected computer. Transcripts were created by the Zoom program which served as the raw data files used in the data analysis process. An electronic file was created for each participant which stored the informed consent, two recorded interviews, transcripts from interviews, schedule of questions, preliminary thematic summaries, and correspondence.

Data Analysis

Raw data included two interviews for six participants, which totaled 12 transcripts. Before describing the analytic steps in detail, sections on reflexive journaling and member checks are presented. These components are outlined before describing the analysis process because they were used throughout and are referenced at various stages in the data analysis section.

Reflexive Journal

I maintained a reflexive journal throughout the data analysis process to track personal and professional biases, contain thought processes that distracted from being present to the data, and document notes about procedural issues. In IPA studies, there is a double hermeneutical process at play (Pietkiewicz & J. A. Smith, 2012; J. A. Smith et al., 2012). The initial intention for journal entries was to track the biases that correlate with my various personal and professional identities. Since I met the criteria to be a research participant, I wanted to create a system to account for potentially activated beliefs and values inherent to my own lived experience as I engaged in data analysis. Table 2 lists the various dimensions of my positionality.

Table 2

Reflexive Journal Identities Chart

Personal Identities and Experiences	Professional Identities and Experiences
1. White, heterosexual, female	7. Obtained SUDP credential in WA State before LMHC
2. Consumer of separate specialized residential abstinence-based SUD/Addiction treatment	8. Have worked in settings that employ both Abstinence-based and Harm Reduction models to SUD/Addiction treatment
3. Consumer of separate trauma processing focused mental health counseling services	9. Had different supervisors and very different supervision experiences as SUDPT and LMHCA
4. In recovery for over twenty years using Alcoholics Anonymous as part of maintaining remission	10. Have experienced being siloed in mental health/professional settings as designated co-occurring counselor
5. Recovery status and medical history reported to the WA State Department of Health Attestation for Recovery Status as "in recovery" signed and filed with DOH	11. Mental health counseling theoretical orientation informed by psychodynamic principles, attachment research, neuroscience, trauma informed approaches, and these models address SUD/Addiction in varying ways and devote varying amounts of time to the topic
6. Have encountered bias, prejudice, and addiction being misunderstood in professional settings	12. Created and developed an Addiction Studies track for an MA counselor education program that attempts to integrate predominant theory and skills

The reflexive journal contained notes and reflections connected to the data analysis process for each participant. The practice allowed for me to document my thought process as well as track the active lens through which I interpreted participants' narratives; the listed number associated with each identity was written next to each journal entry. The chart of identities provided a more efficient way of flagging my journal entries and noticing active biases. The journal served as a reference in my ongoing reflections and contemplative processes in the data analysis. Reflexive journaling was an effective method for me to track and document how

my positionality might be influencing the data analysis. For example, if I found that I was relating to the experience of the participant, I would note what aspect of my positionality was active. Sometimes I would resonate with participants as a person in recovery, or as a DCC colleague, or as counselor educator. Journal entries allowed me to notice with more depth and awareness my interpretive process and became functional beyond initial expectations as a novice researcher.

I reviewed an article (Vicary et al., 2017) highlighting the way keeping a journal can increase rigor and validity in IPA, which correlated with many of my journal entries focused on why I chose to implement procedures and the thought processes connected to the analysis. But I did not initially connect to the idea that journaling could help record the variety of thoughts, emotions, and intentions related to the experience of conducting research for the first time (Vicary et al., 2017). I felt like a monkey swinging through the trees: I was sure there would be another branch to grasp after the one I was currently holding, but needed to employ a certain amount of intuition and trust to fluidly move through the process without exactly knowing where I would arrive. I did not realize how active my mind would be after digesting interviews, transcripts, and producing analytic notes. The journal offered a container for internal developments occurring throughout the study and provided a way to process my learning about conducting a research study.

Member Checks

Member checks, also called member checking, can be used as a method to increase trustworthiness in analyzed qualitative data (Birt et al., 2016; S. Doyle, 2007). Member checks can be conducted in several different ways. Birt et al. (2016) outlined different methods for member checking. Each way of performing member checks carries with it theoretical

underpinnings and ethical considerations (Birt et al., 2016). In consideration of a practice that would align with the selected methodology, I chose an approach to member checks influenced by the dialogical method outlined by Harvey (2015). Harvey (2015) shared about the process in his dialogic approach to member checks, whereby a preliminary thematic summary is constructed for participants to review. Operationally speaking, the dialogic approach fit well with conducting two interviews. I was able to spend time with the first interview, and then generate a list of preliminary themes to be returned to participants for their review before the second interview. According to Birt et al. (2016), participants should be able to recognize their experiences or narratives. The preliminary thematic summaries provided participants with an opportunity to share additions, feedback, revisions, or comment on the language and manner in which I initially interpreted their narrative. Participants either confirmed that the summary was accurate, or in some cases, provided additional information or revisions to certain pieces. By inviting participants to review the initial thematic summaries, a co-constructed data set was created and transferred into the next steps of the analytic process. Because of the IPA double hermeneutical process (J. A. Smith et al., 2012), wherein the researcher is actively interpreting and making meaning of the participants' meaning making processes, member checks allowed for two-way corroboration that my interpretations were reflective of my own engagement with the data and that participants' communicated perspective were being understood.

IPA Data Analysis Overview. The data analysis process for this study involved several steps. IPA encourages innovation in data analysis procedure (Pietkiewicz & J. A. Smith, 2012; J. A. Smith et al., 2012). "In general, IPA provides a set of flexible guidelines which can be adapted by individual researchers, according to their research objectives" (Pietkiewicz & J. A. Smith, 2012, p. 366). The creative license offered in IPA was both exhilarating and the source of

extended periods of deep reflection. I used the IPA analysis steps and components to provide structure to my approach and, at the same time, tried not to apply these guidelines with rigidity in order to retain the essence, voice, or spirit of what the participants were communicating. Ultimately, my approach was to implement a rigorous analytic process that was grounded in reliable methods and provide rationale for each choice I made.

IPA Step One. The first step of IPA analysis is "reading and re-reading" (J. A. Smith et al., 2012, p. 82). In this first stage of analysis, I immersed myself in the data. When I initially designed this study, I thought it would be wise to consult concepts illustrated in two established coding methods. Feeling the need for a bit more structure during this first phase of transcript engagement, in-vivo coding and theming the data as presented by Saldana (2016) both provided tenets that helped organize my approach to the first rounds of reading interview transcripts and made the process less arbitrary. "In-vivo" coding is also termed as "literal coding," "verbatim coding," "inductive coding," and "natural coding" (Saldana, 2016, p. 105). In this approach, the researcher focuses on "impacting nouns, action-oriented verbs, evocative vocabulary, clever or ironic phrases, similes, and metaphors" (Saldana, 2016, p. 107). I read through the interview transcripts to take in the interview as a whole and highlighted the questions I asked the participant. I read the transcripts a second time, and highlighted terms, phrases, words, and language offered by in-vivo coding.

After these initial interactions with the transcripts to digest the participants' narratives about their training experiences, I read through the transcript again studying the highlighted phrases. In this first stage of the IPA process of reading and re-reading transcripts (J. A. Smith et al., 2012), I focused on attuning to the participant's voice, listening for their unique story about lived experience, and tried to see through their eyes. I considered how the narratives represented

participant meaning making processes, thoughts, emotional experiences, reflections, observations, and any unique features of lived experience. During the third read through, I consulted the definition of a theme in the "theming the data" approach to coding outlined by Saldana (2016, p. 198). Theming the data delineates themes as "an extended phrase or sentence that identifies what a unit of data is about and/or what it means" (Saldana, 2016, p. 199). I created a preliminary thematic summary that consisted of descriptive phrases, some with participant verbatim quotes, which described and paraphrased salient features representing the experiences shared by the participant. I engaged in reflexive journaling to track and document thought processes, my active identities listed on the positionality chart, and procedural reflections.

The preliminary thematic summary created from the first step of the IPA analysis process was returned to participants for a member check. The aim of the first round of member checks was adapted from Harvey's (2015) dialogic approach where the participant has an opportunity to review preliminary thematic summaries created by the researcher. Participants were invited to confirm, revise, or add to my initial interpretations of the experiences they shared. The member checks offered a way for the participant to be involved as well as for me to confirm that I was accurately capturing their story and voice.

Second Interview. A few follow up questions were submitted to participants before their second interview to deepen topic areas covered in the first interview, explore topic areas identified by participants, or subtopic areas that were connected to the literature review. The second interview was scheduled, the same procedures employed as the first interview, and a second semi-structured interview was conducted. I concluded the second interview by asking participants if there was anything they wanted to add about their training experience that had

been left unsaid that required opportunity to address. After the second interview was completed, a transcript was produced using Zoom. The same set of analysis procedures applied to the first-round interviews was used for the second interviews and transcripts. A preliminary thematic summary that corresponded to the second interview transcripts was submitted to participants for member checks.

IPA Step Two. The second step in IPA analysis is "initial noting" (J. A. Smith et al., 2012, p. 83). The goal is to deepen the analytic process by reading through transcripts and composing analytic notes that are either "descriptive," "linguistic," or "conceptual" in nature (J. A. Smith et al., 2012, p. 84). During this phase of analysis, I selected one participant to study per day. I watched both interview recordings again and engaged in my reflexive journal, noting any personal or professional biases that were active according to Table 2. The purpose of reviewing the recordings was to connect to the participant's story and once again immerse myself in their lived experience.

After watching the video recordings, I read both interview transcripts, and applied the process outlined in J. A. Smith et al. (2012) for this second phase of analysis. I wrote analytic comments in the margin, and in accordance with the suggestion provided by J. A. Smith et al. (2012, p. 84), I designated three different colors to mark the notes as either *descriptive*, *linguistic*, or *conceptual*. The three domains suggested by J. A. Smith et al. (2012) were established: first, *descriptive* comments were ideas, topics, events, and observations that I interpreted as significant to both the participant and my research question. Second, *linguistic* comments focused on words used by participants, verbatim descriptions, and terms that repeated in the transcript. Third, *conceptual* comments were highlighted and used to represent more abstract themes I was extracting from the transcript. The conceptual analytic comments started to

reveal more of my own interpretations. I engaged in reflexive journaling to track and document thought processes, active identities listed on the positionality chart, and procedural reflections.

IPA Step Three. The third step in IPA analysis is "developing emerging themes" (J. A. Smith et al., 2012, p. 91). In this stage of analysis, the aim is condensing the data into a set of themes that succinctly represent the lived experiences communicated by participants in a manner that maintains depth and complexity. It is in step three that I experienced the hermeneutic cycle described in IPA: the whole of the transcript was deconstructed into elements represented in the themes to create a new whole representing newfound understanding of the phenomenon being studied. J. A. Smith et al. (2012) stated "the themes reflect not only the participant's original words and thoughts but also the analyst's interpretation" (p. 92). At this point in the study, I had two sets of preliminary thematic summaries that have both been submitted to member checks. I made analytic comments in the margins and highlighted salient verbatim data for both transcripts and labeled them with their assigned color as "descriptive," "linguistic," or "conceptual" (J. A. Smith et al., 2012, p. 84). I reflected on the list of preliminary thematic summaries to ensure close proximity to the narrative voice of the participant. The analytic notes were situated closer to my own interpretations and perceptions of the participants' lived experience.

I engaged in reflexive journaling to capture thoughts and reflections related to my experience of moving away from participant voice to infusing more of my own interpretation. Several journal entries focused on my deep sense of responsibility to maintain the integrity of their story and represent it accurately. Other journal entries captured thoughts and feelings connected to conducting a more substantial research study for the first time. I tended to my desire to engage in an analytic process that would facilitate revealing the salient themes as well

as preserve the complexity and authenticity of the participants' narratives by imposing rigorous procedures and dedicating large swaths of time to forming a deep connection to the data.

The analytic notes in each transcript were numbered. I read through the analytic remarks and if they fit with an identified theme from one of the preliminary summaries, I wrote the corresponding number next to it. The action of placing the numbered analytic comments next to member-checked themes revealed an important feature: the frequency at which the theme was represented. If an analytic comment warranted creating a new theme, then a new theme line was added. Some analytic comments did not necessarily reveal additional themes but contributed to my internal process of metabolizing the data.

The sources I used to guide my analytic process did not speak specifically to procedures for multiple interviews and the inclusion of multiple rounds of member checks. I needed to create a means to combine the two sets of member-checked preliminary thematic summaries and the two sets of analytic notes to create one comprehensive data set to bring into the fourth step of the IPA analytic process. While the process was rigorous and time-consuming, I was afforded the satisfaction of generating a robust set of themes to represent participants' lived experiences. J. A. Smith et al. (2012) describe step three development as a "synergistic process of description and interpretation" (p. 92). The culmination of actions described in steps one through three resulted in a master set of themes specific to each of the six participants. The master theme list reflected a synthesis of member checked preliminary themes, corresponding numbered analytic notes, and analytic comments that created new themes. I believe the flexibility of IPA allowed for this technique of merging the preliminary member-checked thematic summaries and analytic notes from two interview transcriptions.

IPA Steps Four and Five. The next phase of IPA analysis is "searching for connections across emergent themes" (J. A. Smith et al., 2012, p. 92). Steps four and five are described together because step four outlines the next analytic procedures for a single participant and step five calls for the same procedures to be applied to the remaining participants. Again, IPA allows for flexibility in approach to organizing themes. I made the decision to follow one of the methods offered by J. A. Smith et al. (2012). To stay focused on each participant as an individual, I did not conduct analytic procedures for multiple participants on any given day. I compiled master theme lists generated after completing step three for each participant. I printed the list of themes on paper and cut them into tangible single themes to spread on a large piece of poster board. I looked at them, moved them around, and meditated on how they related to one another.

