THE WOUNDED HEALER: A PHENOMENOLOGICAL INVESTIGATION
OF THE RECOVERING SUBSTANCE ABUSE COUNSELOR

A Dissertation in
Counseling Psychology

by

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ABSTRACT

The purpose of this study was to better understand the lived experience of recovering substance abuse counselors in connection with the overall meaning and essence of being a recovering counselor, the use of self-disclosure, experiences of countertransference, and spirituality in one's work with substance abuse clients. A phenomenological methodological framework was utilized to better understand the lived experience of the participants from their point of view. In-person interviews were conducted with 10 substance abuse counselors who self-identified as being in recovery from an addiction. Through a phenomenological data analytic process various themes related to the constructs of interest emerged. Themes embedded within the overall meaning and essence of being a recovering substance abuse counselor included a strong commitment to helping addicts to recover, possessing empathy and understanding in identifying with clients, and having a personal experience of recovery that strengthens the therapeutic alliance. Although recovering counselors perceived their recovery as an asset in their work with clients, many felt concurrently ambivalent about being a recovering counselor. The self-disclosure construct yielded three themes including a tendency early in one’s career to over-disclose with clients, judiciously using self-disclosure today to establish rapport with clients, problem solve, or foster hope, and the problems that arise when self-disclosing with clients. Three resulting themes that emerged associated with countertransference indicated that participants experience origins of countertransference related to being reminded of family or self, that they experience emotional and behavioral manifestations of countertransference, and that they employ management strategies such as awareness, supervision, and self-talk. Additionally, participants expressed openness related to spirituality, discussed the necessity of spirituality to recovery, and talked about how they work with clients around spirituality and resistance to spirituality.
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Chapter 1: Study Overview

Introduction

The purpose of this study was to investigate the phenomenon of the wounded healer archetype as embodied in the substance abuse counselor recovering from an addiction. In particular, this study sought to investigate the role of self-disclosure on the part of the recovering counselor in facilitating effective therapy with clients working on substance abuse issues. The construct of countertransference was used as a means to better understand the inner subjective experience of the recovering substance abuse counselor in working with addicted individuals. In addition, the construct of spirituality and its role in the recovery and therapy processes was explored with recovering substance abuse counselors. The study overview includes a brief history of the wounded healer archetype and substance abuse counseling, a discussion of substance abuse counseling as an embodiment of the wounded healer archetype, and an outline of the goals of this study.

The Wounded Healer

The archetype of the wounded healer is an image that has been in existence for thousands of years. The story of the wounded individual who becomes a healer finds its roots in early shamanistic societies, where shamans were often revered for their healing power because of their experience in being wounded (Singh, 1999). Shamanism is the world’s most ancient spiritual, religious, and healing practice, and although shamanism varies somewhat cross-culturally, there are universal characteristics that differentiate shamans from other types of magico-religious practitioners, such as mediums, priests, or sorcerers (Winkelman, 2002). The practice of shamanism involves healing by traveling between the physical and spiritual worlds, which is often accomplished through an altered state of consciousness (ASC; Singh, 1999). Shamanistic
rituals may involve chanting, drumming, the use of plants, and many other components; however, the central concepts of shamanism are identified by Eliade (1974) as “techniques of ecstasy” (similar to ASCs) and interaction with the spirit world, often on behalf of the community. Shamans are selected for training on the basis of having experienced a previous illness or a “calling of the spirits,” usually in the form of a vision or dream (Winkelman, 2002). Shamanistic societies believe in the interconnectedness of the physical and spiritual worlds and value balance, harmony, and wholeness. Therefore, individuals who demonstrate an ability to travel between the two worlds through an ASC, communicate with spiritual forces, and return to the physical realm are seen as expert in healing.

The conception of the wounded healer is also exhibited, and eloquently expressed, through the Greek myth of Chiron. Chiron, the son of Saturn and Philyra, was born part human and part horse, and was subsequently abandoned by his parents (Holmes, 1991). In spite of his misfortune, Chiron developed into a powerful healer. He was given his son and mentee, Asklepios, by the god Apollo, and he also became the mentor of Hercules (Hayes, 2002). That is, Chiron trained Asklepios, and the latter went on to become the father of Greek medicine. One day, however, the poisonous arrows of Hercules accidentally wounded both Chiron and Asklepios, and although they were able to mostly heal their wounds, complete healing proved to be beyond their reach (Grapp, 1992). Chiron suffered deeply, and in order to die, he offered his immortality to Prometheus (Whan, 1987). The story of Chiron and Asklepios is symbolic in that all humans experience both physical and emotional wounds, some of which never fully heal. It may be the case that through learning to live with those wounds and through helping others to heal, that certain individuals are able to construct meaning and purpose in a human existence that otherwise lacks obvious intrinsic meaning (Yalom, 2002).
The Substance Abuse Counselor

While the wounded healer paradigm originated in shaministic societies and became embodied in the Greek myth of Chiron, perhaps the most fitting contemporary parallel is found in the role of the modern psychotherapist. Many who practice psychotherapy have inevitably lived wounded as a part of being human, learned to use their wounds in developing empathic attunement, and will be wounded again through the course of life (Miller, Wagner, Britton, & Gridley, 1998). The archetype of the wounded healer has been particularly relevant for therapists who are recovering from an addiction and have gone on to work in the substance abuse field (White, 2000).

White (2000) traced the involvement of people who have recovered from alcohol addiction in helping others to recover. The first movement based on abstinence from alcohol in the United States occurred within the Native American communities. In response to the exploitation of Native peoples and the alarming rates of alcoholism in Native American communities during the 18th and 19th centuries, an emergence of Native American temperance societies resulted during this period. These societies were abstinence and spiritually based cultural revitalization movements meant to protect Native ways from erosion and destruction by White settlers. Individuals in recovery played important roles in these organizations and constituted the first individuals to use their own recovery from alcohol addiction to help others with the same affliction.

Shortly after recovered people began working with alcoholics in the Native communities, the temperance phenomena began in the European-American population within the United States. Gospel temperance, a moralistic movement, emerged and focused solely on preventing future alcoholics. In addition, therapeutic temperance took root, which advocated the possibility
of recovery. Soon after, Black temperance groups began to form in many parts of the country. Eventually, treatment facilities partially staffed with physicians and counselors opened the doors for recovered people to work with alcoholics seeking recovery in a professional setting (White, 2000). Further important developments in the substance abuse treatment field have included: the formation of Alcoholics Anonymous (AA), the development of the modern treatment facility based on the Minnesota Model, and the emergence of half-way houses to help people maintain sobriety following treatment (White, 2000).

The emergence of AA and the twelve-step approach to recovery has had a strong impact on many treatment programs. In particular, many treatment providers have come to understand the recovery process as maintaining a strong spiritual component (Finlay, 2000). This has been largely due to the presence of recovering counselors working in the substance abuse field who themselves are recovering through the twelve-step approach. AA and other twelve-step programs foster the development of spiritual thinking through advocating that the addicted individual work through the steps one at a time, often with the guidance of a sponsor. A sponsor is an individual who is more advanced in her or his recovery who may serve as a role model and a source of support for the addicted individual seeking recovery. The twelve steps themselves focus on developing a relationship with a “higher power,” making amends in one’s relationships with other human beings, and living a life characterized by honesty, integrity, and a focus on spirituality (Alcoholics Anonymous World Services, 1952).

In addition to the cultivation of spiritual thinking, the AA model of twelve-step recovery encourages individuals who are more advanced in their recovery to share their stories of transcendence with individuals who are early in the recovery process (Hanninen & Koski-Jannes, 1999). Because many substance abuse counselors are in recovery from an addiction and have
found their recovery through the twelve-step approach, it may be that recovering substance abuse counselors tend to share their stories of transcendence with clients in order to help instill hope and a sense of universality (Mallow, 1998). That is, recovering substance abuse counselors may use self-disclosure of their own personal history of addiction to help clients come to terms with their own addiction. In addition, a substance abuse counselor who is in recovery from an addiction may be able to develop more empathic attunement with clients working on substance abuse issues, and may be able to build trust and a therapeutic alliance more quickly than counselors who are not in recovery from an addiction. It may also be the case, however, that substance abuse counselors in recovery from an addiction may be more vulnerable in having their own issues associated with addiction triggered in working with substance abuse clients, and they may have difficulty maintaining a therapeutic distance with substance abuse clients at times. The purpose of this study was to explore some of these issues as they relate to recovering substance abuse counselors who were currently working with clients on issues related to substance abuse and addiction.

The literature on recovering substance abuse counselors is somewhat sparse and does little to capture the meaning of being a substance abuse counselor in recovery from an addiction and how one’s own history of addiction affects work with clients who themselves are struggling with a substance abuse problem. Instead, the majority of the studies on recovery status compare recovering substance abuse counselors with non-recovering counselors on a number of variables, such as efficacy based on client perceptions or clinical outcome, theoretical orientation, beliefs about recovery, or personality characteristics (Culbreth, 2000; Humphreys, Noke, & Moos, 1996). While these studies have generated important knowledge concerning how recovering substance abuse counselors differ from non-recovering counselors in regard to these variables,
we learn little about the internal struggles, insights, and inherent meanings associated with the transformation involved in moving from personally struggling with an addiction to professionally helping other addicts to overcome their own addiction.