Using "abstraction" and "subsumption," I organized the themes into super-ordinate themes (J. A. Smith et al., 2012, pp. 96–97). *Abstraction* involves consolidating themes into groups according to their similarity (J. A. Smith et al., 2012). The grouping shares the same essence or feature and can be bundled together under a new name identifying a super-ordinate theme. *Subsumption* occurs when one of the themes indicates a super-ordinate theme and can house a cluster of themes under its roof (J. A. Smith et al., 2012). I enjoyed this process as it allowed me to interact with the themes in a tactile manner and intuitively discover patterns and relationships through moving the pieces around. Once I had formed the groups of themes, I glued them to the posterboard. For the clusters that were yielded through *abstraction,* I assigned a super-ordinate theme. The groupings that formed under a theme that emerged as a super-ordinate theme, I revised the language to be as succinct as possible. In some instances, several drafts of

language were required to land on an appropriate super-ordinate theme name. Reflexive journal entries were recorded to track reflections and thought processes associated with data analysis.

I repeated this process for each participant. Each individual's super-ordinate themes were represented on a piece of poster board. Underneath the identified super-ordinate theme heading were the pasted themes from the member checked preliminary summaries, the numbered analytic comment lines listed next to the themes, and the analytic notes that warranted their own theme. The visual representations were extraordinarily helpful in processing the data in a new way. J. A. Smith et al. (2012) stated, "The original whole of the interview becomes a set of parts as you conduct your analysis, but these then come together in another new whole at the end of the analysis in the write-up" (p. 91). The quote accurately reflects my experience; I was discovering a new whole that both distilled the data into clear super-ordinate themes, but also maintained complexity. I made several entries in my reflexive journal during Step three, noting thought processes involved in organizing themes. J. A. Smith et al. (2012) warn IPA researchers about the tendency to be influenced by other participants' themes. Using my journal proved to be an effective method of staying present to each individual participant's poster board. Only working on one participant in any given day was an additional safeguard. Moving into the final stages of IPA analysis was thrilling. I had six poster boards representing each participant's super-ordinate themes flanked by the substantiating data. I was ready to proceed to the final IPA analytic stage focused on synthesizing data and themes.

IPA Step Six. The IPA analytic process proposed by J. A. Smith et al. (2012) includes a sixth and final step. The sixth step in IPA is focused on looking for patterns among the participants. I created a table in a Word document that listed themes for each participant. At this point, I referred to the research question to meditate on how the emergent super-ordinate themes

for each participant related back to the heart of the inquiry. A profoundly important lightbulb moment was realizing the super-ordinate themes fit into one of three categories which were directly related to the research question. The categories were *made sense*, *training experience*, and *navigated*. The super-ordinate themes that reflected how the participant *made sense* identified vehicles for meaning making, increasing understanding, or assimilating experiences. *Training experience* super-ordinate themes reflected features or conditions of participant lived experience. Finally, *navigated* designated super-ordinate themes that described activities that assisted in the dance between the SUD/Addiction and MH worlds. A fourth category was included on the table named *other* to address super-ordinate themes salient to the participant, but indirectly related to the research question because they did not precisely fit in the categories of made sense, training experience, or navigated. These super-ordinate themes expressed important aspects of the participants' training experience. Additionally, this category reflected topics or subtopics related to the domains in the literature review.

An individual table was created for each participant showing the super-ordinate themes that were identified in the *made sense*, *training experience*, *navigated*, or *other* categories. These individual tables with super-ordinate themes were created for a third round of member checks. A few terms used in super-ordinate themes were defined and included on the individual table summaries. The terms were "holistic/integrated," "self-directed," "experientially," and "trauma-informed." I included definitions for these terms so participants would be aware of my working definitions of words used to describe their experience. Each individual summary was submitted to participants to provide them with an opportunity to provide feedback on the Super-ordinate themes identified. In IPA, the analytic process carries over into writing up the findings. "It is also the case that analysis continues into the writing phase so that as one begins to

write up a particular theme, one's interpretation of it can develop" (J. A. Smith et al., 2012, p. 108). This proved to be true as I continued to metabolize the data in the process of writing about the findings.

Conclusion

IPA was selected as the framework to support this qualitative research study grounded in constructivist principles. The goal of the study was to understand with depth the complexity of six DCCs' training experiences. The methodological framework best suited to accomplishing this goal was determined to be IPA. The IPA analytic process requires rigor, innovation, flexibility, and immersion into the participants' narratives. Multiple steps were conducted during the analytic process to facilitate the iterative process of interacting with the data in multiple ways such as reading and re-reading transcripts, watching interview recordings, creating thematic summaries, and engaging with analytic notes. Procedures such as member checks and maintaining a reflexive journal were established towards the goals of rigor and trustworthiness. Ultimately, the methodological procedures selected for this study produced salient themes specific to each participant that both directly and indirectly connect to the research question.

CHAPTER IV: PRESENTATION OF RESEARCH

Introduction

The process for an Interpretive Phenomenological Analysis (IPA) study calls for the researcher to consider each participant's narrative and emergent themes separately before looking at broader relationships (J. A. Smith et al., 2012). The practice of considering each participant independently honors the idiographic aspect of an IPA study (Pietkiewicz & J. A. Smith, 2012). In keeping with the IPA framework, sections for each participant are included in the presentation of research findings. Participants are presented in alphabetical order of their chosen pseudonym. The participant sections include a brief description of some demographic information. Additionally, each participant's super-ordinate themes are represented in a table and then substantiated with excerpts of the data or the preliminary thematic summaries that were subjected to member checks. All six participants completed two rounds of member checks for the preliminary thematic summaries produced from the first two interviews. The first two rounds of member checks yielded 100% return rate, and confirmation of preliminary thematic summaries, with additions or revisions offered in some cases. A third round of voluntary member checks was employed after super-ordinate themes were identified and the terms used in the categorization of super-ordinate themes were defined. Each of the six participants endorsed the super-ordinate themes as well as the categorical and descriptive definitions, with one offering an additional note. In the final super-ordinate theme table construction, some minor revisions were applied to the super-ordinate themes to streamline or name more succinctly.

IPA provides a methodological framework which supports an inquiry aimed at understanding the complexity of a lived experience (Pietkiewicz & J. A. Smith, 2012). The terms defined in Table 3 are descriptors that reflect important dimensions of the super-ordinate themes

which ultimately communicate the participants' lived experience. Additionally, these terms are used in a variety of contexts. Therefore, it was important to define what they represent in the context of this research study about the participants' DCC training experiences. The definitions were provided to participants with the super-ordinate themes in the third round of member checks so participants could understand how terms were being used to describe or categorize their experiences.

Table 3

Definitions of Terms Used in Super-ordinate Themes

Term	Definition
Holistic/Integrated	*comprehensive approach to treatment of co-occurring issues; taking into consideration multiple factors in formulating assessment, approach, interventions and being equipped to simultaneously address SUD/Addiction and MH issues*
Self-directed	*in the absence of comprehensive supervision/guidance, trainee must take initiative to identify support/resources/assistance to provide services that they, in some cases, are not developmentally ready/confident to provide*
Experientially	*any combination or all of the following:* *input from outside sources (some provided by supervisors & colleagues/some self-directed) +* *observing effectiveness/ineffectiveness with clients +* *observing experienced counselors +* *stitching activities together internally*
Trauma-informed	*understanding trauma provided important insight in formulating approach to co-occurring counseling*

The research question explored was, *How have dual credentialed counselors in the State of Washington made sense of their training experience when navigating the division between the SUD/Addiction treatment and mental health counseling fields?* The super-ordinate themes that emerged for each participant were products of a rigorous analytic process. Ultimately, the themes represented significant features of each participant's lived experience. In the process of

contemplating and reflecting on the super-ordinate themes, three categories emerged that revealed a direct relationship to the research question. The first category of super-ordinate themes revealed how participants **made sense** of their training experience. I defined this category as *vehicles for meaning making or increasing understanding*. The second aspect of the research question represented in super-ordinate themes was named **training experience**, defined as *features of conditions and lived experience*. This cluster of super-ordinate themes reflected the conditions of the ecosystem within which the DCCs trained. The third category was entitled **navigated** and defined as *activities that assisted in the dance between SUD/Addiction and mental health worlds*. The navigated category represented the super-ordinate themes that demonstrated actions or activities in which participants engaged while navigating their training experience. Some of the participants have *trauma* as a descriptor as part of a super-ordinate theme because their narrative accounts revealed that understanding trauma was fundamental to how they formed a holistic/integrated lens which helped them to navigate DCC training. A fourth category of super-ordinate themes was created and named **other**, defined as *notable/repeated themes or features specific to participant*. I included the fourth category in order to recognize features that emerged from participant's narratives, yet may have been peripheral to the research question, as these seemed salient to include. The super-ordinate themes were either related to topic areas covered in the literature review or indicated additional trailheads for future research. These four categories are portrayed in Table 4 through Table 9 and are used to organize each participant's lived experience.

Jack

At the time of this study, Jack identified as a White male in recovery. Jack became a Substance Use Disorder Professional (SUDP) in the State of Washington and then completed

licensure requirements to be a Licensed Mental Health Counselor (LMHC). Jack had been a DCC for four years.

Table 4

Jack's Super-ordinate Themes

	Made Sense: *Vehicles for meaning making, increasing understanding*	**Training Experience:** *Features of conditions and lived experience*	**Navigated:** *Activities that assisted in the dance between SUD/Addiction and MH worlds*	**Other:** *Notable/Repeated themes or features specific to participant*
Jack	*1. Drew on personal recovery early in training as SUDP, less in MH professional development* *2. Post graduate skills training in models relevant to co-occurring counseling*	*1. Observed problematic biases in both MH and SUDP counselors* *2. Experienced complexity and nuances of doing co-occurring counseling* *3. Mixed experiences with in/effective supervision*	*1. Experientially Developed/Employed holistic/integrated approach*	*1. More integration between MH and SUD needs to occur* *2. Timing is a factor in training experience*

Super-ordinate Themes Related to Made Sense

There were two super-ordinate themes connected to how Jack made sense of his training experience to become a DCC that emerged from his narrative. The first was *drew on personal recovery early in training as SUDP, less in MH professional development*. In reference to how he made sense of training in the context of the segregation of the SUD/Addiction and mental health (MH), Jack stated, "I didn't make great sense of it at the beginning." One vehicle that provided insight early in his training experience as an SUDP was his recovery status. Jack identified as being in recovery, and he shared:

> Being in recovery influenced that whole lens on how to approach it. I think that evolution went from personal recovery to sponsorship to SUDP training to working at that clinician level using that experience, and then getting more training and schooling, going to grad school and learning more about mental health care, and then integrating all that. Recognizing that those basics that I started with were not really clinical, but were really like experiential and I learned more about how to distinguish between those two paths.

As Jack progressed through his counselor education program and acquired work experience hours towards his LMHC, he shifted towards clinical knowledge and skills presented in his training to be a mental health counselor. He shared how he started out drawing from his recovery to inform his counseling as an SUDP, but that as his knowledge and wellness expanded so did his ability to see "broader possibilities" and "different perspectives." As a result, it was important to craft the first super-ordinate theme for **made sense** to accurately describe how personal recovery informed his early training experience. However, as more knowledge and skill acquisition occurred, recovery status was more a part of the fabric of his identity rather than something he relied on in his clinical approach. Jack shared, "I identify as a person in recovery, and so I don't shy away from that, but I also don't bring it up front as much as I used to."

The second super-ordinate theme related to how Jack made sense of training to be a DCC was *post graduate skills training in models relevant to co-occurring counseling*. Jack shared, "I've gotten additional training in [a specific skills model] and [another specific skills model] and that's been really helpful to broaden [my] tool base." Jack indicated that his graduate school offered introductory foundational knowledge about SUD/Addiction treatment and co-occurring work. However, he shared that co-occurring counseling requires additional training. Given the complexity and skill set required, he sought out additional training models that helped him increase understanding of how to effectively deliver SUD/Addiction and mental health services.

Super-ordinate Themes Related to Training Experience

Three super-ordinate themes were identified in this category. The first was *observed problematic biases in both MH and SUDP counselors.* Jack shared from the perspectives of being a person in recovery and as a professional counselor about his observations and reflections of biases in colleagues. He stated, "[Bias] did show up in places where I feel instructors were not well versed in SUD in grad school." Additionally, he stated:

> I am hopeful that they [counselors in training] will get a more thorough education to be able to address substance use because I think the myth or the misconception they have is if I am not working in treatment, I am not going to deal with this and everybody is going to encounter it.

Jack named accounts of observing bias related to Twelve Step support groups. He shared about his internal process about not wanting to have conversations with misinformed colleagues from a place of defensiveness, but also felt a sense of responsibility to correct misinformation on behalf of clients who might benefit from Twelve Step programs. Jack's experience reflected internal processes related to observing biases among colleagues of training to be a DCC. He shared:

> Somebody was talking about how people are shamed out of meetings [12-Step] because of relapse and I am thinking 'well actually they're welcomed when they relapse' and so it's those kind of things that I hear from counselors that are really disturbing.

Jack offered additional input which clarified his perspective that bias exists on the part of some SUDP's who might lean on Twelve Step fundamentals to inform their approach, while some mental health counselors might not fully appreciate the resources inherent to Twelve Step recovery.