This exploratory journey into the lived experiences of recovering substance abuse counselors and their work with clients sought to come to a deeper understanding of what it means to transcend one’s own addiction and to serve as a therapist for others seeking to overcome addiction. That is, this study sought to facilitate a richer understanding of what it means to be a wounded healer. This study investigated recovering substance abuse counselors’ self-perceived overall meaning and experience of being a recovering counselor, their use of self-disclosure (concerning their own personal history of addiction), and their experiences of countertransference with substance abuse clients, as well as their views on spirituality and its role in the recovery and treatment process.
Chapter 2: Review of the Literature

Introduction

The following review of pertinent literature will encompass theoretical and empirical literature related to the wounded healer archetype, substance abuse counselor recovery status, self-disclosure, countertransference, and spirituality in the recovery and treatment processes. Specifically, the phenomena of self-disclosure, countertransference, and spirituality will be explored as they relate to the work of substance abuse counselors who are themselves in recovery from an addiction and their experience of these constructs in the recovery and treatment processes with clients who are working on substance abuse issues. The literature review will begin with theoretical considerations of the wounded healer archetype, followed by a review of empirical literature focused on wounded healers. Next, the literature pertaining to substance abuse counselors and recovery status will be reviewed, followed by sections on therapist self-disclosure, countertransference, and spirituality in the recovery and treatment processes.

Wounded Healer Theoretical Framework

Miller et al. (1998) presented a framework for understanding the wounding of healers while in training as mental health professionals. It was proposed that the mental health fields tend to attract a large percentage of individuals who have experienced significant wounds in their personal histories. Indeed, Guggenbuhl-Craig (1978) noted that individuals in the helping professions tend to be drawn to the “healer-patient archetype…for a great variety of psychological reasons” (p. 104). The claim that “wounded” individuals tend to be drawn to the helping professions is supported by numerous empirical studies that indicate higher rates of depression, anxiety, and relationship problems among psychologists, psychiatrists, and counselor trainees compared with the general population (White & Franzoni, 1990). As a result, these
individuals possess “soft spots” that may be touched upon through their entry into or transitions within school or work environments (Gelso & Hayes, 2007; Miller et al., 1998). It is often the case that people entering the field become increasingly aware of the power differential in work environments, or may even have negative experiences with authority figures. These negative experiences may increase isolation or apathy, further damaging the wellness of the trainee or entry-level professional (Miller et al., 1998). Miller et al. (1998) argued that because the wounded vs. healthy relationship tends to be conceptualized as a dichotomy as opposed to a continuum within the mental health professions, individuals who are in training or even experienced in the field may deny or hide their wounds, creating a situation where burnout and illness are more common (Miller et al., 1998).

Miller et al. (1998) recommend that trainees and practicing psychotherapists honestly evaluate their own wounds and attend to them periodically. While certain school or work environments may be unsupportive of this practice, it remains the responsibility of the individual to seek outside support and work toward an environmental change. In addition, senior members in the field are encouraged to create environments where woundedness is conceptualized on a continuum rather than as a dichotomy, thus allowing individuals the freedom to be more honest and open about their woundedness and need for self-care. Miller et al. (1998) claimed that environments, like people, have personalities, and that these personalities function in healthy ways when empathy, understanding, and forgiveness are promoted as the norm.

Hayes (2002) presented a model for the use of the self that integrates the inner subjective experience of the therapist in the clinical encounter. The therapist’s use of self in this model was presented as emanating from the “soul” of the therapist, or from an awareness that integrates personal history, subjective experience, and wisdom gained through partial transcendence of
personal woundedness. This model was presented within a framework that conceptualizes woundedness as existing on a continuum, as opposed to the dichotomous view too often found in the mental health fields.

Hayes (2002) discussed the various roots of clinical epistemology, or the ways in which therapists come to understand the human condition. These pathways to understanding can be understood as ranging from the personal to the impersonal. While impersonal understanding comes through public knowledge, authority, or didactic learning, personal knowledge originates from private, subjective, experiential, and affective sources. Hayes (2002) suggested that the latter are more powerful modes of knowledge in the therapeutic encounter due to the integral use of self by the therapist for effective treatment.

Hayes (2002) offered countertransference as the vehicle by which therapists may connect their own internal frame of reference to the client’s shared experience, creating a situation where intimacy and empathy are enhanced. That is, Hayes (2002) argued that there may be positive manifestations of countertransference that allow therapists to develop a higher degree of empathic attunement with the client precisely because they have experienced a similar type of wound in their own personal history. Because therapists have a more informed internal frame of reference as to how one experiences the particular type of wound, as well as how one may transcend it, they are more effectively able to develop understanding and empathy for the client, and may be better equipped to guide the client through dealing with the specific problem. The notion of the wounded healer becomes significant here, because awareness and attentiveness to one’s wounds enables therapists to better understand and clearly communicate empathic attunement with the client. By acknowledging one’s own vulnerability and affirming the healing
potential in the client, the therapists facilitate the client self-healing process through intimate connection and empathic engagement (Hayes, 2002).

Miller and Baldwin (1987) presented a model for understanding the implications of the wounded healer paradigm for the use of self in therapy. They proposed that the therapeutic encounter always contains some degree of projection of the wounded healer polarity by patient and helper. Because the patient has failed to consciously realize and integrate her or his own internal healer, there may be the tendency to project that healer onto the therapist. Likewise, if the therapist consciously denies her or his own internal woundedness, the wounds may be projected onto the patient. Therefore, it is important that the therapist remain mindful of her or his inner-woundedness and remain open to the experience of vulnerability. Miller and Baldwin suggested that wholeness, creativity, and vulnerability are closely related in their capacity to help the therapist resist burnout. By relating to the patient within the “I-Thou” orientation expounded by Buber (1970), the therapist rejuvenates her or his own inner-healing potential, sense of wholeness, and creativity, thus allowing for more effective clinical interventions.

The models presented above of the wounded healer paradigm complement one another and enhance our understanding of what it means to partially transcend one’s own wounds and go on to become a healer in some capacity. This study sought to explore and more fully understand the conception of the wounded healer as embodied in the substance abuse counselor who is recovering from an addiction to alcohol or other drugs.

Empirical Investigations into the Wounded Healer Framework

The wounded healer phenomenon and its implications in counseling have been empirically investigated in numerous studies. As previously noted, some have argued that individuals who are attracted to the helping professions tend to have a higher rate of
psychological problems than the general population (Guggenbuhl-Craig, 1978; Miller et al., 1998). In fact, there have been quantitative investigations into the mental health of psychologists and counselors-in-training that have supported these claims. In one example, White and Franzoni (1990) administered the Minnesota Multiphasic Personality Inventory (MMPI), the Adult Nowicki-Strickland Internal-External Control Scale (ANSIE), the Life Style Personality Inventory (LSPI), and the Coping Resources Inventory for Stress (CRIS) to 180 counselors-in-training. The sample was composed of 155 women and 25 men enrolled in master’s programs in counseling. The average age of participants was 31.7 years and the sample was mostly European-American (86.6%). Results of this study indicate a higher rate of pathology in the sample when compared to the general population. Specifically, counselors-in-training were found to have higher levels of psychopathology on six of the seven MMPI clinical scales that were analyzed. The only scale that indicated no significant difference was scale 1, hypochondriasis. Counselors-in training scored highest on the paranoia scale, with a mean score of 66.83, compared with the standardized sample score of 50 (White & Franzoni, 1990).

In their review of the literature on the mental health of psychologists, counselors-in-training, and psychiatrists, White and Franzoni (1990) indicated that a total of 9 studies consistently found that these mental health professionals and students have higher rates of depression, anxiety, and relationship problems. They further hypothesized that perhaps these individuals are attracted to the helping professions in a quest to heal their own wounds. Other studies, however, such as Good, Thoreson, and Staughnessy’s (1995) survey of counseling psychologists suggested relatively low levels of psychological problems among counseling psychologists. Nevertheless, as evidenced by the studies discussed above, it is clearly the case that at least some individuals enter the mental health profession with significant psychological or
emotional problems, and other individuals develop such problems during the course of their careers. One manifestation or consequence of therapists' psychological problems may involve the use of alcohol or drugs in an attempt to cope with psychological or emotional pain. In fact, even though Good et al. (1995) found relatively low rates of psychological problems among counseling psychologists, approximately 10% of the 393 members of APA Division 17 who were surveyed reported having been confronted for their substance abuse at some point in the past. While quantitative studies have yielded some interesting findings concerning the possible rates of psychological and emotional wounds among mental health professionals, the embodiment of the wounded healer archetype defies a holistic investigation with the use of quantitative methods. Researchers using qualitative methodologies based on constructivist assumptions have been able to more holistically investigate the wounded healer archetype.

Cain (2000) conducted a qualitative study that examined the experiences of ten psychotherapists who had been hospitalized for psychiatric disorders and how these experiences affected their professional lives. Cain was particularly interested in the countertransference issues encountered by these psychotherapists, management of the countertransference issues, how countertransference issues influenced treatment decisions with clients, and participants’ perceptions of stigmatization of mental illness within the mental health fields. Cain was also interested in the psychotherapists’ levels of self-disclosure concerning past psychiatric hospitalizations to supervisors and colleagues.

Cain’s (2000) sample consisted of seven social workers, two psychologists, and one psychiatrist, ranging in age from 32 to 57. These respondents varied greatly in their time of psychiatric hospitalization, the diagnoses ascribed to them, and their perception of the hospitalization experience. While some of the respondents had very positive experiences in the
hospital, others described it as the worst experience of their lives. Although there was great variance in respondents’ experiences, the results indicated some patterns associated with countertransference experiences in working with clients in psychotherapy. Participants reported experiences of countertransference in connection with hospitalizing clients, in comparisons of self with clients, in identification with clients, and in over-identification with clients (Cain, 2000).

Cain (2000) noted that all of the participants reported both positive and negative consequences of countertransference for the psychotherapeutic process with clients. All of the psychotherapists claimed that their efficacy had been enhanced by their past mental illness by increasing their level of empathic attunement with clients. Additionally, all of the participants indicated that they had encountered, or feared encountering, some degree of stigmatization from other mental health professionals due to self-disclosure of their previous psychiatric disorder (Cain, 2000).

Cain’s (2000) study sheds important light on the experiences of wounded healers in the mental health professions. It is interesting to note that all of the participants indicated that they felt as thought their level of empathic attunement and subsequent clinical efficacy had been enhanced through their previous psychiatric disorder. Also of interest are some of the countertransference manifestations in the psychotherapists' work with clients. Specifically, the occurrence of psychotherapists comparing themselves with clients and identifying with clients raises questions about the possibility of increased efficacy with clients through a deeper understanding of their issues, while at times possibly complicating matters through over-identification and the potential for crossing boundaries in therapy.
In another qualitative study, Grapp (1992) investigated psychotherapists who identified themselves as having been wounded at some previous point in their lives. Nine psychotherapists were interviewed concerning their experiences of having been wounded, subsequent therapy, their levels of self disclosure to clients, and their career development. While all of these therapists had undergone some form of personal therapy, women tended to have experienced more invasive trauma, such as sexual abuse, and received more personal therapy in their recovery. Findings indicated that these therapists believed their previous wounds enhanced their subsequent work with clients. Respondents indicated that they believed their previous experiences allowed them to be more “present” with clients. That is, they felt as though their previous experiences enhanced their empathic attunement and ability to relate to clients. In addition, all but one of the respondents indicated that they used self-disclosure of personal content for specific purposes in the course of therapy with clients (Grapp, 1992).

In both Cain's (2000) and Grapp's (1992) qualitative studies all of the participants discussed how their previous wounds enhanced their ability to work with clients in an effective manner, specifically through an increased level of empathic attunement. It seems as though these psychotherapists felt that they were perhaps better able to understand the inner subjective experiences of their clients due to their own personal history of being wounded. It may be that these cases are examples of psychotherapists who are able to connect their own internal frame of reference to the client’s shared experience, creating a situation where intimacy and empathy are enhanced. That is, they may be instances of what Hayes (2002) identified as positive aspects of countertransference that have enhanced clinical efficacy.

While the studies discussed above investigated therapists with a history of personal trauma or mental illness, there is also an existing body of literature that explores therapists who
have experienced a particular type of mental illness, namely, addiction. The next section will focus on counselors in recovery from addiction to alcohol or drugs and their work with clients on substance abuse issues.

**Substance Abuse Counselors and Recovery Status**

The first substance abuse counselors were themselves in recovery from an addiction (White, 2000). This approach was based on the wounded healer model of effective substance abuse counseling. The theory posits that those who had experienced and overcome an addiction in their own lives would be best suited to help other people overcome their own addiction. As the field has become more professionalized over the years, however, the incidence of younger, non-recovering substance abuse counselors with master’s degrees has increased in the substance abuse field. In turn, there has been considerable debate over the relative efficacy of recovering and non-recovering counselors (Culbreth, 2000). There have also been a number of studies that investigated the role of recovery status as a variable in substance abuse counselor efficacy, treatment approach, and personality characteristics.

Argeriou and Manohar (1978) examined outcome measures for 273 individuals who were working on substance abuse in therapy with seven alcoholism counselors through the Traffic Safety Project in Boston during the early 1970s. Four of these counselors had been in recovery from alcoholism for an average of six years, and the remaining three had no previous experience with addiction to alcohol. Clients were randomly assigned to counselors, and there appeared to be no significant demographics differences across groups, although the sample was predominantly European-American. Client outcome measures were examined relative to recovery status of their counselor while in treatment. Recovering counselors appeared to be more effective with younger clients (under 35) than non-recovering counselors based on the
observation that a positive change in drinking behavior was more common with younger clients counseled by recovering counselors, however, this trend was not observed with clients over the age of 35 (Argeriou & Manohar, 1978).

Although Argeriou and Manohar (1978) found that younger clients counseled by recovering therapists showed significant reduction in their drinking behavior, the implications of the findings for this study are limited. The number of therapists was quite small and the outcome measures were poorly defined or explained. In addition, the trend that showed no significant difference in older client outcomes, regardless of their therapist’s recovery status, is not adequately addressed in the discussion. Likewise, the finding that younger clients responded more favorably to recovering counselors is unclear. Due to the limitations of the study, it cannot be concluded that recovering counselors demonstrated significantly better outcomes with clients struggling with alcohol problems.

In a later study, Lawson (1982) investigated the role of counselor recovery status and client perceptions of their counselors in 28 counselor-client dyadic pairs in southern Illinois. Clients in this study received either outpatient or inpatient therapy. Ten of the counselors were in recovery from alcoholism and the other 18 were not in recovery. Counselor experience ranged widely from 4 months to 27 years, with a mean of 4.9 years. Recovering counselors were an average of approximately 10 years older than non-recovering counselors (Lawson, 1982).

Lawson (1982) administered the Counselor Information Questionnaire (CIQ) to substance abuse counselors in the sample, and the Barrett-Lennard Relationship Inventory (BLRI) to clients in order to rate their counselor. Lawson found that recovering counselors scored significantly lower on one of the CIQ subscales, degree of professionalism. In addition, recovering counselors received significantly higher BLRI total scores and significantly higher
scores on two of the BLRI subscales, level of regard and unconditionality. The difference in the mean of BLRI total scores was relatively large, with recovering counselors averaging 114.3 and non-recovering counselors averaging 77.61, although it is unclear if there were other group differences that may have affected these differences. Whereas the subscales scores for regard and unconditionality were significantly higher for recovering counselors, scores on the empathy and congruence subscales were not significantly higher. Experience and level of professionalism were shown to be unrelated to overall BLRI scores and all subscales (Lawson, 1982).

Lawson's (1982) findings point to a possible advantage that recovering counselors have in building a trusting relationship with clients relative to non-recovering counselors. It is unclear, however, why recovering counselors did not score higher on empathy or congruence. It may be that recovering counselors in this sample were more unconditionally accepting of their clients due to their own personal history with addiction, but were not perceived as more empathic or congruent. In considering Lawson’s findings, it is important to note that efficacy and clinical outcomes involve many different variables that go beyond the relationship. While recovering counselors may have an advantage in relationship building with clients, non-recovering counselors may be better equipped to maintain a therapeutic distance or may be more highly trained in clinical interventions due to a higher level of education. Regardless, the impact of recovery status on counseling process with clients struggling with substance abuse issues is an important issue for further exploration.

Culbreth (2000) reviewed 16 studies that addressed the differences in substance abuse counselors in recovery in relation to those who are not in recovery. These studies were of three types: studies of clinical efficacy, differences in treatment approach, and personality differences between the two groups. After discussing some of the findings in these studies, Culbreth
concluded that there seemed to be no significant difference between the relative efficacies of recovering versus non-recovering substance abuse counselors. In addition, he stated that it is time to shift from studying differences in clinical outcome between these two groups and to move on to studies of counseling process in order to better understand how each group achieves its relative efficacy. Culbreth called for this shift based on the observation that numerous studies that examine either client perceptions or treatment outcome variables have shown no significant difference between recovering and non-recovering counselors.

While Culbreth (2000) noted that the accumulation of studies on recovery status point to no significant differences in clinical efficacy, he indicated that there is evidence of significant differences in recovering and non-recovering counselors in terms of clinical decision-making and personality. Culbreth stated that these studies show a general pattern that recovering counselors are more likely to diagnose chemical dependency and that they differ from non-recovering counselors in terms of client conceptualization and treatment approaches, including a strong adherence to twelve-step approaches to recovery. In addition, differences in personality between recovering and non-recovering counselors have been shown in that recovering counselors have been found to be more rigid in adoption of the disease model, less autonomous and flexible, more concrete and “tough-minded,” more likely to impose their own agenda on clients, less supportive of non-recovering counselors, and less likely to value education and clinical supervision (Culbreth, 2000).

As Culbreth (2000) indicated, it is important that research move beyond investigating differences in efficacy relative to counselor recovery status. Instead, future research should focus on the counseling process and how recovering and non-recovering substance abuse counselors achieve their relative efficacy. That is, it is important to investigate how counselors
connect with clients, facilitate a corrective experience, and guide clients along the path to psychotherapeutic change. The current study investigated how recovering substance abuse counselors work with clients who are dealing with substance abuse issues, and how this work is affected by the counselors’ personal histories of addiction. The following section explores one of the ways in which a recovering counselor’s personal history of addiction may affect work with current clients, through counselor self-disclosure of her or his previous addiction and subsequent effects on the therapeutic process.