The second super-ordinate theme in the training experience category was *experienced complexity and nuances of doing co-occurring counseling*. Jack noted how being knowledgeable and skilled as a co-occurring counselor required addressing the nuance inherent to co-occurring work. Some examples of complexity that he identified were accurate assessment, diagnosis, and

tracking the relationship between SUD/Addiction and MH issues in clients. Jack stated that, “It’s not a one size fits all.” He shared about the skill development involved with tracking both SUD and MH issues. Jack shared about processing co-occurring work in supervision:

> That was really good to recognize there are these two things [MH and SUD] going on but the substance use is still prominent and that needs to get looked at and those kinds of interventions were really helpful to me to maintain focus on what is going on in the moment because I can get a little bit too much into what is this mental health problem that needs to be addressed.

The third super-ordinate theme for the category of training experience was *mixed experiences with in/effective supervision.* Jack shared about supervision experiences that were helpful, not as helpful, or partially addressed clinical work. Jack stated that three adjectives to describe his training experience were “inconsistent, adequate over time, improving.” Jack also described effective features of supervision. For example, he described the features of one effective supervision experience and then pointed out that the supervisor “didn’t have substance use as part of [their] background.”

He reflected on his experience overall:

> To think back to my experience of supervision and training and how that evolved over time, and who was really helpful. I’ve gotten bits and pieces from everybody along the way, and so it’s been an overall positive experience for me. I’ve gotten pretty lucky. I’ve been in good places and had good people around me, but just the idea that I think you are working on, which is how do we supervise all of those things and kind of have all of it identified? It’s important. It’s a big thing because I definitely didn’t get it all at once. It was all spread among many supervisors and different pieces of training.

Jack’s narrative did not reference an established integrated framework, but rather reflected mixed experiences that he stitched together as he underwent his DCC training.

Super-ordinate Themes Related to Navigated

Jack’s narrative revealed a super-ordinate theme in the category of **navigated** which was *experientially developed a holistic/integrated approach.* The term *experientially* was used to denote an amalgamation of activities that contributed to Jack’s formation of an

integrated/holistic approach, and that he assumed the assimilation process. Jack shared that it was an ongoing evolution to understand co-occurring issues and how to treat them. Over time he increased his understanding of clinical applications for abstinence-based, harm reduction, or medication assisted treatment through clinical experience. Jack talked about his professional development as a process, and that it was necessary to be humble and open to input. As he moved through his training experience, he learned how to increase his range in approach to work with clients based on their needs. He shared, "Whatever is working for the individual I am open to." Theoretical influences and personal style were additional components of forming an integrated approach. The development of a holistic/integrated approach happened through experiential learning and putting pieces together in his own way. He stated:

> I think I would have gotten where I am faster because I think I got all those things but not at the same time. It would be good to have that integrated. [An approach that included] talking about the person in recovery, talking about the person as counselor, as mental health counselor as substance use counselor, and all of those as tools, but part of [the] person [and] then as a tool in counseling [while] using all these other clinical things. I think that is where I am getting to, but it could have happened in a more structured way if my path had been different.

Super-ordinate Themes Related to Other

Two super-ordinate themes not directly related to the research question, and still salient, emerged from Jack's narrative. The first was *more integration between MH and SUD needs to occur.* Jack identified the need for more integration between mental health and SUD/Addiction. He shared about being aware of more integration in a different state and said "we don't have that so much here [WA] and that gap needs to get closed" and "so we [WA] are more well-rounded." Additionally, he noted an awareness of the need for more DCCs in the field.

The second theme in the other category was *timing is a factor in training experience.* Jack started as a person in recovery training to be an SUDP, who eventually completed a masters in mental health counseling program and became an LMHC. Since the AA/BA level coursework

to be an SUDP was completed first and then Jack completed MA level courses, there was more of a natural scaffolding in development. Jack shared "I think because of timing I lucked into the easier way of doing it because I got the CDP [SUDP] first." Additionally he disclosed "I didn't have to do it separately after getting a masters, so I had it before going to grad school."

The superordinate themes in the other category were two features that were salient to Jack's DCC training experience.

Jane

At the time of this study, Jane identified as a White female and as experienced with being an affected significant other in recovery, and not SUD/Addiction recovery. Jane reported being a DCC for approximately 15 years, having first completed her master's degree and then pursued the SUDP post graduate school.

Table 5

Jane's Super-ordinate Themes

	Made Sense: *Vehicles for meaning making, increasing understanding*	**Training Experience**: *Features of conditions and lived experience*	**Navigated**: *Activities that assisted in the dance between SUD/Addiction and MH worlds*	**Other**: *Notable/Repeated Themes or Features Specific to Participant*
Jane	*1. Self-directed internal reflective processes* *2. Experiential learning through clinical work* *3. Drew from personal work/recovery/growth process*	*1. Witnessed/ aware of stigma* *2. Experienced complexity and nuances of doing co-occurring counseling* *3. Mixed experiences with in/effective features of supervision*	*1. Processing with experienced colleagues* *2. Experientially Developed/ Employed holistic/integrated trauma informed approach*	*1. Little attention given to SUD/Addiction in graduate program* *2. Agencies not supporting counselor self-care contributes to burnout*

Super-ordinate Themes Related to Made Sense

The first super-ordinate theme related to the **made sense** category was *self-directed internal reflective processes*. Jane identified experiences early in training where at times, she was providing co-occurring services with insufficient support. Jane was required to internally process and struggle through how to coalesce knowledge and skills to provide co-occurring services. She shared, "I just was making these connections sort of on my own." Jane described how she employed *self-directed internal reflective processes* to make sense of working with clients presenting with SUD/Addiction and mental health issues. She stated, "I remember feeling alone. Thrown to the wolves out here, and I am supposed to help this person get better. I felt overly responsible for that because I didn't have help around me."

Jane's narrative included phrases like, "I was kind of a lone wolf," and "I was out of my depth." She indicated that clinical settings that are under resourced are prone to assign complex cases to DCCs without providing adequate support. Jane's DCC training experience required her to shoulder the burden of making sense of co-occurring work early in her professional development, and *self-directed internal reflective processes* was one of the vehicles she used. Jane disclosed, "It was really confusing to see those two things (SUD and MH) as separate. and I felt like I had to do quite a lot of self-discovery."

The second super-ordinate theme related to how Jane **made sense** of her DCC training experience was *experiential learning through clinical work*. In the absence of an integrated framework to guide her process of making sense of co-occurring counseling, Jane used the insights and discoveries gleaned from real-time clinical experience. In one instance, Jane shared about the process of how she tracked clients' relapse process to identify which pieces did not get addressed or what undermined their recovery process. Jane shared in one excerpt:

> Watching clients go through their process and then [asking] okay why didn't this model work for them? Or, seeing successes and seeing, relapses and realizing okay, here's the theme, over time, here's what I'm noticing. And [then] making sense of that.

Jane shared reflections like "the clients taught me, you know, they were the ones that said, this is it. And then watching their growth was like wow, ok this is working," which revealed that she used *experiential learning through clinical work* as a vehicle to make sense of her DCC training.

The third super-ordinate theme in the category of **made sense** was that Jane *drew from personal work/recovery/growth process.* In part, Jane attributed her personal process and fundamentals from Twelve-step recovery for family members as one of the vehicles that offered insight during her training experience. She expressed:

> I am so grateful that I have worked a recovery program and understand what that looks like and the kind of meaning you can gain from it, because I think there is a limitation if you have not done that work personally, [and] not understanding how that change can be possible.

Jane shared that getting into the treatment field was "really freeing" as she was with clinicians and teams that understood SUD/Addiction as a medical condition versus a moral issue. Her experience with Twelve Step recovery for impacted family members yielded change and results that she did not experience in her own therapy. Recovery fundamentals such as living by principles, integrity, spiritual centeredness, service, and finding purpose inspired her to support individuals in their healing process and provided insight to apply to her clinical work. She reflected:

> I got this exposure to treatment and to [people] that were in recovery, and it was so inspiring. It was like, wow, this is such meaning making. People in recovery are questioning the most meaningful parts of life. They're asking about spirituality and asking about, who they want to be in the world, and how do they want to contribute in the world. The recovery principles of service, accountability, integrity, were just personal values that I had. So, it was like I found this lens that I didn't know existed before. I got into Al-Anon recovery and I was noticing my own change and growth like years of therapy hadn't gotten me, the kind of change that Twelve-step recovery gave me. That was also pretty profound for me.

Jane's personal recovery and healing process was a source of inspiration and motivation to do co-occurring work as well as a vehicle for making sense of her training experience. She was able to draw from the change process she underwent to increase understanding of how to facilitate the recovery process with clients.

Super-ordinate Themes Related to Training Experience

The first super-ordinate theme in the category of **training experience** was *witnessed/aware of stigma*. Jane's narrative demonstrated that she was aware of stigma and that it was a part of the backdrop of Jane's DCC training experience. Jane talked about her process of coming to some understanding of the stigma held by some health care professionals; primarily, that it is a result of misunderstanding and not enough education about SUD/Addiction. She communicated:

> It's unfortunate because I also think ultimately patients are the ones that suffer from clinicians and professionals across the board really not understanding the disease that they have. And with health professionals in general, their physicians aren't asking the right questions. They're in therapy for years and they've never been asked, or people get so afraid to ask a question. When really people are kind of dying to explain what's happening to them. Not everyone in active addiction wants to admit that they're active in addiction, but they are suffering. I think a lot of people, if asked directly would answer or would give some clues. And so I think it prolongs people getting help that they deserve and need.

The second super-ordinate theme for training experience was *experienced complexity and nuances of doing co-occurring counseling*. In a variety of ways, Jane spoke to the nuances of co-occurring counseling. She reflected:

> [Co-occurring counseling requires] understanding the nuance, and that delicate balance of [how] we need to do both [SUD and MH] and [asking] how can we provide the foundational resources to [clients] that are in active addiction or early recovery?

Jane shared about her process connected to self-disclosure of recovery status, a nuance inherent to providing co-occurring counseling. As a family member impacted by addiction, she had experience with recovery from an impacted significant other's perspective. It was a process

to figure out how she would use self-disclosure clinically. She reflected on her process in the following:

> As a clinician [asking myself] how do I self-disclose my status and recovery? And I felt very awkward and, and wished, at times that I was just able to say I have so many years sober. I've been in recovery this long or whatever and, and eventually found my way with how I answer those questions, and comfort, within myself and as a clinician.

Jane's narrative communicated that co-occurring work is multi-faceted and there is a lot to take into consideration as well as to learn when training to be a DCC. She talked about her learning process regarding abstinence-based, harm reduction, skills models, and mental health approaches. Jane reflected on training experiences within specific agency contexts. Jane's narrative about her training experience revealed nuances and complexities inherent to co-occurring service delivery as a key element of the clinical landscape.

The third super-ordinate theme for training experience was *mixed experiences with in/effective features of supervision*. Jane shared instances of working with supervisors who assisted in her development and integration of SUD/Addiction and mental health. Jane also described some of her supervision experiences as being inconsistent or insufficient. For example in phrases such as, "There was a lack of knowing, [and] no one knew me clinically." Jane discussed the challenge of integrating inputs from SUD/Addiction counseling and mental health paradigms.

For example she stated:

> I think if there had been helpful supervision around [an] integrated lens early on, it would have helped me really feel more confident and ultimately impacted client care, and helped me feel more confident as a clinician. Overall, I think it just would have been an obviously better experience.

Jane's mixed experiences with supervision were described more as a part of the conditions within which she trained to become a DCC.

Super-ordinate Themes Related to Navigated

The first super-ordinate theme pertinent to how Jane **navigated** her training experience was *processing with experienced colleagues.* The relationships she developed with other colleagues were important to her growth and development. For example in this statement: "I sought different supervision, with colleagues I trusted. Being able to share cases and share my case conceptualization, I think that was really how I grew." Jane found the process of collectively arriving at clinical decisions as a team valuable. She talked about the importance of collegial interactions and consultation to process, co-facilitate groups, observe skill implementation in peers, debrief, and generate ideas. Jane reflected:

> Processing with colleagues I think with every case, [to address the] wrestling of what's the best approach? Bringing it to the team, and being able to talk about it with colleagues really helped me think through what's the best option.

Jane also shared about the value of peer consultation focused on clinical skill development:

> I got to co-facilitate some groups and that was validating. That shifted my confidence and my skill, because it was someone else in the room with me. Riffing with me a little bit, seeing other people work, being able to observe them. [I would say] 'okay, tell me how you did that. Or, why did you know to pay attention to that?' I think that helped me quite a lot as well.

The second super-ordinate theme under the category of navigated was *experientially developed/employed a holistic/integrated trauma informed approach*. Jane's narrative included phrases such as: "When I was training, I was really trained separately" and, "I feel like my training was not like rooted in anything." Her development of a holistic/integrated trauma informed approach was the result of experientially cobbling together multiple components from a variety of sources. Jane shared about her lens:

> Pulling a little bit from everywhere of folks that I've worked with and trained with and learned from. I go back to [named specific model] in my regular day to day work because I'm focused on substance use treatment and recovery work. [I am also] looking at family systems.

Because of the number of times and ways Jane related the intersection between trauma and SUD/Addiction as being a bridge for understanding co-occurring counseling, *trauma informed* is a part of this super-ordinate theme. During graduate school, Jane began to think about the relationship between trauma and SUD/Addiction. Phrases such as: "The trauma response and working with PTSD is so applicable to recovery and the recovery principles."

Jane recounted how learning specific skills models assisted her development. She initiated the process of seeking out additional information and training to learn models that helped her develop an integrated lens. Jane shared:

> Going to trainings. Those things helped me continue to formulate my lens and feel inspired. [It was] something new that we can try, and then being able to try it and have it work helped me continue to create how I look at it.