**Therapist Self-Disclosure**

The occurrence of therapist self-disclosure is a vital component in an analysis of the wounded healer theoretical framework as embodied in the recovering substance abuse counselor. Substance abuse counselors who are themselves in recovery from an addiction are confronted with the choice of whether to disclose their recovery status to clients, and this choice will ultimately affect the psychotherapeutic process. While it may be the case that many clients working on substance abuse issues more easily connect with or trust a counselor who has transcended her or his own addiction, it may also be the case that recovery status is a non-issue for many clients and has minimal impact on their ability to work effectively with a counselor. Nevertheless, in order to gain a clearer picture of the inner experiences of recovering substance abuse counselors and of their work with clients, it is imperative to explore the use of self-disclosure of recovery status, and implications of such disclosures on the psychotherapeutic process.

Freud (1912) addressed the disclosure of personal information to clients and warned against such a practice by outlining many of the complications that may result from this occurrence in the therapeutic relationship. According to Freud, self-disclosure may make
resistance more difficult to transcend, may at times tempt the patient to strongly desire more information about the therapist, may place the focus on the therapist, or may make the resolution of certain transferences more difficult to obtain. Self-disclosure on the part of the therapist may inhibit her or his ability to maintain objectivity and detachment, which serves to cloud the exchange of transference in the clinical encounter. In addition, self-disclosure may serve to gratify the patient’s wish rather than to analyze the wish, and may complicate the facilitation of a controlled regression where transference may take place (Freud, 1912).

As alternative approaches to psychotherapy have emerged, however, conceptions of the role of therapist self-disclosure have also been modified. For example, Rogers (1961) felt that therapist self-disclosure was a key ingredient in the construction of a congruent therapeutic relationship with clients. That is, therapists should express their feelings, emotions, and reactions to the client in order to promote a therapeutic atmosphere built on openness, honesty, and genuine behavior. In addition, feminist therapy holds that therapists have a responsibility to disclose to clients in order to reduce the inherent power differential in the therapeutic relationship (Knox & Hill, 2003; Simi & Mahalik, 1997). Cognitive-behavioral therapists have also been supportive of therapist self-disclosure due to the possibility that self-disclosing statements may effectively model client disclosure, as well as enrich the therapeutic bond. While some practitioners may maintain a conservative approach to self-disclosure, even the traditional psychoanalytic approach that completely inhibits revelations by the therapist has been somewhat modified in recent years to be more lenient in regard to therapist self-disclosure (Knox & Hill, 2003).

Therapist self-disclosure may take a variety of forms and be used by the therapist for a variety of reasons. Knox and Hill (2003) outlined a number of types of therapist self-disclosure
that includes disclosure of facts, feelings, insights, strategy, support, challenge, and immediacy. These different types of self-disclosure are used by a therapist at different times and for different purposes, and may have different effects on therapy. Knox and Hill suggested that practitioners use self-disclosure because it is a helpful intervention, but they also warned that self-disclosure should be “used infrequently and judiciously” (p. 532). In addition, they recommended that therapists consider carefully the content of their revelations, gauge the disclosure to the particular client, use appropriate levels of intimacy in disclosures, return the focus to the client following the disclosure, and ask clients about their reactions to the disclosure. Finally, Knox and Hill suggested that therapists disclose about issues that they have mostly resolved, as opposed to those that they are still working on, in order to keep therapy from addressing their own needs.

Although modifications of the role of therapist self-disclosure have largely been initiated through the development and diffusion of particular theoretical orientations, they have also been sparked and supported by empirical investigation into the effects of therapist self-disclosure. The first attempts to systematically study the effects of self-disclosure were conducted by Jourard (1959) and colleagues, but these investigations were conducted outside of the “therapeutic relationship,” and primarily examined the effects of self-disclosure among college students, between family members and friends, among colleagues, between interviewer and interviewee, and even the relationship between self-disclosure and nursing student grade point average. Jourard and Lasakow (1958) developed the first instrument to measure self-disclosure, *The Self-disclosure Questionnaire* (SQ). Although the original form of the SQ asked respondents to rate the frequency and depth to which they have self-disclosed to other individuals about 60 item-specific topics that were clustered into 6 different content areas (e.g., attitudes and opinions, tastes and interests, personality), later versions of the instrument ranged
from 15-40 items and were abbreviated versions of the original. The work of Jourard and colleagues is important as an early attempt to systematically investigate the effects of self-disclosure, but offered little to our understanding of the effects of self-disclosure in psychotherapy or substance abuse counseling.

In a more recent attempt to study self-disclosure, specifically among psychotherapists, Barrett and Berman (2001) instructed 18 therapists working at a university counseling center to increase their frequency of self-disclosures with one of their clients and to refrain from self-disclosing to another client. Results indicated that clients reported a lower level of symptom distress as measured by the Hopkins Symptom Checklist when therapists increased their frequency of self-disclosure as compared with clients who received less therapist self-disclosure. In addition, clients reported liking their therapist more when the frequency of therapist self-disclosure was increased (Barrett & Berman, 2001).

The results of Barrett and Berman’s (2001) study offer evidence that therapist self-disclosure may in some cases be beneficial to the therapeutic process. While there may be other factors that contributed to the observed decrease in clients’ level of symptom distress, it may be that the increased frequency of therapist disclosures had a positive effect on the therapeutic relationship. This explanation is further supported by the fact that clients reported liking their therapist more when the frequency of disclosures was increased.

Other studies that investigate frequency of therapist self-disclosure and outcomes are scarce. Nyman and Daugherty (2001) measured client perceptions of efficacy among therapists who disclosed their personal use of prayer either before or following a client disclosure of some personal information. Results from this study indicated that clients perceived the counselor who disclosed after the client as more attractive and favorable than the therapist who disclosed prior
to a client disclosure. While the implications of this study are somewhat unclear, it may be that clients value not only the occurrence and frequency of therapist disclosures, but also the timing and appropriateness of such disclosures. If so, these findings lend support to the notion that although therapist disclosures may have a positive impact on the counseling process, they should be used in a judicious manner.

In an earlier study, Hendrick (1988) administered the Counselor Disclosure Scale, an instrument that measures potential client attitudes toward therapist self-disclosures on various topical areas, to 235 undergraduate students and found that these potential clients would like their therapists to disclose information about themselves. The respondents were particularly interested in therapists’ professional qualifications and experiences, but they were also interested to know about therapists’ personal lives, including information about their interpersonal relationships and feelings (Nyman & Daugherty, 2001). These findings offer additional support to the notion that therapist disclosures may have a beneficial impact on the therapeutic relationship. Clients seem to prefer some level of reciprocity in terms of the sharing of personal information and feelings, and it seems reasonable to suspect that such give and take may have a positive impact on building rapport and trust in the therapeutic relationship.

Simone, McCarthy, and Skay (1998) surveyed 120 psychotherapists to inquire about their likelihood to use self-disclosure in relation to certain variables. These variables included client age and diagnosis, counselor gender, experience, and exposure to other counselors who disclosed to them while in psychotherapy. Results indicated that disclosure likelihood was highest when working with clients who had less severe diagnoses. Therapists also reported an increased likelihood to disclose when their own previous psychotherapist had disclosed to them. Respondents gave reasons for disclosing that included the promotion of universality, to give
encouragement, modeling, rapport-building, and to explore alternatives for clients. Respondents also gave reasons for not disclosing that included boundary issues, premature termination, and counselor welfare (Simone, McCarthy, & Skay, 1998). These findings point to therapists’ knowledge acquired through direct clinical experience pertaining to the value of self-disclosure, reasons to disclose, and the inherent dangers in excessive or inappropriate disclosures. While the finding that disclosures are reduced with more disturbed clients makes intuitive sense due to boundary concerns, the finding that psychotherapists whose own therapist disclosed to them are more likely to disclose is interesting. It may be that theoretical orientation is a mediating variable affecting the relationship between therapist disclosure and the occurrence of her or his own previous therapist disclosing to her or him in psychotherapy.

Edwards and Murdock (1994) surveyed psychologists to investigate therapist variables that affect frequency, content, and reasons for therapist self-disclosure. Results from this study indicated that psychologists tend to disclose most frequently about professional experience and qualifications, and that they often disclose to increase similarity between clients and themselves. Additional findings indicated that therapists self-disclosed with equal frequency irrespective of their gender or ethnicity (Edwards & Murdock, 1994). This study offers further support to the notion that therapists disclose to clients to have a positive impact on the therapeutic relationship, as well as to inform clients about their qualifications as a psychotherapist. The latter is important because it may build client trust in the process and assist with the instillation of hope.

More closely associated with the current study, Sweeney (1996) qualitatively investigated the use of self-disclosure by recovering substance abuse counselors. She conducted interviews with eight substance abuse counselors who were in recovery from a personal addiction to alcohol or drugs. Sweeney found that the participants in her study generally did not disclose freely to
clients, but had at times in the past when asked. In addition, all stated that the decision to disclose to clients was not to be taken lightly, and that such a decision to disclose must be made based on an assessment of the client's needs at the time. Furthermore, Sweeney found that certain themes emerged in her interviews with recovering substance abuse counselors.

Sweeney (1996) found that the most common theme that emerged in interview responses concerned the impact on the working relationship as a result of therapist self-disclosure of recovery status. Respondents voiced both positive and negative possible consequences of disclosure. Possible positive consequences included reducing client level of fear, connecting with the client, and normalizing the recovery process. However, participants also voiced concerns and reservations about indiscriminate disclosure, and possible negative impacts of such occurrences. A number of the therapists were concerned about possible consequences of self-disclosure and concerns that clients may perceive them as insistent upon the twelve-step, abstinence-based model of recovery. Other concerns expressed included ambivalence associated with serving as a "role model" and having too much influence over a client. Finally, one therapist indicated that she came to understand many of her previous disclosures as self-serving and not based on the client's present needs (Sweeney, 1996).

Another common theme that emerged in Sweeney's (1996) investigation concerned the therapists' amount of time in recovery relative to her or his decision to disclose to clients. Therapists largely agreed that they disclosed more freely in the early phases of their own recovery, and gradually became more conservative in disclosure as they came to a deeper understanding of its impact on the psychotherapeutic process. Two of the participants indicated that early in their recovery process they had been influenced by the "excitement" of being newly in recovery. Another therapist indicated that his addiction was so long ago that it doesn't seem
particularly relevant anymore (Sweeney, 1996). While responses varied somewhat in their rationale, it seems important to note that therapists became more conservative over time in their frequency of disclosure of recovery status.

The results of Sweeney's (1996) investigation are informative and serve as an important foundation of exploratory information concerning the role of self-disclosure among recovering substance abuse counselors, but the findings are limited due to the small number of participants. Additional qualitative inquiry of the use of self-disclosure by recovering substance abuse counselors is needed to build upon Sweeney’s findings.

Barrett and Berman (2001) conducted a review of the literature on therapist self-disclosure and concluded that there has been relatively little empirical investigation into therapist self-disclosure and its impact on the counseling process or clinical outcomes. Instead, studies have tended to focus on therapist self-disclosure as it relates to variables such as therapist theoretical orientation, client self-disclosure, and client perceptions of the therapist (Barrett & Berman, 2001). Nevertheless, it is clear that most therapists use some forms of self-disclosure in their practice with clients, especially concerning professional qualifications and experiences. In addition, it appears that clients like for their therapists to disclose some information about themselves. The research findings on therapist self-disclosure combined with the proliferation of theoretical orientations have led to a modification of the general viewpoint on therapist self-disclosure among psychotherapists. Self-disclosure is no longer a forbidden practice for the psychotherapist seeking to serve as a mirror or “blank-slate.” Instead, therapist self-disclosure has become understood as a powerful tool that must be used judiciously and wisely by practicing psychotherapists (Knox & Hill, 2003).
Therapist self-disclosure is an important consideration in exploring the lived experiences of recovering substance abuse counselors due to the inherent complication that these individuals face in working with substance abuse clients and whether or not they should disclose their personal history of addiction. Furthermore, if a recovering therapist chooses to disclose her or his recovery status, it is important to investigate the level of detail of such disclosures. While some clients may trust a counselor more quickly if she or he is also in recovery from an addiction, one’s personal recovery status is clearly a private matter and perhaps not relevant to the client’s own struggle with addiction. This study sought to better understand the role of therapist self-disclosure as experienced by recovering substance abuse counselors who are working with clients on substance abuse issues.

In exploring this topic, this study attempted to gain a more clear understanding of how recovering substance abuse counselors use self-disclosure to enhance the therapeutic experience, or to explore instances when such disclosures were counterproductive. This study also explored instances where therapists felt they should not self-disclose or should not have disclosed their personal histories of addiction, and the rationale for such decisions. Findings will be considered in light of Sweeney's (1996) investigation of the use of self-disclosure by recovering substance abuse counselors and will seek to build upon her findings, which are limited due to a small number of participants. This study also sought to better understand the use of self-disclosure by participants in light of their experiences of countertransference and spirituality in the treatment and recovery processes. It is hoped that a better understanding of the function of substance abuse counselor self-disclosure of personal addiction will further clarify the inner meanings and experiences of recovering substance abuse counselors, particularly in their work with clients who are dealing with substance abuse issues.
Countertransference

Intimately connected to self-disclosure on the part of the psychotherapist is the construct of countertransference. According to Freud (1912), countertransference involves the influence that the patient’s transferences may have on the therapist’s unconscious processes. Freud at times expressed rather restrictive ideas concerning countertransference, indicating that the therapist should have a similar approach to “a surgeon, who puts aside all his feelings, even his human sympathy, and concentrates his mental forces on the single aim of performing the operation as skillfully as possible” (p. 115). He held that countertransference poses a potential danger to the therapist’s objectivity and to the treatment process. Freud (1912) described the role of the psychotherapist by stating that, “the physician should be impenetrable to the patient, and like a mirror, reflecting nothing but what is shown to him [or her]” (p. 18). It may not be the case that Freud actually practiced in such a manner, but his written statements clearly had an impact on the development of the psychoanalytic tradition. As with early ideas about therapist self-disclosure, however, conceptions of countertransference and its role in the therapeutic context have been revised since the time of Freud.

Heimann (1950) departed from the Freudian view of countertransference by viewing it as an important occurrence in coming to a better understanding of the client’s unconscious processes. According to Heimann, countertransference allows for the therapist to experience and understand the client more deeply. That is, it provides valuable data upon which the therapist begins to more fully understand the unconscious process of the client. In addition, Heimann sees countertransference as encompassing all conscious and unconscious reactions the clinician has in experiencing the client. This definition of countertransference is termed the “totalistic” definition, as opposed to the “classical” definition offered by Freud (Gelso & Hayes, 2007).
An alternative understanding has emerged in more recent years that is termed the “moderate” perspective. The moderate perspective is broader than the classical definition, but more specific than the totalistic definition (Gelso & Hayes, 2007). Rosenberger and Hayes (2002) explain:

…the “moderate” perspective, maintains that CT (countertransference) represents the counselor’s reactions to the client that are based on the counselor’s unresolved conflicts. This definition is broader than Freud’s classical definition in that CT reactions are not viewed as occurring solely in response to the client’s transference, nor is CT necessarily considered negative. On the other hand, the moderate definition is narrower than the totalistic definition in that it distinguishes counselor responses that are grounded in the shared reality of the counseling relationship from those originating in the counselor’s unresolved issues, reserving CT for the latter. (p. 80)

Research in more recent years has primarily used the moderate definition to conceptualize countertransference (Rosenberger & Hayes, 2002). For this reason, this study will also use the moderate definition of countertransference in seeking to better understand this construct as it relates to the work of recovering substance abuse counselors who are currently working with clients dealing with substance abuse issues. The moderate definition is inclusive of positive manifestations of countertransference that are rooted in the therapists’ own personal issues or experiences of woundedness that have been for the most part, but not fully, transcended, and of which the therapist maintains awareness, monitors, and effectively manages.

The empirical literature on countertransference indicates that there have been significant improvements over the years in analogue research methodology investigating countertransference, and field studies examining countertransference in actual settings have begun to emerge (Gelso & Hayes, 2007). In a review of the empirical research since 1977, Rosenberger and Hayes (2002) point out that analogue research investigating countertransference has seen substantial improvements in methodology and has operationalized the construct in ways that have allowed for the investigation of countertransference in terms of not only behavioral
manifestations, but also cognitive and affective expressions. In addition, investigators have begun to study countertransference management through either a two-step process involving awareness of feelings and theoretical orientation, or through traits of counselors that are generally thought to facilitate countertransference management. While the research in this area is in the early stages, it appears that counselors who are aware of their feelings and who are able to stay grounded in a theoretical framework may be more equipped to manage their countertransference reactions. Furthermore, there is evidence to support the notion that anxiety management and self-integration in the therapeutic process are effective strategies that may reduce the likelihood of negative countertransference reactions. Analogue studies have also investigated risk factors for countertransference that include homophobia and counselor gender (Rosenberger & Hayes, 2002).

The field studies that have begun to emerge have focused on variables such as countertransference behavior, management, and effect on outcomes. In one example, McClure and Hodge (1987) investigated the relationship between countertransference and counselor feelings toward clients. They found that counselors tended to misperceive clients as either artificially similar or dissimilar to them based on if they liked the client or not. These findings are troubling in that counselor feelings towards their clients seem to be related to inaccurate perceptions of similarity or dissimilarity, which may negatively affect the therapeutic process for some clients.

In another study, Hayes, Riker, and Ingram (1997) surveyed 20 counselor/client dyads and found that counselor empathy and self-integration were inversely related to countertransference behavior. In addition, they found that counselors who liked their clients tended to misperceive clients as overly similar to themselves, and that counselors who did not
like their clients as overly dissimilar to themselves. These findings point to important factors, empathy and self-integration, that help to mitigate countertransference behavior and possible negative effects on the counseling process. In addition, findings from this study lend additional support to McClure and Hodge’s (1987) findings that counselors tend to inaccurately perceive clients as either similar or dissimilar to themselves depending on how much they like the client.

In a study that included both quantitative and qualitative methods, Williams, Judge, Hill, and Hoffman (1997) found that countertransference reactions tended to be in response to client content that was similar to the counselor’s own unresolved issues. Results showed that counselors managed their countertransference by focusing on the client, suppressing their own reactions and feelings, and using self-awareness. Results of this study also indicated that countertransference reactions did not affect counselor effectiveness (Williams et al., 1997). This study points to various ways in which counselors attempt to manage countertransference, and calls into question if such management inevitably affects counselor effectiveness.

Another qualitative study conducted by Hayes et al. (1998) involved interviewing 8 counselor/client dyads following each counseling session, with a total of 127 interviews. Results of this study indicated that counselor needs, cultural issues, family issues, and issues specific to the counseling process accounted for most reported instances of countertransference. It was often the case that countertransference was triggered by subjective perceptions of the counselor, including perceptions of client progress or client similarity to the therapist (Hayes et al., 1998). Results of this study indicate that the phenomenological world of the counselor is particularly relevant in the manifestations of certain countertransference reactions.