She acknowledged the importance of developing a holistic lens to include the mind, body, and spirit of clients receiving co-occurring counseling. Jane shared about the importance of a holistic/integrated approach to co-occurring SUD/Addiction and mental health: "If we tend to both at the same time, ultimately relapse rates and recovery rates will shift, if people are getting everything tended to."

Super-ordinate Themes Related to Other

The first super-ordinate theme in the **other** category was *little attention given to SUD/Addiction in counseling education program*. Jane's graduate school course on SUD/Addiction was informed by an antiquated moral lens. Phrases such as: "I just remember feeling really frustrated that it was this limited exposure," and being aware of the material being outdated, indicated the gap. Jane shared further that she has seen how curriculum has advanced in some schools. Her narrative revealed her perspective of the importance of integrating SUD/Addiction into counselor education programs.

The second super-ordinate them in the other category was *agencies not supporting counselor self-care contributes to burnout.* Jane disclosed her experiences with agencies not supporting counselor self-care, and how this leads to burnout. In looking back at one of her early training experiences, she realized:

> I had no clue I was experiencing burnout. It was very much in my body. It wasn't even burnout. It was just trauma. It was like I had been sitting with trauma all day long. I was seeing clients eight hours a day. It was like a no breaks kind of a thing.

Jane's lived experience as a DCC has caused her to think about how to contribute to healthy clinical environments and teams in which clinicians and trainees can thrive.

Jenni

At the time of this study, Jenni identified as a White female and as being in recovery. Jenni had been a DCC for seven years. She obtained her master's degree and then attended community college to complete coursework to become an SUDP.

Table 6

Jenni's Super-ordinate Themes

	Made Sense: *Vehicles for meaning making, increasing understanding*	**Training Experience**: *Features of conditions and lived experience*	**Navigated***:* *Activities that assisted in the dance between SUD/Addiction and MH worlds*	**Other***:* *Notable/Repeated Themes or Features Specific to Participant*
Jenni	*1. Self-directed internal reflective processes* *2. Experiential learning through clinical work* *3. Drew from personal work/recovery/growth process*	*1.Witnessed/ aware of stigma* *2. Experienced complexity and nuances of doing co-occurring counseling* *3. Mixed experiences with in/effective features of supervision*	*1. Processing with experienced colleagues* *2. Experientially Developed/ Employed holistic/integrated trauma informed approach*	*1. Timing and trajectory of training is a factor* *2. Agencies not supporting counselor self-care contributes to burnout*

Super-ordinate Themes Related to Made Sense

The first super-ordinate theme in the category of **made sense** for Jenni was *self-directed internal reflective processes.* Jenni shared that one of the aspects of co-occurring counseling is the intensity and extreme emotional dysregulation experienced by clients. She reflected, "Tolerating those extreme states, those feelings, that are so intensely arising for people when they are going through the healing of an addiction." The process of developing the capacity to be present to the intensity of co-occurring work was revealed: "Time and time, coming back again, sitting with the discomfort, tolerating again, tolerating again." Jenni recounted how her training experience involved a great deal of internal emotional, intellectual, and spiritual processing. For example, she shared that, "The drives home [were a time for] that real reflection process." In another piece, she explained "and that means working with clients and doing a lot of my own

healing and feeling and grieving at the same time." Jenni reflected on the internal assimilation process connected to her development:

> So, it makes me think of the developmental process. I have this human developmental process, then I have the developmental process of being a mental health therapist, and then developmental process of being an SUDP. Then, I have this developmental process of integrating these two pieces into my work.

Jenni employed a great deal of internal reflective processes to attend to clinical work and make sense of her training experience. Because her training to become a DCC happened over the course of several years and involved many different people and clinical contexts, internal reflective practices had to be employed to increase understanding of her exposures as a DCC trainee.

The second super-ordinate theme in the category of **made sense** was *experiential learning through clinical work*. Jenni shared about the recursive process of working with clients, internal reflection on her work, and then adjusting. She shared, "My training was basically doing it and not knowing, having feelings about it, asking questions." Real-time experiential discovery was a cornerstone of Jenni's DCC training. She told herself, "It's okay for me to not know, it's okay for me to experiment, it's okay for me to try things. It's okay for me to learn how to be a therapist." Jenni reflected, "It feels to me like my SUDP training was much more experiential than anything else." Jenni described herself as an experiential learner, but the experiential learning also seemed to be in part due to a lack of integrated framework guiding the training process. In other words, she had to stitch together experiences from a variety of sources which was demonstrated in phrases such as, "It was working in an agency. It was working with clients" or "I think it was probably for me, a lot of trial and error."

The third super-ordinate theme related to how Jenni **made sense** of her training experience was *drew from personal work/recovery/growth process.* She shared, "I think one of

the things that has helped me the most, in being able to work with people who are recovering from addictions, is that I am in recovery myself." Jenni recounted how her own personal recovery, healing process, or experience was critical regarding her motivation to become a DCC. In part of an excerpt related to her own personal process, Jenni disclosed:

> I remembered back to all of the psychotherapists that I had worked with, and I don't remember any of them asking me about alcoholism, or it wasn't even on the radar screen. It wasn't on the radar screen for me as a training therapist, until it was introduced through this experience that I had. That was the turning point for me to actually enter into becoming dually credentialed. I said to myself, I want to become a therapist who knows everything that she can about addiction. Because if I'm going to work with people, I don't want others to experience what I did, which was not being identified as growing up being impacted by addiction.

Jenni indicated that commitment to growth, humility, open-mindedness, and being willing helped her in the process of training to become a DCC. Jenni's experience as a person in recovery, her own healing processes, provided support, guidance, grounding, wisdom, and resilience. Jenni credited her personal recovery and spiritual practices with affording her the capacity to be okay not knowing all the answers, being humble, open-minded, and open-hearted. These attributes seemed to be an important source of resilience for her during her training to become a DCC. Jenni maintained a deep commitment to being knowledgeable, skilled, and proficient working with co-occurring clients. She shared:

> So I really tried to walk that walk and express [to] people [that] no matter where they are, taking care of yourself is a really good thing. It's going to help with everything, it's going to help with your mental health, it's going to help with your relationships.

Jenni also talked about the importance of doing personal counseling and healing in training to be a DCC. She shared about the parallel process of going through her own change processes while simultaneously facilitating growth in clients with whom she worked. She explained:

> I think there's a big difference in being a therapist who is really working from kind of an embodied experience, rather than just a conceptual one. So, this is one of the things that I love most about being a co-occurring disorders therapist is that I feel like I get to

> be more relational, I get to be more involved with my clients, I get to bring more of myself.

As she discovered and implemented strategies to support her own self-care, boundaries, and limit setting, Jenni realized how these measures directly translated to her work with clients.

Super-ordinate Themes Related to Training Experience

The first super-ordinate theme in the **training experience** category *was witnessed/aware of stigma*. She articulated her perspective on a collective unwillingness in American culture/society to fully address addiction, its real roots, and its impacts. She stated in regard to the collective:

> To me it's like, no, let's look at our culture, and look at how rampant compulsive behavior is in all of its facets. We're in denial, if we're training our therapists as an afterthought to learn about this [addiction].

Jenni indicated that she maintained a compassionate awareness that stigma is a result of misunderstanding SUD/Addiction. Jenni explained:

> I understand the stigma. I think it comes from fear and misunderstanding and the desire [for people] to distance and separate. [People adopt an attitude of] 'those criminals or those addicts'. To me, that's kind of part of this human condition. It's like [people respond by saying] we're going to separate because I'm scared, or I am not seeing correctly, or I don't understand.

The second super-ordinate theme under training experience was *experienced complexity and nuances of doing co-occurring counseling.* Phrases such as "I am still learning a lot," "It's very complex," or "it's very complicated" indicated the multi-dimensional nature of co-occurring counseling. Jenni identified that advanced clinical skill necessary to administer co-occurring counseling. She expressed, "I think people actually need more training, to be able to do skillful group therapy, to do skillful teaching, and to actually work with trauma." Additional examples of nuances that Jenni named were: how to approach collecting observed or unobserved urinalysis (UA) tests from clients, increasing comfort with therapeutic confrontation, developing skills for

accurate assessment/placement, the influence of third-party payors on treatment, and the use of self-disclosure of recovery status.

Jenni's narrative also highlighted agency culture and approach as a feature that impacted training experience. It was part of her training process to sort through variances in agency cultures, approaches, funding sources, and clientele served. For example, Jenni commented on third party payors as one of those variances: "It's complicated because then we've got insurance, right, how many places take Medicare? How many therapists take Medicare? So it's complicated." She talked in multiple ways about the range of service delivery for co-occurring services. Related to the context of searching for a sustainable way to administer co-occurring services Jenni shared, "That's been another part of being dual diagnosis is that I feel like I'm straddling these two worlds."

The third super-ordinate theme related to training experiences was *mixed experiences with in/effective supervision.* Jenni received training in clinical contexts that were doing co-occurring work and shared the valuable learning received from the teams with which she worked. Jenni's experience of supervised clinical hours came from multiple people in various sites. Regarding the supervision received for SUDP hours, she stated, "I feel very fortunate I was able to work with people in the SUD field that I really respected." As for the mental health counselor licensing supervision, the process was more challenging. In addition, she disclosed features related to mental health supervision that were more helpful. At one point Jenni made the comment: "I don't think that substance use disorders, should be like a thing over here, and then there's mental health and substance use disorders over there." The excerpt exemplified a compartmentalization that is problematic.

Super-ordinate Themes Related to Navigated

The first super-ordinate theme in the category of **navigated** was *processing with experienced colleagues.* The spaces provided by colleagues helped Jenni to navigate her professional development as a DCC. Throughout her narrative, Jenni shared about the specific people that held space for her to process and increased understanding of co-occurring cases. For example, she reflected:

> Different people along the way that are just kindred spirits. They just get you and you get them, and that's always just been such a gift. So, I would say, being reflected, having loving kindness be reflected through my colleagues.

Collegial relationships and peer support provided a container and source for processing her DCC training experience. Ideally, this would have been the function of supervision attuned to the training needs of a DCC. In some cases, Jenni was able to get some needs met in clinical supervision, and yet her narrative revealed that these ancillary collegial relationships were also critical to her development.

The second super-ordinate theme in the category of navigated was *experientially developed/employed a holistic/integrated trauma informed approach.* Jenni spoke in various ways about how a trauma informed integrated approach encompassed the complexity and nuances of co-occurring work, including cultural and systemic influences. Jenni shared how she worked from her theoretical orientation, and in listening to her story, the term *experientially* was used to represent Jenni's process of melding components of learning together to create a holistic/integrated trauma-informed framework. For example, when Jenni said, "It was pretty confusing what the right approach was initially." Her development of an integrated approach seemed to emerge through her own piecing together of components. For example, Jenni shared at on point:

> I'm listening to myself. I'm listening to everything I can. I'm trusting, trusting in the moment to the best of my ability. Whatever that is. To me that sort of intersection of mindfulness and spirituality and clinical presence, is listening and trusting, and I think that comes with just being put in a lot of different situations.

Jenni expressed reflective phrases like the following: "So that's what I would like to bring, the conglomeration of my experiences as kind of a more holistic lens." *Trauma informed* was part of the super-ordinate theme because Jenni indicated that understanding the connection between trauma and addiction was helpful to understanding co-occurring work. This descriptor was exemplified in phrases such as: "In my opinion addiction is an expression of trauma."

Super-ordinate Themes Related to Other

The first super-ordinate theme in the other category was *timing and trajectory of training is a factor.* Jenni completed her graduate degree first, and then pursued her SUDP. This meant that she had to attend community college classes after her master's degree for two years to complete the education requirements to be an SUDP. She recounted how an additional two years of courses was challenging. Additionally she was required to attend community college to learn about SUD/Addiction counseling at an academic level inconsistent with her professional development. The sequencing of receiving a masters degree and then attending community college may not be the ideal trajectory for DCCs. Jenni's narrative highlighted timing and trajectory of the education component of DCC training as a factor for consideration.

The second super-ordinate theme for Jenni in the other category was *agencies not supporting counselor self-care contributes to burnout.* Jenni named hours, caseloads, intensity of clinical work as a few of the conditions that make co-occurring counseling in agency settings difficult to sustain. Phrases such as, "I felt that it was not feasible," indicated the challenge. She talked about her desire to provide co-occurring counseling, but that some clinical settings are not

always conducive to supporting the counselor's limits and boundaries, making it difficult to provide services over time.

Jill

At the time of this study, Jill identified as a White female and as not in recovery from SUD/Addiction. She had been a DCC between 1–2 years.

Table 7

Jill's Super-ordinate Themes

	Made Sense*: Vehicles for meaning making, increasing understanding*	**Training Experience***: Features of conditions and lived experience*	**Navigated***: Activities that assisted in the dance between SUD/Addiction and MH worlds*	**Other***: Notable/Repeated Themes or Features Specific to Participant*
Jill	*1. Self-directed internal reflective processes* *2. Drew from personal work/growth process*	*1.Witnessed/ aware of stigma* *2. Experienced differences in approach and lenses between SUD and MH*	*1. Processing with experienced colleagues* *2. Experientially Developed/Employed holistic/integrated trauma-informed approach*	*1. Integrated approach to supervision for DCC training would have helped development* *2. Logistics of obtaining DCC In WA State was cumbersome*

Super-ordinate Themes Related to Made Sense

The first super-ordinate theme in the category of **made sense** was *self-directed internal reflective processes.* Jill described how integrating the two disciplines of SUD/Addiction treatment and mental health was "largely an internal process." She reflected, "it was almost kind of a private conversation that I was having with myself." In the absence of supervision or training that addressed the nuances and complexities of co-occurring work, Jill relied on internal

reflective processes. She disclosed, “I felt a little isolated, I think, in some of the experience.” The internal dialogues in which she would engage surfaced in her narrative. For example:

> If you’re processing something or putting something together and you don’t really have any other spaces, it feels like you’re kind of on your own. For me, I often kind of go more of the self-questioning route of like, how is this realistic? Is this like way off base? Or how does this makes sense to me? But I’m not really hearing it reflected back so, is this nonsense or am I onto something?