Rosenberger and Hayes’ (2002) review of the literature indicated that countertransference becomes embodied in a variety of therapist behaviors, including inaccurate perceptions of
clients, an inability to accurately remember client information, reactive and defensive behavior, misunderstanding, uncertainty, and even changes in treatment planning. In addition, countertransference may be indicated by a number of therapist emotions that range from anxiety to anger to nurturing feelings. It is also important to note that countertransference may be present in various nonverbal behaviors that have yet to be formally investigated (Gelso & Hayes, 2007).

More specific to the substance abuse field, Imhof (1991) explored the therapeutic encounter with the addicted individual and the countertransferences that may arise in this work. Imhof stated that perhaps the most important factor in the treatment of substance abuse is the quality of the therapeutic relationship and the emotional reaction of the therapist. Unfortunately, substance abusers have consistently had a negative reputation among professional psychotherapists. Imhof discussed some of the negative attention that substance abusers have received in the literature over the years, indicating that they have a reputation for being difficult to work with and that they often relapse. He pointed out that while improving the treatment of addiction has received significant attention in the professional literature, consideration of therapists’ reactions to substance dependent clients has been seldom addressed.

Because clinicians often perceive substance dependent clients as difficult and perhaps untreatable, the emotional reactions of these clinicians may negatively influence the outcome of treatment. Imhof (1991) suggested that maintaining an empathic and supportive orientation allows for the creation of a stronger therapeutic alliance with the addicted individual and serves to offset the negative influences of countertransference. In addition, he offered some suggestions to raise the awareness of clinicians, which may help to mitigate the negative effects of countertransference. Imhof stated that the most important tool to raise therapist awareness of
countertransference and its possible negative consequences is the therapist’s own therapy. If the therapist has had the opportunity to engage in productive and growth inducing therapy prior to working with substance dependent clients, it is more likely that she or he will successfully circumvent problematic countertransference. Other important tools in raising clinical self-awareness include quality supervision, adequate training, exacting personal standards, and continuing education.

Countertransference may be a particularly relevant construct for substance abuse counselors who are themselves recovering from an addiction. While the non-recovering counselor may have difficulty understanding the client’s struggle with substance dependence, the recovering counselor may at times have difficulty maintaining a therapeutic distance, allowing clients to grow and change at their own pace. Recovering substance abuse counselors may have relatively crystallized ideas about how the recovery process should unfold, and may be rigid in their approach to working with clients who are struggling with substance abuse issues. It may also be the case that recovering substance abuse counselors are able to connect their own internal frame of reference to the client’s shared experience, creating a situation where intimacy and empathy are enhanced, thus actualizing an embodiment of Hayes' (2002) conception of a positive manifestation of countertransference. This study sought to explore and better understand the phenomenological world of recovering substance abuse counselors and how their history of addiction affects their countertransference with clients who are working on substance abuse issues.

Spirituality and Substance Abuse Counseling

The role of spirituality in the recovery process has received significant attention in recent years (Brooks & Matthews, 2000; DiLorenzo, Johnson, & Bussey, 2001; Jarusiewicz, 2000;
Matthews, 1998; Miller, 1998; Morrell, 1996; Sherman & Fischer, 2002). The influence of Alcoholics Anonymous (AA) and other twelve-step approaches to recovery has infused a strong focus on spiritual issues in the recovery community (White, 2000). According to Bill Wilson, a co-founder of AA, the twelve-step philosophy of AA was itself influenced by the spiritually oriented thought of both William James and Carl Jung (Finlay, 2000). The twelve-step tradition calls for recovering individuals to develop a relationship with a higher power, to make amends to those affected by one's addiction and subsequent behavior, and to live a life based on honesty, integrity, and with a focus on spirituality and community (Alcoholics Anonymous World Services, 1952). As a result, many treatment programs also incorporate a focus on spirituality and the twelve-step philosophy (White, 2000). Therefore, researchers have begun to investigate the role of spirituality in the recovery and treatment processes (Brooks & Matthews, 2000). Because this area of research is in its early stages of development, and the construct of spirituality has proven to be somewhat elusive, the findings of the following studies are limited.

In order to investigate the relationship between spirituality and recovery from addiction, Jarusiewicz (2000) administered the Spiritual Beliefs Scale (SBS) and the Fowler Interview Process (FIP) to individuals with at least 2 years of recovery and individuals with a pattern of chronic relapse. She found a significant relationship between individuals’ level of spirituality and success in recovery from addiction. Specifically, individuals with at least two years of sobriety scored significantly higher on the SBS and the FIP than did those individuals who had demonstrated a tendency to relapse. In another study, Sherman and Fischer (2002) administered the Spirituality in Recovery Questionnaire to 81 respondents in various treatment programs and at different stages in the recovery process. They found that individuals with more than nine
months of recovery time scored significantly higher on the Spirituality in Recovery Questionnaire than did individuals with less than nine months of recovery time.

While the two studies discussed above are specific to clients and not counselors, they are important in considering how recovering counselors facilitate the recovery process. It may be that recovering substance abuse counselors operating within a twelve-step framework seek to facilitate a heightened level of spiritual beliefs within clients. In other words, those counselors who have a heightened sense of spirituality may be better prepared to guide their clients to a similar state of consciousness. The following studies address spiritual thinking and spiritual well-being in substance abuse counselors.

Schaler (1996) administered the Spiritual Beliefs Scale (SBS) to 295 substance abuse counselors in order to measure their levels of spiritual thinking. Respondents belonging to AA scored significantly higher on the SBS, indicating a higher level of spiritual thinking. Spiritual thinking was also moderately correlated with the amount of time spent in AA, self-identification as in recovery from an addiction, past participation in AA, abstinence from alcohol and other drugs, and educational status. In addition, female treatment providers scored higher on the SBS than did males in this sample. This study provides valuable information on the spiritual thinking of substance abuse counselors and its correlation with other variables. Specifically, it is important to note that counselors in recovery and affiliated with AA scored higher on levels of spiritual thinking, indicating a possible link between twelve-step recovery and the development of spiritual thinking (Schaler, 1996).

Finally, Brooks and Matthews (2000) investigated the relationships between substance abuse counselors’ spiritual well-being, values, self actualizing characteristics, and their clients’ spiritual well-being. Forty-five certified addictions counselors in Virginia completed the
Spiritual Well-Being Scale (SWBS), the Rokeach Value Survey (RVS), and the Personal Orientation Inventory (POI). Eleven counselors were from inpatient facilities and comprised a convenience sample to examine the relationship between counselor spiritual well-being and client spiritual well-being. Ninety-four clients under the care of these eleven counselors were given pre- and post-test of the SWBS in order to examine this relationship (Brooks & Matthews, 2000).

Brooks and Matthews (2000) found significant relationships between counselor spiritual well-being and one subscale of the POI, self-acceptance. Counselor spiritual well-being was also significantly correlated with one of the RVS subscales, loving. These findings are relatively inconclusive, however, due to the small sample size. Only 11 inpatient substance abuse counselors and 94 of their clients were surveyed to examine the relationship between counselors’ and clients’ spiritual well-being. That is, because substance abuse counselors’ spiritual well-being was only measured in eleven participants, it is difficult to generalize to other substance abuse counselors outside of this study. In addition, because statistical power was low in this study, even the findings of significance are not necessarily convincing.

Investigation into the role of spirituality in substance abuse counseling and the recovery processes is currently at an early point of development. Because there is a paucity of clearly conceptualized studies that investigate the role of spirituality in the recovery and treatment processes, this study seeks to explore and better understand the role of spirituality in the recovery and treatment processes as conceptualized by substance abuse counselors who are in recovery from an addiction. One assumption of this approach is that substance abuse counselors who are in recovery from an addiction may be able to offer valuable insight into the mechanisms within spirituality that affect the recovery and treatment processes. It is anticipated that recovering
substance abuse counselors may place great emphasis on the importance of spirituality in the recovery and psychotherapeutic processes.

Conclusion

The review of pertinent literature has covered theoretical and empirical literature related to the wounded healer archetype, the substance abuse counselor and recovery status, self-disclosure, countertransference, and spirituality in the recovery and treatment processes. This study was designed to investigate the essential meanings associated with being a wounded healer as embodied in a recovering substance abuse counselor, and implications for therapy with clients. In addition, specific constructs that have been chosen through a review of the pertinent literature are explored. As a result, this study involved the investigation of recovering substance abuse counselors' lived experiences of the following constructs: the overall meaning and essence of being a recovering counselor, the use of self-disclosure of one's personal history of addiction with clients, experiences of countertransference in working with substance abuse clients, and the role of spirituality in the recovery and treatment processes. In conclusion, this study sought to better understand the lived experiences of recovering substance abuse counselors in connection with the constructs noted above, as well as the influences of those experiences on their work with clients.
Chapter 3: Methods

The Qualitative Research Approach

A qualitative research design was chosen for this project. Creswell (1998) identified numerous reasons to choose a qualitative design in research. The primary reason offered is that the nature of the research question is best suited for qualitative inquiry. This is clearly the case with this study. Seeking to better understand how a recovering substance abuse counselor’s previous addiction affects her or his self-perceived meaning associated with being a recovering counselor, as well as her or his work with clients who themselves are dealing with substance abuse issues is a very complex question, and we currently know very little about the constructs involved. That is, this study sought to explore the phenomenological worlds of recovering substance abuse counselors and their work with clients on substance abuse issues in individual or group psychotherapy. In addition, this study sought to understand the essential meanings and essences of being a recovering substance abuse counselor from the counselor's point of reference, and was therefore best suited for investigation within the qualitative tradition, which is built on the constructivist paradigm.