S*elf-directed* was used for this super-ordinate theme because of the initiative on the part of Jill that emerged in her narrative. Phrases such as: “I found resources” or when she described how she had to ask herself questions such as: “How do these things complement each other?” Jill disclosed inner dialogue that further portrayed these internal processes:

> I think it was predominantly an outcome of me trying to reconcile these things of like how [to] kind of bring these two very different orientations together. How does that really make sense for me? And where do I see them really inform each other? And, in some cases, the integrating of these things sort of resolve some of the shortcomings of the other.

The second super-ordinate theme for **made sense** was *drew from personal work/growth process*. Jill shared that her personal experience with work connected with an issue other than addiction provided insight and a point of reference for gaining understanding about effectiveness in work with SUD/Addiction. Jill referenced her personal work/growth process:

> My own experience of what behaviors are an outworking of pain has really informed my training experience. How I made sense of the training that I was going through and kind of integrated different aspects. For example, when doing a class on relapse prevention, which in a lot of ways is very behavioral and interpersonal. I kind of integrated my own experiences. [I asked myself] What would be then the barriers to following this relapse plan? Like what could I see for myself coming up, that would [be] a great idea on paper, but I’m unlikely to do it. And, how might I address that? How would that then also be the conversation with a client?

She referenced her own personal process connected to a different issue as “similar to folks that were in recovery from substance use disorder.” She used the insight gleaned from her own process to gain understanding of “what precipitates those behaviors and the importance of paying

attention to [the behaviors] in regard to recovery and in regard to relapse prevention." As a DCC trainee, Jill consulted her personal work/growth experience to increase insight about how to provide co-occurring services.

Super-ordinate Themes Related to Training Experience

The first super-ordinate theme for **training experience** was *witnessed/aware of stigma.* Stigma in a variety of forms emerged as a component of the backdrop of Jill's training experience. Jill disclosed:

> I think that broadly, there is an aspect of stigma that impacts all mental health. It seems one thing that stood out to me with the substance use training was an additional layer of stigma for substance use that impacts the treatment and the recovery experience, because that stigma shows up in different ways. It kind of belongs to different realms like there's a societal stigma to it, there's an internalized sense of stigma. And then there's also for the individual seeking treatment. There also seems to be a level of stigma held by care providers, and all of that felt more pronounced and more of a factor than in mental health treatment.

Jill observed some others' beliefs, including professionals, that SUD/Addiction is something people bring on themselves. She indicated that stigma includes a blame/fault finding thought process. Jill attributed some bias amongst other health care providers as not fully understanding the impact on the central nervous system. Another excerpt reflected stigma as a part of her training experience:

> There's the layers of stigma I think [that] are really imbued in the culture and even in the training for mental health, and I think that's tremendously limiting. And so that would be something I would really want to see in an integrated program of how are we working with our countertransference about this? How are we really understanding where stigma plays a role?

A second super-ordinate theme in the category of training experience was *experienced differences in approach and lenses between SUD and mental health.* Jill's narrative revealed many components related to the difference in approach characteristic to SUD/Addiction treatment and mental health counseling. These differences seemed critical to understanding the

context within which she trained to be a DCC. Jill discussed processes of assimilation between her graduate school education and then training as an SUDP. For example, Jill disclosed:

> I think a lot of substance use training that I experienced was really valuable in that it was a little bit more concrete, and there were some things that were totally new. I think just because the language is really different, my grad program's approach to motivation and how you establish rapport with patients and clients was really different.

She named different features of co-occurring work, such as the urgency inherent to working with SUD/Addiction. Jill shared:

> When you're working with someone who has an anxiety disorder, you're not really talking about life or death in quite the way you are talking about it with someone who has an opioid use disorder or an alcohol use disorder. That just changes the nature of the conversation a little bit. I think even when someone has like chronic suicidal ideation the risk of fatality can be pretty high, but it doesn't feel quite as imminent as the substance use does. If it were, we'd be hospitalizing that person. It would be a very quick response, where it's almost like substance use disorders live in this realm of imminent risk but prolonged work.

Jill experienced SUD/Addiction treatment approaches as more focused on day-to-day functioning, stabilization, life skills, self-care, recovery management, and relapse prevention. She had to bridge her experience of a more behaviorally orientated SUD/Addiction treatment approach with her training as a mental health counselor. Her mental health counseling training and theoretical lens focused more on higher order processing and meaning making. She shared, "I don't really see [my] orientation show up in substance use disorder treatment." Jill expanded:

> My background [named specific theories] was not really behavioral. It's more like, how do we make meaning and understand context and such. So it was a huge departure to then focus on training and substance use disorder treatment because so much of it was behavioral in regard to relapse prevention and coping plans and those kinds of things.

The use of self-disclosure was another area where Jill experienced differences between SUD/Addiction treatment and mental health approaches. She remarked on the use of self-disclosure of recovery status in SUD/Addiction treatment:

> One of the things I noticed immediately was the level of self-disclosure in substance use disorder work felt dramatically different to me than what I had been educated on or was at that point, comfortable doing. I would see the clinicians lead with a lot of self-disclosure like that was their approach, and that was how they built rapport. Clients would be really direct asking, 'are you in recovery?' That just felt like a completely different world because I was used to minimal to no self-disclosure, and it has this very specific unlimited purpose. Observing a clinician lead a group and open with self-disclosure was [like], 'my mind doesn't know what to do with this yet.'

The nuances and complexities that Jill named throughout the narrative colored the clinical landscape experienced during her DCC training.

Super-ordinate Themes Related to Navigated

The first super-ordinate theme under the category of **navigated** was *processing with experienced colleagues.* Jill shared about the need for levity in the face of working with the intensity of co-occurring counseling and collegial connection as a source of resilience. She shared:

> I think with [the] collegial aspect I really gravitated towards people who maintain an attentiveness to their own continuing growth as people. The genuine effort there has given them capacity to be honest with how they feel and find a sense of levity [to] acknowledge frustration, or things about patients, or about the work, but because they're not in this kind of depersonalized or chronic burnt out state, it still has a level of respectfulness to the people we serve.

Jill articulated that processing with colleagues assisted her integration of SUD/Addiction and mental health. She valued hearing SUDP coursework instructors talk about clinical experiences, and she named several individuals along her path who understood co-occurring work, as critical to her development. She shared, "They were just really helpful to consult with and kind of talk through things with."

The second super-ordinate theme in the navigated category was *experientially developed/employed holistic/integrated trauma-informed approach.* After listening to Jill's narrative, there was a real sense of the way she integrated her theoretical orientation with her SUDP training to form a holistic approach to co-occurring work. She shared:

> I have maintained the grounding of my theoretical orientation from my grad program and from my personal experience with therapy which is more [named orientations]. Then kind of threading in substance use disorder training and working with individuals in recovery and making sense of the different approaches like that.

Trauma informed is included in this super-ordinate them because Jill shared multiple times about how trauma and pain are very common underlying factors in clients with SUD/Addiction. Understanding the relationship between trauma and SUD/Addiction as well as developing skills that reflected a range of approaches was crucial to navigating her training. "What I found was, I would say almost everybody that I spoke with what immediately precipitated the substance use disorder like when the substance use became problematic was some instance of trauma." Jill shared about how effective co-occurring care requires skillful attunement to the relationship between physiological impact of addiction on nervous system and presentation of mental health symptomology. Jill shared that one aspect of training to be a DCC was learning to assess and implement approaches that fit clients' needs. Jill stated, "I think you could argue that there should be more approaches, because there's so many different types of people and so many different people need different things."

Super-ordinate Themes Related to Other

One super-ordinate theme that emerged in the **other** category for Jill was *integrated approach to supervision for DCC training would have helped development.* Jill's narrative revealed that an integrated framework would have grounded her clinical work during her DCC training experience. Jill articulated that addiction/co-occurring work is complex and requires a great deal of energy, skill, education, and support. She shared that having a supervisor that knew "both worlds" would have been helpful. Additionally, integrated supervision would have made it feel a little less "ad hoc," and that her training experience was "very much like cobbled together." In addition to counselors considering their countertransference as it relates to working

with clients presenting with co-occurring SUD/Addiction and mental health issues, potential biases held related to recovery status, and stigmas related to SUD/Addiction, Jill shared what she believed would be important to address:

> Giving a good focus on abstinence-based models [as] it's really valuable to have a grounding in the history of the field, and what the development of the field has been because you see there so then the strengths and the limitations. [Additionally, identifying] the dominant approach, and the alternatives.

The second super-ordinate theme in the category of other for Jill was *logistics of obtaining DCC In WA State was cumbersome.* Jill shared in several ways how obtaining the SUDP after mental health licensing was "complicated." For DCCs like Jill who complete a master's program and then supervised work experience hours to be an LMHC, they are then required to complete education requirements and supervised work experience hours for the SUDP. Jill shared about the logistical challenges with obtaining the two credentials. Jill indicated that this may reflect a barrier for licensed counselors to pursue the SUDP to become a DCC.

Ralph

At the time of this study, Ralph identified as a White male who also identified as being in recovery. Ralph had been a DCC since 2006, or approximately 15 years. Ralph became an SUDP first and then attended graduate school and completed requirements to be an LMHC.

Table 8

Ralph's Super-ordinate Themes

	Made Sense: *Vehicles for meaning making, increasing understanding*	**Training Experience***: Features of conditions and lived experience*	**Navigated**: *Activities that assisted in the dance between SUD/Addiction and MH worlds*	**Other**: *Notable/Repeated Themes or Features Specific to Participant*
Ralph	*1. Experiential learning through clinical work* *2. Self-directed assimilation process*	*1. Aware of stigma* *2. Experienced differences in approach and lenses between SUD and MH* *3. Mixed experiences with in/effective supervision*	*1. Experientially Developed/Employed holistic/integrated approach*	*1. Supervisors and trainees working in publicly funded agencies struggle to get needs met*

Super-ordinate Themes Related to Made Sense

The first super-ordinate theme that reflected how Ralph made sense of his training experience was *experiential learning through clinical work.* Multiple times he named on the job, real-time observation, experiential learning of effective and ineffective approaches to clinical work as a vehicle for increasing understanding.

Ralph shared:

> To be stuck in the middle of them [SUD and MH] trying to balance both parts, it was just a learning process. I think I had to learn a lot of it, experimenting and doing it and figuring it out.

He shared several instances where he was assigned clinical work where he experientially discovered how to approach various client presentations. Ralph shared in reference to the experiential learning related to his training experience:

> To me, that experience was growth and learning. It's like, oh, there's other options and I don't know that I thought clearly like that, but that's what I was doing. It was exploring other options with clients about how to help them.

Without integrated supervision or a holistic model available to ground his clinical approach, Ralph's training involved real-time experiential learning with clients in both individual sessions and group work. He shared, "I had to figure out what I thought was right [that would] work." He reflected at one point:

> I wasn't really having these high-level thoughts about it, like I'm a researcher or something like that. I was just in the experience all the time. And the experience was that I'm learning, I'm growing. There's a different way to do this than that.

The second super-ordinate theme related to **made sense** was *self-directed assimilation process*. Ralph's training experience involved relying heavily on his instincts, self, and knowledge that he had at the time to make sense of how to offer services to clients in need of co-occurring counseling. He shared, "If I wanted something, I had to figure out how to get it, and where to get it, and it had to come from my own energy." Ralph indicated that in the context of overworked counselors in under resourced agencies, like some of those from which he received training, counselors are often asked to take cases for which they are not necessarily developmentally ready. While this was the reality of his training experience and he indicated being an experiential learner, he also alluded that this system was not necessarily an ideal way to learn. He reflected in one instance:

> When I was running a co-occurring group [for] people who had [SUD/mental health issues] I didn't really have any experience working with people [with those clinical presentations]. Here I am just thrown in to doing this group because I have more experience than anybody else in the agency.

Ralph described himself as a person who deals with things in the moment that are right in front of him. However, from a training perspective, Ralph's lived experience indicated a lack of supervisory and systemic support.

Super-ordinate Themes Related to Training Experience

The first super-ordinate theme related to Ralph's training experience was *aware of stigma.* Regarding stigma, Ralph indicated that he was aware of bias and stigma connected to addiction in society. He stated, "in the general world, there's still a ton of stigma around addiction." Regarding mental health setting where he trained, Ralph did not experience too much concern with others knowing his recovery status. However, he could see how stigma might cause professionals to be wary of self-disclosing recovery status in professional settings. Ralph shared:

> I think it makes it really difficult for people who are in recovery to want to talk about it, or to talk about it openly, because they're worried about what people are going to think about them, which is not a great thing.

He was able to find a way to reconcile that he would encounter stigma from time to time professionally. As Ralph shared, I did not get the impression that stigma significantly impacted him as a person in recovery, but his descriptions revealed that to a certain degree, stigma and bias were a part of the clinical climate within which he trained.

The second super-ordinate theme related to Ralph's training experience was *experienced differences in approach and lenses between SUD and MH*. In the context of when he received training early in his development, Ralph disclosed:

> There was not really overlapping training. They were two very very separate fields, they were funded separately, treated separately… and so there wasn't any place to go to talk to somebody who did both kinds of work, and the approaches are significantly different.