Ponterotto (2005) discussed the constructivist paradigm as an alternative to the naïve realism of positivist and postpositivist points of view. He pointed out that constructivists advocate a relativist position that includes multiple and equally valid realities. Constructivists maintain that meanings and truth cannot be objectively investigated and discovered in the external world, but that reality and meanings are constructed in the mind of the individual (Hansen, 2004). In addition, the constructivist paradigm includes a hermeneutical approach, which holds that meanings are hidden and must be discovered through deep reflection. Such reflection occurs through an interactive dialogue between researcher and participant, and
findings are jointly constructed through this collaboration (Schwandt, 2000). Furthermore, constructivism stresses the goal of comprehending the "lived experiences" of participants, which is a goal that is incorporated into phenomenological research. Because lived experiences may at times be outside of the individual's awareness, it is through deep reflection and co-construction with the investigator that meanings may emerge (Ponterotto, 2005). The goals of this study clearly fit into the constructivist paradigm, and were therefore best suited for qualitative, and specifically phenomenological inquiry.

Creswell (1998) identified additional reasons for qualitative inquiry that include the need to present a detailed view of the topic and the importance of studying a phenomenon in the field setting. The present study sought to explore, better understand, and present the lived experiences of recovering substance abuse counselors through a detail oriented view. In order to better understand the impact that their personal history of addiction has on their work with clients who are dealing with substance abuse issues, it was necessary to present the lived experiences of recovering substance abuse counselors in a way that conveyed the complexities of such experience. This study presents the participants' inner meanings and essences associated with being a recovering counselor, experiences of countertransference, self-disclosure, and the role of spirituality in the therapeutic process with substance abuse clients from the respondents’ point of view. The goal of this study was to capture the richness of their perspectives, and therefore it was best suited for the phenomenological approach.

This study gathered data from the field in the form of interview responses from ten recovering substance abuse counselors who are currently working with clients on substance abuse issues in either individual or group psychotherapy. It was assumed that substance abuse counselors who themselves are in recovery from an addiction and who are currently working
with clients on substance abuse issues are best able to comment on the constructs under investigation from a recovering counselor’s point of view.

Phenomenology

The phenomenological methodological framework was utilized in this study. A phenomenological approach was chosen for this study because this study sought to describe a phenomenon, that is, the lived experiences of the research participants in connection with the constructs under investigation. In addition, the phenomenological approach was chosen over other qualitative methodologies because the phenomenological approach is most closely bound to constructivist assumptions, and therefore is most reflective of the principal investigator’s worldview. Phenomenological investigation seeks to understand and describe a phenomenon from the perspective of the individual who experienced that phenomenon (Moustakas, 1994).

While the term phenomenology can be traced back to the philosophy and writings of Kant, Hegel was the first to formulate a clearly constructed approach to understanding human consciousness through immediate awareness and experience. According to Hegel, phenomenology is knowledge as it appears to human consciousness. That is, it is a science that involves a detailed description of what one senses, perceives, and knows through one’s immediate experience and awareness (Kockelmans, 1967).

Phenomenological investigation was further developed and refined by Husserl (1901/1970). In developing phenomenology, Husserl was heavily influenced by Descartes, particularly in his development of the concept of *epoché*. Epoché calls on the researcher to transcend suppositions and to raise one’s knowledge beyond doubt, extending towards absolute knowledge (Moustakas, 1994). Husserl, much like Kant and Descartes, believed that knowledge rooted in intuition and essence precedes knowledge acquired through empirical means. Husserl
valued the discovery of essences and meanings of experience, and his approach to the cultivation of knowledge is reflective of this belief. Husserl (1970) stated,

Ultimately, all genuine, and, in particular, all scientific knowledge, rests on inner evidence: as far as such evidence extends, the concept of knowledge extends also. (p. 61)

Husserl (1939/1954) began a phenomenological investigation with two epochs. The first epoché is the "epoché of natural sciences," which calls for the investigator to temporarily put aside, or *bracket*, scientific theories, hypotheses, explanations, and conceptualizations of the subject matter. That is, the researcher attempts to clear her or his mind of preconceived notions connected with the phenomenon under investigation. While this state of consciousness may not be attainable in a pure sense, it is the spirit of attempting to clear one’s consciousness of preconceived notions that is important in phenomenological investigation (Moustakas, 1994).

When the researcher does identify preconceived notions about the phenomenon under investigation, they are clearly documented and set aside for the time being, a process called bracketing. The researcher may then return to reflecting on these preconceived theories and understandings following completion of the study in light of the findings of the inquiry (Moustakas, 1994).

The epoché of natural sciences allows the researcher to experience manifestations of the subject matter as they exist prior to and independent of scientific knowledge. Wertz (2005) explained,

This return to phenomena as they are lived, in contrast to beginning with scientific preconceptions, is a methodological procedure and does not imply that such knowledge is false; it simply suspends received science, puts it out of play, and makes no use of it for the sake of fresh research access to the matters to be investigated. (p. 168)

The epoché of the natural sciences allows the researcher to experience the pre-scientific world as it is lived and encountered in everyday situations. That is, it leads the researcher to the
"natural attitude," and is sufficient for physical scientific research. Research that investigates meaning and subjectivity requires an additional epoché, however, the "epoché of the natural attitude." The epoché of natural attitude is a methodological operation used to put aside our belief in the existence of that which presents itself in the life-world, so that the investigator can consider the constitutive meanings and essences of the phenomenon. Furthermore, the epoché of natural attitude allows the researcher to recall her or his own experiences and to understand the phenomenon from the research participant's perspective. Wertz (2005) stated,

> This second epoché and the analyses that follow from it allow us to recollect our own experiences and to empathically enter and reflect on the lived world of the other persons in order to apprehend the meanings of the world as they are given to the first-person point of view. (p. 168)

The culmination of these processes is termed the *phenomenological psychological reduction*, and results in the reduction of awareness to the purely psychological. The reduction of awareness to the psychological allows the researcher to comprehend and describe the meanings and psychological processes of lived-through situations (Wertz, 2005). While the phenomenological psychological reduction may not be possible in a pure sense, the researcher continually brackets the presuppositions that come to mind in an attempt to experience the phenomenon under investigation in its most fundamental manifestation (Moustakas, 1994).

Two concepts that are central to phenomenology need further explication prior to a more specific discussion of this study: *intentionality* and *intuition*. Intentionality refers to the relationship between consciousness and the external world. This concept is rooted in Aristotelian philosophy and it refers to the orientation of the mind to its object. That is, the object exists within the mind in an intentional way; it is perceived, judged, and evaluated. Intentionality is the internal experience of being conscious of the world. When one becomes
aware of intentionality, it requires that we are present to ourselves and the world, and that we are aware of the inseparable nature of self and world as components of meaning (Moustakas, 1994).

For Descartes and Husserl, intuition was the primary epistemological tool in experiencing the self in relation to its object. By stripping away preconceived notions, assumptions, and the “everyday sense impressions and natural attitude” (Moustakas, 1994, p. 32), one may come to a more clear perception of the phenomenon that is being perceived in relation to oneself. Hence, by coming to know the essence of the phenomenon in its naked presence, one comes to know oneself as the perceiver who intuits and comprehends the phenomenon that is being experienced.

It was in the spirit of phenomenological investigation that the principal investigator and the co-analyst of this study sought to bracket preconceived notions, assumptions, biases, and everyday ways of thinking in the process of investigating the phenomenon at hand. Every effort was made to perform the mental procedures and psychological reductions described above during the data collection and analysis processes, and results of this bracketing will be described in the following section.

The Researchers and Bracketing

The Principal Investigator

As the principal investigator of this study, I am a fifth year doctoral student in counseling psychology. I hold a master’s degree in community counseling with an emphasis in addictions counseling, and part of the degree requirements for this program involved completing a part-time practicum at an outpatient substance abuse facility, as well as a full-time semester long internship at an inpatient substance abuse facility, where I also stayed on briefly as a substance abuse counselor. While functioning in these roles, I had the opportunity to interact extensively with numerous other substance abuse counselors, recovering and non-recovering, as well as a
large number clients at both facilities. It should be noted that I am not recovering from an addiction to either alcohol or drugs, and it is interesting that none of the participants in this study inquired about my recovery status. Nevertheless, because of my background and training, I have been exposed to many of the stereotypes, generalizations, and commonly held ideas about recovering substance abuse counselors. These exposures have, of course, influenced my thinking about recovering substance abuse counselors in many ways, and have therefore affected my preconceived notions, ideas, and expectations about the findings of this study. At the onset of this study, I noted my preconceived notions and expectations about the study material and they are listed as follows:

1. I expect that recovering substance abuse counselors will see the overall meaning and essence of their experiences as a way to “give back” and to help others who are struggling with addiction.
2. I expect that recovering substance abuse counselors will see their own recovery history as affecting their work in positive ways. Specifically, I expect that they will express that it increases their empathic attunement with clients and that it helps to build a positive working alliance.
3. I expect that recovering counselors will utilize self-disclosure to build the working alliance and trust with clients. I also expect that they will indicate that they have become more judicious in their use of self-disclosure over time.
4. I expect that recovering counselors will report a wide variety of countertransference experiences, but that there will be patterns in their management techniques, such as seeking supervision.
5. I expect that recovering counselors will see spirituality as a highly important in their work with clients due to the fact that they likely recovered in a twelve-step program. I also expect that
they will indicate that they encounter resistance in clients when talking about spiritual concepts, especially in relation to possibly attending twelve-step meetings.