Ralph described the characteristics of different clinical contexts focused on SUD/Addiction treatment such as the use of therapeutic confrontation, the structure employed in abstinence-based residential and intensive outpatient programs, the use of Twelve Step involvement, or the other clinical contexts that employed more of a harm reduction approach. In some mental health centered clinical contexts, he observed SUD/Addiction not being adequately addressed. For example he shared:

> [In early training] I took on like 20 clients at this agency. And every one of them had substance use issues and not any of them had anything in their charts anywhere about it. I sit there and talk to them for a couple minutes and I'll get it and I understand it and I can see it … It gets left out a lot.

Overall, he was aware of the different lenses being employed, a degree of tension at times between the two fields, and the separation that exists in service delivery.

The third super-ordinate theme related to training experience was *mixed experiences with in/effective supervision*. Ralph shared about an effective supervision experience and noted that the supervisor did not have SUD/Addiction knowledge or experience. He stated that in many settings he "had supervisors and consultants but not who were dually certified or trained." He disclosed:

> I think that was one of the areas that I struggled with my internship supervisor was that [they] didn't understand addiction and asked me about it. I'm [the] intern, [and] that just didn't make sense to me. If [they] had a better understanding, that would have changed that dynamic considerably.

A recurring experience for Ralph was not having enough time or access to supervisors, as well as too much time being dedicated to paperwork or documentation issues. Ralph spoke a great deal about the quality of supervision being a systemic issue, and of instances where he would have benefited from more support in his professional development.

Super-ordinate Themes Related to Navigated

The super-ordinate theme related to **navigated** in Ralph's case was *experientially developed/employed a holistic integrated approach* to co-occurring clinical work. Without the framework of an integrated supervision model or holistic approach to co-occurring counseling to guide his clinical practice, Ralph shared how he developed his own structure. His perspective is that SUD/Addiction and mental health treatment is complex, and a one size fits all approach is not realistic or effective. He shared about the importance of being able to align approach with clients' needs. Additionally, Ralph clarified and added that a holistic approach needs to include

or address “homelessness, socioeconomic status, medical issues, and most importantly trauma experiences and responses.” Ralph stated:

> I think there’s a need for a lot more integration of the two fields, than there already is. We’ve come a long ways I have to say, since I started we’ve come quite long ways. I mean, there are a lot more dually credentialed [counselors] out there than there used to be. There are people providing some supervision and some training and that’s good stuff. That’s helpful but it’s not nearly enough.

Super-ordinate Themes Related to Other

A super-ordinate theme that emerged in the category of **other** was *supervisors and trainees working in publicly funded agencies struggle to get needs met.* Ralph added to his narrative that SUD/Addiction is a difficult condition to effectively treat, and that trainees “are underpaid and are being asked to work with one of the most difficult to work with populations, without the training or support they need to be more successful.” Ralph spent many years training and working in publicly funded agencies. He added to his narrative, “Publicly funded service providers are just squeezed and squeezed.” Ralph shared how this impacts supervision, “The supervision [does not provide] time to develop clinical skills.” Ralph reflected on how quality of supervision is a systemic issue. He said, “Supervisors are overloaded. They’re underpaid.” The reflections Ralph offered related to systemic issues that impact DCC training and workforce were salient to his lived experience.

Rebecca

At the time of this study, Rebecca identified as a White female who also identified as a non-recovering person. Rebecca went to graduate school first, then obtained required education credits from to be an SUDP through the alternative learning pathway. She had been a DCC since 2020.

Table 9

Rebecca's Super-ordinate Themes

	Made Sense: *Vehicles for meaning making, increasing understanding*	**Training Experience**: *Features of conditions and lived experience*	**Navigated**: *Activities that assisted in the dance between SUD/Addiction and MH worlds*	**Other**: *Notable/Repeated Themes or Features Specific to Participant*
Rebecca	*1. Spiritual principles and practices* *2. Integrated training and supervision from a DCC*	*1.Witnessed/ aware of stigma* *2. Experienced complexity and nuances of doing co-occurring counseling*	*1. Processing with experience colleagues* *2. Experientially Developed/ Employed holistic/integrated trauma-informed approach*	*1. Logistics of obtaining DCC In WA State was cumbersome*

Super-ordinate Themes Related to Made Sense

The first super-ordinate theme in the category of **made sense** was how Rebecca turned to *spiritual principles and practices*. She shared about the "madness" and "heartbreak" of working with addiction that exists simultaneously to witnessing "beautiful transformations" and "redemption." The nature, intensity, and extreme states with which clients with co-occurring issues present offered important opportunities: to come to terms with her role as counselor; to enact better self-care; to practice stronger boundaries; and to process the grief that she realized accompanied co-occurring counseling. Rebecca identified *spiritual principles and practices* as a vehicle she used to make meaning and reconcile these aspects of DCC training. For example in phrases like "I think my own understanding of my/a faith perspective". She explained:

> It's my job to be responsible and do all the things that I can, but it's never my job to make someone sober, or make someone stop using, or save someone. That's between them and their higher power. Having that understanding that there's something bigger than me, and knowing that being really solid in my role. I'm a witness, and I accompany people versus I do something is very orientating.

Rebecca's spirituality assisted her in coming to some acceptance about the realities and challenges of working with clients with co-occurring issues. For example, she identified as part of her spirituality the attributes of humility and not being attached to an outcome; these assisted with emotional and psychological sustainability and helped her to work with clients.

The second super-ordinate theme for Rebecca under **made sense** was *integrated training and supervision from a DCC*. She stated, "I built my identity as a clinician using both lenses at the same time." Rebecca recounted:

> I think I had a really loving generous experience. So, my supervision process for both mental health and SUDP [was with a] supervisor [who] was dually credentialed. They started their journey from a mental health perspective and also went into specializing in chemical dependency and was working from a lens of both.

She described in various ways how receiving integrated training and supervision assisted her skill and knowledge development for considering both SUD/Addiction and mental health:

> The environment of the treatment center that I was in, that is how I learned. The felt, lived, embodied experience and actually seeing it work. That all happened within my work environment. The encouragement, the shared struggles, the frustrations, my own stuff that came up, and being able to work through that and holding both in myself and in the other person, that was all the treatment environment. Multiple times a week to have case consult with all the clinicians and our supervisor and clinical director.

Rebecca also expressed an awareness of her experience being fortunate which was demonstrated in phrases like: "I am so aware of the amount of privilege I was in" or " to land with a supervisor who had both and could care for both. So rare and such a jackpot." Rebecca's narrative accounted integrated training and supervision as a vehicle for understanding co-occurring work. It was noteworthy that she communicated this in a way that indicated an awareness of integrated training or supervision not necessarily being the norm in the field.

Super-ordinate Themes Related to Training Experience

The first super-ordinate theme related to training experience was *witnessed/aware of stigma.* Rebecca reflected on her awareness of stigma and social justice issues related to

SUD/Addiction. She recognized clients with SUD/Addiction as marginalized and underserved. She developed a great deal of respect and love for individuals with SUD/Addiction, and providing access to care was a source of motivation in her training experience. She shared, "I saw how marginalized this community can be." For Rebecca, her awareness of stigma occurred on more of a societal level and served as motivation to be an ally to individuals with co-occurring issues. She stated:

> If you've survived addiction, and you now find yourself in recovery you know something about pain and suffering and life and death and sacrifice and intimacy and relationship, especially if you're on the recovery side, and humility and powerlessness. I think everybody on this planet needs to know [those things]. I think it was [the] draw. [I saw people in recovery as] they're like, this is a wise, fierce community, and I want to be around them. I want to be in that with them.

Rebecca's descriptions of stigma and bias coupled with her descriptions of how that motivated her to be an ally or advocate reflected the social justice aspect of the role of DCC.

The second super-ordinate theme in the category of training experience was *complexity and nuances of doing co-occurring* work. Rebecca's narrative revealed that nuances and complexities were inherent to her DCC training experience. Drug interactions, withdrawal, confidentiality laws, harm reduction, abstinence-based, role of Twelve Step, group process, and interdisciplinary teams are just some of the components of co-occurring service delivery that formed the backdrop for Rebecca's DCC training. She talked about the intersection of SUD/Addiction and mental health issues that arise during co-occurring work with clients. For example phrases like, "It's really hard to be sober when you don't have access to community. It's really hard to be sober when there are a lot of mental health concerns."

Self-disclosure of recovery status was a nuance Rebecca named. Rebecca went to graduate school for mental health counseling first, and shared, "[I] come from a mental health perspective," which is grounded in the rationale for not using self-disclosure, or minimal

self-disclosure to avoid interfering with a client's process. Rebecca experienced the nuance of self-disclosure of recovery status as part of the clinical context of the SUD/Addiction treatment culture where it is not uncommon for counselors to be open about their recovery status and experience.

Rebecca reflected on additional nuances inherent to SUD/Addiction or co-occurring treatment such as dynamics of group process, relapse, and confidentiality issues. She shared about her experience doing group process with people in SUD/Addiction treatment:

> [The] group may not have a lot to talk about or [there may be] conscious or unconscious resistance to actually trust each other and lean in, because you're with a group of people that have potentially a lot of instability and unpredictability about them because of the nature of relapse. And because of the risk that comes with, intimacy with someone who could relapse and then they could die, or you could never see them again.

Rebecca discussed the feature of helping clients to explore Twelve Step programs and spirituality, another nuance of co-occurring counseling. She talked about the process of learning to help clients unpack spiritual aspects of recovery which exemplified another aspect of skill development necessary in co-occurring work. In one segment, Rebecca shared an example of a dialogue she would have with a client about the process of the Twelve Steps and utilizing a Higher Power:

> [To a client] The first three steps you have to identify something that's bigger than you. So for the client I don't care what it is, but [I would ask], What can you be connected to that is helping you breathe and have some freedom and make some progress?

Rebecca named many features inherent to co-occurring service delivery that comprised the backdrop of her training experience and are critical components to address in DCC training.

Super-ordinate Themes Related to Navigated

The first super-ordinate theme in the category of navigated was processing with experienced colleagues. During her training experience, it was critical to debrief and process interactions with clients in group and individual sessions. She indicated that some of the

clinicians she was surrounded by were DCCs, some were SUDPs, and both were important to her development. Rebecca disclosed:

> My peers were really powerful knowledgeable people in the SUDP world that I respect tremendously and was just absorbing from them and wanting to make sure that I was pulling my own weight. It had so much more I think to do with my own sense of self and wanting to rise to the occasion of these amazing clinicians around me.

She reflected on how processing with experienced colleagues helped her to gain confidence in working with SUD/Addiction. Rebecca recounted about peer interaction:

> Being able to walk into my coworkers offices and sit on their chair and be like, 'oh my goodness, listen, just what happened, what is going on?' It was the environment. It was an environment of curiosity and support and learning. We really knew that we could not do this work alone, or as individuals. That we needed each other, and I needed what that clinician could do really well in this piece, and then I would team up and do this piece really well. And we would all come together to support the one client, or to support the group, or just support whatever. And so that I think that makes it or breaks it.

The second super-ordinate theme in the category of navigated was *experientially developed/employed holistic/integrated trauma-informed approach.* Rebecca stated, "I feel like I have been in a pretty fortunate position where I haven't felt like there's been a split in at least [my] educational process for the mental health piece. Addiction was an ongoing part of the conversation." She discussed her theoretical orientation and its application to addiction and trauma. For example, Rebecca stated:

> I just come from a [named model]- trauma theory, which is really just the investment in the stories that we tell ourselves about ourselves, and the stories that other people have told us about ourselves, and what does that do to our sense of identity? … And what are all those ways that the stories that we've told ourselves, or that others have told us, that essentially our light has been dimmed, and so that can look like well addiction has dimmed my light, or the codependency, or the trauma.

The coursework for SUDP added some important knowledge. Regarding this feature of her DCC training experience Rebecca shared:

> The [SUDP] training was more of the daily looks of it. [It focused] more [on] practicalities of relapse and withdrawal and intoxication, and here's how different drugs can interact with one another.

Although Rebecca enjoyed more integration, there appeared to still be an experiential component to developing an integrated framework in the coalescing of training components.

Super-ordinate Themes Related to Other

One super-ordinate theme that emerged in the category of **other** was *logistics of obtaining DCC In WA State was cumbersome.* Rebecca reflected on the process of tracking supervised work experience hours and documentation required by the Washington State DOH to become a DCC as cumbersome and confusing. Specifically, she pointed out how finding an approved site to complete the supervised work experience hours was a barrier. Rebecca said, "But I remember it being incredibly overwhelming and just so many unnecessary steps and so it felt more like barriers." Rebecca panned out from her own personal experience to offer thoughts about the logistical process potentially being a barrier to increasing the workforce with DCCs.

Conclusion

The IPA data analysis process employed in this study revealed super-ordinate themes directly related to the research question by either demonstrating how participants made sense, experienced, or navigated through their training to be a DCC. Each individual described their development in a unique way and emphasized various features. The semi-structured interviews provided space for participants to have the freedom to deepen into topic areas salient to them. The next chapter provides a discussion about the relationships and themes revealed amongst the participants. In addition, a section is devoted to considering what these results say about future research that should be conducted.

CHAPTER V: SUMMARY, IMPLICATIONS, AND OUTCOMES

Introduction

The purpose of this IPA study was to explore in depth the lived experience of six Washington State DCCs. In service of adequate co-occurring counseling services, there is continual need for counselors and other health care providers that are trained to screen and treat SUD/Addiction (Office of the Surgeon General, 2016; SAMHSA, 2020). Although research has shown that integrated care is optimal for individuals in need of co-occurring SUD/Addiction and mental health services, there are several obstacles to implementation. Two of the four challenges to integrated care listed in the Surgeon General's Report (2016) were: "the substance use disorder treatment system is underprepared to support care coordination," and "the existing health care workforce is already understaffed and often lacks the necessary training and education to address substance use disorders" (p. 6-27). Therefore, a great need exists to connect individuals with co-occurring SUD/Addiction and mental health issues to an effective and efficient workforce of health care professionals competent to identify, screen, refer, or treat individuals with co-occurring issues (Office of the Surgeon General, 2016).

DCCs in Washington State have completed the Department of Health requirements necessary to administer co-occurring services. A report conducted by the Washington Workforce Training and Education Coordinating Board and the Center for Health Workforce Studies at the University of Washington (O'Connor et al., 2019) identified the need for more mental health counselors and substance use disorder professionals in Washington State. One small brick may be laid toward building a bridge between SUD/Addiction and mental health counseling services by gaining insight into the necessary support and professional development of DCCs. Participants' experiences from this study show how DCCs have been acquiring their education

and work experience hours in a fragmented, compartmentalized manner. A review of the literature revealed a gap when it comes to integrated training resources specifically designed to address the complexity of administering co-occurring counseling and the professional development needs of DCCs. Additionally, as their stories showed, participants often had to independently cobble together input, resources, education, and feedback during their training process. With a range of experiences amongst participants, there existed areas of overlap and areas of divergence. The next section is devoted to considering the relationships between super-ordinate themes amongst participants.

Summary of Findings

The research question for this IPA study was, *How have dual credentialed counselors in the State of Washington made sense of their training experience when navigating the division between SUD/Addiction treatment and mental health counseling fields?* Super-ordinate themes directly related to the research question were categorized under **made sense, training experience**, or **navigated** (Table 10). The individual narratives of the participants and the super-ordinate themes that emerged from their lived experiences lend important insights about the training of DCCs in Washington State. This section will summarize observations about the super-ordinate themes exhibited or shared by participants in the categories of **made sense**, **training experience**, and **navigated**, which were directly related to the research question. In some cases, excerpts from participants' narratives are used to review the essence of super-ordinate themes. The implications of the shared super-ordinate themes as well as other discoveries are unpacked in the *Discussion* section.

Table 10

Super-ordinate Themes Shared by Participants

Super-ordinate Theme	Number of Participants
Made Sense	
Self-directed internal reflective processes	3
Self-directed assimilation process	1
Experiential learning through clinical work	3
Drew from personal work/recovery/growth process	2
Drew from personal work/growth process	1
Drew on personal recovery early in training as SUDP, less in MH professional development	1
Spiritual principles and practices	1
Post graduate skills training models relevant to co-occurring counseling	1
Integrated training and supervision from a DCC	1
Training Experience	
Witnessed/aware of stigma	4
Aware of stigma	1
Observed problematic biases in both MH and SUDP counselors	1
Experienced complexity and nuances of doing co-occurring counseling	4
Experienced differences in approach and lenses between SUD and MH	2
Mixed experiences with effective/ineffective features of supervision	4
Navigated	
Processing with experienced colleagues	4
Experientially developed/employed holistic/integrated **trauma** informed approach	4
Experientially developed/employed holistic/integrated approach	2

Shared Super-ordinate Themes for Made Sense

The category of **made sense** was defined as *vehicles for meaning making or increasing understanding*. Three participants shared the super-ordinate theme of *self-directed internal reflective processes,* and one participant had the super-ordinate theme of *self-directed assimilation process*. Not one participant cited an established model for co-occurring counseling that was used to guide their training. Within the vacuum of a guiding professional framework, participants initiated their own process. For instance, Jenni stated:

> So, it makes me just think of the developmental process. I have this human developmental process, then I have the developmental process of being a mental health therapist, and then developmental process of being an SUDP, and then this developmental process of integrating these two pieces into my work.

Without a framework, model, or integrated approach to training, these four DCCs shouldered the assimilation process and may have benefited greatly from additional support. For example, Jane shared, "I remember feeling alone, thrown to the wolves out here, and I am supposed to help this person get better. I felt overly responsible for that because I didn't have help around me." Jill stated, "It was almost kind of a private conversation that I was having with myself." In the absence of an integrated framework to assist DCCs as they learned how to bridge the gaps that existed between SUD/Addiction and MH counseling, they assumed a great deal of the meaning making and assimilation processes.

Closely related, three participants shared the super-ordinate theme of *experiential learning through clinical work.* While experiential learning is a common component of most training experiences, at times these DCCs did not have sufficient support. Ralph shared, "To be stuck in the middle of them [SUD and MH] trying to balance both parts, was a learning process. I think I had to learn a lot of it, experimenting and doing it and figuring it out." Jenni reflected, "I think probably for me, a lot of trial and error." These experiences revealed an important opportunity to provide more support to the experiential learning aspect of training.

One participant, Rebecca, generated *integrated supervision from a DCC* as a super-ordinate theme for **made sense**. She expressed this in phrases such as: "I am so aware of the amount of privilege I was in," "to land with a supervisor who had both and could care for both," and "so rare and such a jackpot." Rebecca's supervisor was well-versed in co-occurring counseling which afforded her an opportunity to receive a more integrated training experience. Further, Rebecca's statement seemed to imply an awareness of the rarity of receiving supervision

from a DCC. The shortage of DCCs in the workforce is problematic when it comes to availability of supervisors that are DCCs.

Finally, three participants shared super-ordinate themes that reflected their personal recovery influenced their development as a DCC. Two participants shared the super-ordinate theme of *drew from personal work/recovery/growth process*, and one participant named *drew on personal recovery early in training as SUDP, less in MH professional development.* Scholarly works have explored various aspects of recovery status on clinical work and supervision, and indicated that recovery status is indeed an important factor to consider (Culbreth, 2000; Curtis & de Tormes Eby, 2010; Crabb & Linton, 2007; Doukas & Cullen, 2011; K. Doyle, 1997; Kinney, 1983). For example, Jenni stated, "I think one of the things that has helped me the most, in being able to work with people who are recovering from addictions, is that I am in recovery myself." These participants' narratives reflect research findings that point to recovery status as an important aspect of supervision and training for DCCs.

Shared Super-ordinate Themes for Training Experience

Super-ordinate themes categorized as **training experience** represented *features of conditions and lived experience* that repeated in participants' narratives. Four participants shared the super-ordinate theme of *witnessed/aware of stigma*, one generated *aware of stigma*, and the remaining participant had the super-ordinate theme of *observed problematic biases in both MH and SUDP counselors.* Some participants shared experiences of observing stigma connected to SUD/Addiction in society. For example, Jill stated, "There's the layers of stigma I think [that] are really imbued in the culture and even in the training for mental health, and I think that's tremendously limiting." Others shared examples of bias that occurred with colleagues which added *witnessed* to the super-ordinate theme. Jane shared, "It's unfortunate because I also think

ultimately patients are the ones that suffer from clinicians and professionals across the board really not understanding the disease they have." Stigma is a feature that should be addressed in DCC training.

Four out of six participants shared the super-ordinate theme of *experienced complexity and nuances of doing co-occurring counseling*. The remaining two participants shared the super-ordinate theme of *experienced differences in approach and lenses between SUD and MH*. Self-disclosure of recovery status, conducting urinalysis tests, confidentiality laws, ethics, integration of harm reduction and abstinence-based approaches with theoretical orientation are just a few of the nuances that participants named.

Four out of six participants discussed their *mixed experiences* with supervision. Participants shared supervisory experiences that were helpful and effective. For example, Jack stated:

> I've been in good places and had good people around me, but just the idea that I think you are working on, which is how do we supervise all of those things and kind of have all of it identified? It's important. It's a big thing because I definitely didn't get it all at once. It was all spread among many supervisors and different pieces of training.

Participants also shared about supervision experiences that did not address all of the complexity and nuance related to their DCC training needs. Jane shared, "I think if there had been helpful supervision around [an] integrated lens early on, it would have helped me really feel more confident, ultimately impacted client care, and helped me feel more confident as a clinician." Overall, this super-ordinate theme suggested an inconsistency in supervision practices stemming from multiple sources of supervision with differing approaches and goals.

Shared Super-ordinate Themes for Navigated

The category of **navigated** was defined as *activities that assisted in the dance between SUD/Addiction and MH worlds.* Most notable in this category was that four participants shared

the super-ordinate theme of *experientially developed/employed holistic/integrated trauma informed approach,* and the other two shared the super-ordinate theme of *experientially developed/employed holistic/integrated approach*. The descriptor of *trauma* was added for participants who repeatedly named an understanding of trauma as a bridge to creating an integrated approach to co-occurring counseling. For example, Jane shared statements like, "The trauma response and working with PTSD is so applicable to recovery and the recovery principles." Another example emerged when Jill shared, "What I found [working with co-occurring clients] was almost everybody that I spoke with, what immediately precipitated the substance use disorder was some instance of trauma." These excerpts demonstrated how understanding trauma assisted trainees in their formulation of an integrated lens.

The fact that all six participants found it necessary to develop an integrated approach to navigate their training experiences points to an important factor. None of the participants referenced a model or framework that guided their approach to co-occurring counseling. Instead, they shared about the paradigms, approaches, models, or concepts that they stitched together to address the complexity of the clinical work they were undertaking. For example, Jack shared:

> It would be good to have that integrated. [An approach that included] talking about the person in recovery, talking about the person as counselor, as mental health counselor as substance use counselor, and all of those as tools, but part of [the] person [and] then as a tool in counseling [while] using all these other clinical things. I think that is where I am getting to, but it could have happened in a more structured way if my path had been different.

A review of the literature revealed a gap when it came to identifying integrated frameworks for DCC training and supervision. Jill described about her training experience "cobbled together." Participant narratives reflected the necessity to independently formulate an integrated model as they were not introduced to cohesive framework in their training experiences.

The intention of this research study was to adopt an attitude of curiosity and explore with depth the lived experiences of DCCs in Washington State. The hope was to discover more about the experiences of trainees' in the context of dancing between the two clinical worlds of SUD/Addiction and mental health counseling. The participants' stories offered important information about the training conditions for DCCs, and highlighted important areas for consideration moving forward.

Discussion

The findings from this research study identified opportunities to advance professional development resources for DCCs. In many ways, my own training as a DCC mirrored the range of features described in the lived experiences of the participants. I enjoyed the natural scaffolding of starting out as an SUDP followed by graduate studies in mental health counseling to complete requirements to become an LMHC. However, I was always dancing between the two worlds of SUD/Addiction and mental health counseling, and have been for the majority of the 20 years I have been in the field. I shared the experience of participants who described independently cobbling together components or elements of paradigms that seemed to be effective for clients. Much of my experience was self-directed and experiential in nature which, at times, ushered in feelings of isolation. In service settings more focused on SUD/Addiction treatment, at times, I observed a lack of awareness or under addressing of trauma and mental health issues. Additionally, at times in mental health settings and counselor education programs, I observed a lack of understanding about SUD/Addiction counseling and concerning biases, similar to those named by participants. I longed for colleagues and supervisors that would help me assimilate the range of components that I was trying to piece together to be effective as a DCC; they were few and far between. Locating colleagues that have helped with integration

during my training experience and beyond has felt like finding gold. I wanted to design a research study that would allow for my positionality and experience. However, I wanted to uncover others' experiences from a place of curiosity and not knowing. Listening to participant stories elicited feelings of pride to be their colleague, and I felt like a member of an underground force dedicated to serving clients with co-occurring issues despite the difficulties in professional training and practice.

Conducting this research study renewed my dedication to developing training resources for DCCs and working towards building a bridge between SUD/Addiction and mental health counseling. More specific ideas about development opportunities focused on DCC training are outlined in the *Future Research* section of this chapter. The next sections are devoted to considering the validity of this research study as well as its limitations.

Assessing Validity

Yardley (2000) named four components for assessing validity in qualitative research studies. The first aspect to consider is "sensitivity to context" (Yardley, 2000, p. 219). This aspect refers to the researcher's commitment to addressing sociocultural factors connected to the participants' experience or phenomenon being studied (J. A. Smith et al., 2012; Yardley, 2000). A strength of this study was its inclusion of relevant context. The literature review covered crucial aspects of the ecosystem within which participants received their training. Additionally, the interview schedule reflected sociocultural influences represented in the literature review such as the historical underpinnings of the segregation between SUD/Addiction treatment from other behavioral health disciplines and predominant models used to treat SUD/Addiction.

The second component in assessing validity is "commitment and rigour" (Yardley, 2000, p. 219). The goal of the research study was to examine at depth the lived experiences of the six

participants. I believe this was another strength of the study. The data analysis method utilized for this study involved several rounds of immersion and interaction with the data. The interview recordings were viewed multiple times, the interview transcripts were carefully studied, and several steps were employed to extract themes. Additionally, three rounds of member checks were completed with a 100% return rate from participants, which either confirmed themes or provided additional input to increase accuracy.

Yardley (2000) identified "transparency and coherence" as the third feature of sound qualitative research (p. 219). Applying principles of IPA, clarity and accuracy were achieved by articulating the steps related to selecting participants, data collection, and outlining procedures employed in the analysis process (J. A. Smith et al., 2012). In addition to thoroughly outlining the methodology utilized for this study, I engaged in a reflexive journal. I created a table outlining my held identities that could be active during any step of the data collection or analytic process. The reflexive journal served as a supplementary vehicle for tracking and reflecting my relationship with the data.

The fourth component for assessing validity according to Yardley (2000) is "impact and importance" (p. 219). My own professional experience factored into the perspective on this component. As a counselor trained as a DCC, in practice as a DCC since 2009, having created an addiction studies program for a graduate level counselor education program, and providing consultation, I am situated to understand the phenomenon through personal experience. While I took pains to ensure my choices were informed by the literature, applied methods from IPA research so that the results were indicative of participant voices, I could not deny my belief that this study and its results contained value for the field. However, a true assessment of impact and

importance may hopefully lie in the future with continued improvement on resources for DCC training.

Limitations

A common thread of limitations in this study was representation of voices. First, there was diversity amongst the six individuals that participated in the categories of age, gender identity, and recovery status. However, all of the participants identified as White and thus the experiences shared and the resultant themes may be representative of more Eurocentric perspectives. Similar studies focused on DCC training which include more variance in racial identity would capture more voices and experiences germane to understanding a broader scope of the lived experiences of DCCs.

Second, the inclusion criteria for this study required participants to be credentialed as an SUDP and licensed as an LMHC in Washington State. The intention behind this choice was to explore the lived experiences of counselors who had completed the process to be a DCC and could reflect on the entire trajectory of the experience. However, the criteria precluded participants in the midst of completing requirements to be a DCC, and those who may have begun the process but stopped or halted their progress. Thus, a broader perspective from individuals representing various points on the DCC training spectrum are not represented. The exclusion of these perspectives may result in missed opportunities to understand more recent trends, conditions, and barriers that DCCs face.

Finally, this research study was focused on DCC training experiences in Washington State. As previously documented, different states have separate credentials for administering SUD/Addiction treatment (ASPE, 2019). Because this study focused on DCC training in the State of Washington, the data from this study reflected conditions and experiences within the

context of training to be a DCC according to standards and requirements set forth by the Washington State Department of Health. Consequently, the results from this study may not transfer to the understanding of DCC experiences in other states. Future studies that include participants from other states could prove valuable in terms of identifying state-specific training needs, and collated results across states could produce national trends related to DCC training.

Future Research

This study offers insight into further research that could be conducted to increase understanding on a range of issues surrounding DCC training. The fourth category of super-ordinate themes, named **other,** was created to house themes that represented salient features of the participants' experience that were peripherally related to the research question. In many instances, the super-ordinate themes in the **other** category related to topics in the literature review. Additionally, in some instances the super-ordinate themes in the **other** category pointed to additional opportunities for exploration, evaluation, or development and are addressed in this section. Table 11 exhibits an overview of the **other** category of the super-ordinate themes shared by participants.

Table 11

Other Category of Super-ordinate Themes

Other	
Little time and attention given to SUD/Addiction in graduate program	1
Timing and trajectory of training is a factor	2
Logistics of obtaining DCC in WA State was cumbersome	2
Agencies not supporting counselor self-care contributes to burnout	2
Supervisors and trainees working in publicly funded agencies struggle to get needs met	1
More integration between SUD and MH needs to occur	1
Integrated approach to supervision for DCC training would have helped development	1

Counseling Education Programs

In 2009, the Council for the Accreditation of Counseling and Related Education Programs (CACREP) identified SUD/Addiction counseling as a specialty area and created standards for counseling education programs who wanted to include the specialty as part of their program (Hagedorn et al., 2012; Lee, 2014). Currently in the United States, there are 14 counselor education programs that have a CACREP accredited SUD/Addiction specialty program, and none of those reside in Washington State (CACREP, n.d.). Salyers et al. (2005) points out that given the prevalence of clients with co-occurring issues seen by counseling interns, it is important to provide adequate education and training on SUD/Addiction in counseling programs. One participant had the super-ordinate theme of *little time and attention given to SUD/Addiction in graduate program.*

I had the privilege of developing an SUD/Addiction counseling certificate program for a counselor education program. It was a wonderful chance to create a program that was centered on teaching SUD/Addiction counseling in an integrated, trauma-informed manner. However, during that time I was the only full-time instructor who taught the intro to addiction counseling course, which was a required for the counseling education program. I felt siloed in my position and unable to enjoy collaboration with colleagues to develop the SUD/Addiction program due to the fact that there was little experience or interest amongst my peers. It was difficult to recruit and hire adjunct instructors who were available or able to teach courses from an integrated lens.

Lee (2014) recommended that further studies be conducted to explore various aspects of how CACREP counselor education programs are including SUD/Addiction counseling topics into course curriculum. I concur with Lee's (2014) recommendation, and would like to see additional research analyze the prioritization and coverage of SUD/Addiction counseling

amongst CACREP accredited counselor education programs. Research aimed at increasing awareness of the coverage SUD/Addiction counseling in CACREP counselor education programs and the number of instructors with SUD/Addiction counseling background would provide important data for identifying specific opportunities for development. Further research could be helpful in bolstering the focus of SUD/Addiction counseling within counselor education programs.

Conditions That Impact DCC training

The super-ordinate themes connected to conditions that impact DCC training highlighted more pragmatic issues related to the implementation of integrated care. The opportunity for future research focused on the factors identified in this section may be best explored by conducting surveys or program evaluations. Additional analysis of topic areas identified in this section could provide important information about how to reduce barriers to becoming a DCC, increase incentives for counselors interested in training to be a DCC, and identify opportunities for improving implementation of integration between SUD/Addiction and mental health disciplines. In this section, the super-ordinate themes explored in the **other** category relate to conditions that impact DCC training in Washington State. Additionally, these super-ordinate themes point to opportunities for further investigation.

Two participants had the super-ordinate theme of *timing and trajectory of training is a factor.* The two participants who shared this theme discussed the order in which they received their education and training as a factor. Jack obtained his SUDP first and attended community college to complete his coursework at the BA level and then completed his masters in mental health counseling program second. He stated: “I think because of timing I lucked into the easier way of doing it because I got the CDP [SUDP] first.” This super-ordinate theme was also

identified for Jenni, who alternately completed her graduate program first and then went to community college to complete the SUDP education requirements. She shared about some of the challenges that are somewhat inherent to receiving BA level education after MA level education. To some degree, Washington State has addressed this issue by allowing Licensed Mental Health Counselors to pursue an alternative training pathway which reduces the number of education credits required to obtain an SUDP (WAC 246-811-076, n.d.).

I would like to see more CACREP accredited SUD/Addiction specialization tracks in counselor education programs. In 2009, CACREP identified standards for SUD/Addiction counseling specializations in counselor education programs, and to date, according to the CACREP (n.d.) website directory, there are only 14 total in the United States (Council for Accreditation of Counseling and Related Education Programs, 2016). Counselor education programs that choose to create SUD/Addiction counseling specialization tracks, or build-in state education requirements to be an SUDP, support students who want to be DCCs. Furthermore, institutions with CACREP accredited SUD/Addiction counseling specializations could participate in the larger movement towards prioritizing knowledge and skill acquisition necessary to address SUD/Addiction in mental health settings by effectively preparing counselors to work with clients presenting with co-occurring issues. Additionally, increasing the number of CACREP accredited SUD/Addiction counseling tracks across the country might increase the number of faculty with SUD/Addiction counseling backgrounds.

Another super-ordinate theme within the **other** category, which was shared by two participants, was *logistics of obtaining DCC in WA State was cumbersome*. DCCs are required to satisfy requirements to be an LMHC and an SUDP which requires two separate application processes, two separate sets of supervised work experience, and two separate sets of education

requirements. The process of completing two application processes with all of the necessary documentation was challenging for the two participants who shared this theme. If the goal is increasing the workforce with DCCs, and other DCCs in training are experiencing the challenges and barriers that these two participants shared about, it would be worthwhile to evaluate the process and how it might be streamlined.

These experiences mirror that of many of the DCC trainees that I have worked with over the years. When trainees are accruing supervised work experience hours towards the LMHC and SUDP credentials, they must be aware of how they are documenting their SUDP and LMHC hour accrual. The lack of clarity related to this process can create confusion about how to document hours. It can also be challenging to establish clinical roles at sites to simultaneously accrue hours towards both credentials. Streamlined processes for acquiring and documenting supervised work experience hours and increasing the number of settings authorized to provide supervised work experience hours, could reduce confusion and barriers for trainees. It is critical to understand how features of the application process may be contributing to the lack of DCCs in the field, which poses an opportunity for counselors, supervisors, and counseling organizations to proactively communicate their experiences.

Two participants shared the super-ordinate theme of *agencies not supporting counselor self-care contributes to burnout*, and one participant had the super-ordinate theme of *supervisors and trainees working in publicly funded agencies struggle to get needs met.* Once again, if the goal is to infuse the workforce with additional DCCs, then an analysis of how to provide more resources, support, and incentives to agencies providing co-occurring counseling is needed. My experience of working in SUD/Addiction treatment centers and community mental health agencies mirrors the narratives of the participants. Working with severe SUD/Addiction,

complex trauma, and the myriad of other issues that are related to individuals with co-occurring issues is extremely challenging in the best of circumstances. The intensity of the work coupled with the lack of resources and support leads to burnout. DCC trainees early in their development are left to shoulder the burden of navigating the emotional, psychological, and clinical challenges commensurate with counseling clients with co-occurring issues. The lack of resources, integrated frameworks, support, and time devoted to supervision are problems that need to be addressed in order to support additional DCCs to enter the workforce.

Research study designs that include methods for collecting data from site supervisor perspectives about what is needed to improve conditions in agencies are recommended. Clinical supervisors or site managers possess experiences and perspectives about the resources and personnel necessary to improve conditions for DCC trainees. Additionally, surveys conducted at a range of settings which offer co-occurring counseling may garner more data from a wider range of DCC trainees and could point to important themes related to professional sustainability.

Integrated Supervision Model

The literature review conducted for this research study identified a gap between integrated SUD/Addiction and mental health supervision models. One supervision model (Powell & Brodsky, 2004) was created to address the administering of SUD/Addiction counseling, but that was in 2004. Many reliable supervision models exist for overseeing mental health counseling trainees (Bernard & Goodyear, 2019; Stoltenberg & McNeill, 2010). However, there is a gap when it comes to supervision models that address the complexity and nuance of co-occurring clinical work. All six participants shared super-ordinate themes that either indicated the nuances of co-occurring counseling or an awareness of the differences in approach between SUD/Addiction and mental health. Additionally, all six participants shared super-ordinate themes

related to the necessity of developing a holistic/integrated approach to co-occurring counseling. None of the participants named an integrated model as a vehicle for making sense or navigating their training experience. These findings point to a recommendation for future research focused on the development of integrated supervision models and training resources for co-occurring counseling.

The development of an integrated supervision model for DCC training is recommended. The counseling profession uses supervision models as guideposts for providing ethical and intentional support to supervisees (Bernard & Goodyear, 2019; Stoltenberg & McNeill, 2010). Furthermore, the American Counseling Association Code of Ethics C.2.b. (2014) *New Specialty Areas of Practice* states, "Counselors practice in specialty areas new to them only after appropriate education, training, and supervised experience." The creation and implementation of an integrated supervision model for DCCs is vital to provide ethical, effective, and quality co-occurring counseling services.

Grounded theory (GT) is an identified method from which to develop a theoretical framework because of its focus on exploring a process and its phases (Creswell & Poth, 2018). A study utilizing GT as a methodological framework would support an inquiry to determine critical components to be addressed in DCC training, from the DCC perspective. If a supervision model specific to the supervision needs of DCCs is created, it would be enhanced by accounting for the lived experiences of training to be a DCC. Further, a GT study could produce a template that reflects the necessary elements to be included in a supervision model. I invite my colleagues in counselor education and the broader counseling profession to view the creation of a supervision model or training resources for DCCs as an opportunity and, above all, a responsibility.

Conclusion

For decades SUD/Addiction treatment has been separated from the broader health care system. The Office of the Surgeon General's Report (2016, p. 6-4) states the following:

> When health care is not well integrated and coordinated across systems, too many patients fall through the cracks, leading to missed opportunities for prevention or early intervention, ineffective referrals, incomplete treatment, high rates of hospital and emergency department readmissions, and individual tragedies that could have been prevented.

National and regional trends are working towards integration of SUD/Addiction services with other health care disciplines (Governor Inslee's Communications Office, 2018; Office of the Surgeon General, 2016). However, the workforce as it stands cannot meet the demands (O'Connor et al., 2019). Therefore, more DCCs are needed to realize increasing access to integrated co-occurring services.

The purpose of this study was to examine the lived experience of training to become a DCC in the State of Washington. DCCs are not only the individuals who have committed to working with clients presenting with co-occurring issues, but later in their careers often assume positions as supervisors and counselor educators. The DCC participants who shared their stories for this research study persevered through multiple obstacles, learned to integrate skills from two professions, and stayed committed to providing needed services to a population in desperate need. The narratives shared by the participants revealed important themes related to the training experiences of DCCs. These themes not only increased understanding of the lived experience of counselors training to become DCCs but identified important trailheads for future research.

As a DCC and counselor educator, I have not only experienced the challenges that accompany integrating SUD/Addiction treatment and mental health but also contemplated the solutions. Over the years, some progress and movement has been made, but more integration can

occur. For me, imagining the construction of a bridge symbolized the structure that needs to be built brick by brick to continue to bring the two worlds of SUD/Addiction treatment and mental health counseling closer together. There are many bricks required to build this bridge, each one representing a facet of change or improvement that will be required to realize the goal of integration. In this study, I chose one brick on which to focus: learning about the training experiences of DCCs. The findings of this study highlighted research and advocacy opportunities in counselor education programs and for the counseling profession at large. I hope for colleagues to join me in addressing the existent gap in the education, clinical training, and supervision of trainees learning to effectively serve those in need of co-occurring SUD/Addiction and mental health counseling services.

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