As I collected data and analyzed the results, I attempted to embody an attitude that was empathic toward the participants throughout the research process, leaving my own world behind in order to enter fully into the situations and worldviews of the participants (Wertz, 2005). That is, I attempted to join with the participants in their lived experiences of the phenomena at hand. This sharing of experience served to enhance later reflection on the meanings and experiential processes involved in the research.

The Co-analyst

The co-analyst of the study was Dr. Kai Dawn Stauffer LeMasson. She holds a Ph.D. in human development and family studies, as well as a master’s degree in psychology. Her background is in qualitative research, specifically grounded theory methodology. Her primary research interests are in the sexual objectification of women and how women internalize and are affected by such objectification. She had no previous exposure to the substance abuse counseling field, other than being married to a former substance abuse counselor (the principal investigator), and joined this study primarily because of her expertise in qualitative data analysis and to assist with the data analysis process. Dr. Stauffer LeMasson is not in recovery from an addiction to alcohol or drugs. She noted her preconceived notions and expectations prior to the data analysis phase for this study and they are listed as follows:

1. I expect that recovering counselors will use self-disclosure of their substance abuse history as a tool to build rapport with clients. However, I expect that self-disclosure will be used selectively based on the needs and characteristics of clients or the therapeutic setting. I also suspect that self-disclosure will vary based on the therapist's education and length of recovery.
2. I expect that recovering counselors will believe that their own substance abuse history provides them with a greater ability to understand clients and to empathize with the needs and challenges of their clients than non-recovering counselors.

3. I expect that recovering counselors will identify with the wounded healer archetype. Counselors will feel a special calling to do substance abuse counseling that arises from their pain and suffering, and the need to construct meaning and purpose in their own lives.

4. I expect that recovering counselors will widely vary in how they understand and manage countertransference in the treatment process. I suspect that some will struggle to maintain therapeutic distance from clients. I also suspect that awareness and management of countertransference will depend on the therapeutic setting and therapist's level of education.

5. I expect that recovering counselors, especially those with an AA background, will place importance on spirituality in the treatment and recovery process, and this will be reflected in their work with clients.

Data Collection Procedures

Recruitment of Participants

Qualitative data was collected for this study in the form of interviews conducted by the principal investigator with 10 substance abuse counselors who self-identified as recovering from an addiction and who currently work with clients on substance abuse issues in individual or group psychotherapy. In addition, participants’ work with clients in psychotherapy took place in a professional setting, and was not lay counseling taking place in such settings as half-way houses or churches. Participants were required to have at least one year of experience in working as a substance abuse counselor in a professional setting and at least two years of recovery from an addiction. All of the actual participants in this study far exceeded these
minimum qualifications. While there were no restrictions placed on participants’ level of education, they must have had some formal training in the provision of psychotherapy (i.e., master’s training, counselor training program, on-site job training in a professional setting). In addition, participants were required to comprehend and discuss the constructs under investigation following an explanation of such constructs. The constructs under investigation were explained in the recruitment letter and participants were asked to participate in the study only if they could substantively discuss these constructs.

Prospective participants were informed of the requirements for participation in the study, which included consent for audio taping of the interviews and consent to be contacted at a later date to give feedback concerning the accuracy and quality of the analysis of the interview. All participants were given a recruitment letter, participant letter, and signed an informed consent form prior to participation (See Appendices A, B, & C). Participants also completed a demographic questionnaire prior to being interviewed (See Appendix E). Participants were offered twenty-five dollars as reimbursement for their time.

Participants were recruited through personal contacts of the principal investigator in one state in the southeastern United States and another state in the northeastern United States. Participants were recruited and interviewed in these two states only. Recruitment of additional participants was accomplished through the use of the snowball method. That is, the principal investigator inquired through personal contacts in the field about possible individuals who may be interested in participating, and some participants referred other possible participants, some of whom did participate. Additionally, the method of *purposive selection* was utilized in this study to include only participants who could substantively contribute to the study and speak to the experience and constructs under investigation. Purposive selection involves the conscious choice
of participants who can offer particularly meaningful material that is relevant to the experience at hand (Polkinghorne, 2005).

The number of participants to be included in this study was difficult to predict or determine at the onset of the study. While the phenomenological approach expounded by Creswell (1998) called for approximately five to eight individuals to be interviewed, Wertz (2005) indicated that it is impossible to accurately predict the number of participants that may be needed for the purposes of any one phenomenological study. Wertz went on to explain that it depends on the nature of the research problem and the goals of the primary investigator. Fischer, Eckenrod, Embree, and Jarzynka (2001) indicated that of the 240 phenomenological dissertations produced in the Duquesne counseling and clinical psychology doctoral programs, the number of interviews rarely exceeded six due to the depth and rigor of such interviews and analyses.

This study sought to reach a point of saturation, or a point in which the data began to show repetition (Patton, 2002). At the onset of the study, it seemed reasonable to expect that saturation may be reached following interviews with between six to ten participants, as the constructs under investigation were somewhat broad and complex in nature. Following the tenth interview, the principal investigator made the decision to terminate the data collection process because saturation had clearly been reached with the constructs under investigation.

**Characteristics of Participants**

Ten recovering counselors, seven men and three women, were interviewed for this study. All of the recovering counselors identified themselves as European-American. Participants ranged from 36 to 66 years of age with the majority (70%) either being in their fifties or sixties (See Table 1). Only one recovering counselor was under 40 years of age. Given the middle age
and older status among participants, most had been in recovery for more than 20 years at the time of the interviews. Specifically, years in recovery ranged among the group from 18 to 28 years.

All recovering counselors had earned at the very minimum a bachelor’s degree at a college or university. Four counselors held a master's degree in counseling or social work, and one counselor held a doctorate in psychology. Counselors provided information about their years of counseling experience after earning their highest degree. Years of counseling experience among recovering counselors ranged from 5 to 23 years, with a median of 14 years of counseling experience.

Recovering counselors utilized various therapeutic approaches with clients including CBT, solution-focused therapy, reality therapy, client-centered therapy, motivational interviewing, narrative therapy, and a strengths-based approach. Six of the ten recovering counselors identified having more than one theoretical orientation, with two counselors having used the term “eclectic” to refer to their counseling style. The theoretical orientation mentioned most often by recovering counselors was CBT (4 counselors), followed by eclectic (2 counselors), and solution-focused therapy (2 counselors).

*Interview Procedures*

The principal investigator traveled to the research participants’ location in order to conduct the interviews. The specific locations were chosen by the participants and took place in a relatively private setting, such as a private office or home. Interviews were audio taped and later transcribed by the principal investigator or a professional transcriptionist. The interviews lasted approximately 1.5 hours. The principal investigator asked participants during the first portion of the interview to reflect on their lived experiences of being a substance abuse counselor who is in recovery from an addiction and how their personal addiction affected their work with
clients. The principal investigator asked participants to reflect specifically on the constructs of countertransference, the use of self-disclosure, and the role of spirituality in the therapeutic and recovery processes during the subsequent portions of the interview. The principal investigator also asked that participants comment on anything else that was important for them as a substance abuse counselor in recovery from an addiction at the end of the interview.

Overall, the interviews were flexible and somewhat unstructured, as indicated by the phenomenological approach (Moustakas, 1994). The principal investigator sought to understand the participants’ lived experiences from their perspectives, and to understand the meanings and essences of their experiences as they relate to the clinical encounter with substance abuse clients. While the interviews were flexible and unstructured, there were six basic questions that were asked of participants in some form. These questions were based on the review of the pertinent literature and were designed to address the study goals outlined in Chapter 2 in a holistic and comprehensive fashion. Research participants were also given these questions, along with the moderate definition of countertransference, at least two weeks prior to the interview in order to give them time to reflect on and prepare for these questions. The terms “self-disclosure” and “spirituality” were not defined and instead was left open to the participants’ own interpretations. The interview questions, which were supplemented with the definitions of the terms referenced above, are located in Appendix D.

Phenomenological Data Analysis

Prior to explicating the data analysis procedures for this study, it should be noted that there is no single correct way to analyze phenomenological data. Instead, the specific procedures that are used depend on the purposes of the researcher, her or his specific abilities, the nature of the research questions, and the data that emerge (Hein & Austin, 2001). In addition, the methods
chosen at the outset of a phenomenological study should be viewed as providing general guidelines, and may need to be modified as the research process unfolds (Hein & Austin, 2001). That said, the following data analysis procedures were drawn primarily from the guidelines outlined by Creswell (1998), Moustakas (1994), and Wertz (2005) for phenomenological data analysis, taking into account the specific peculiarities, practical concerns, and needs of this study.

As previously noted, the principal investigator was assisted in the data analysis phase of this project by a co-analyst, Dr. Kai Dawn Stauffer LeMasson, who has expertise in qualitative research and data analysis. The addition of a co-analyst added additional validity to the analysis of the interview material through the remediation and integration of dual perspectives, a process termed triangulation with multiple analysts (Patton, 2002). The principal investigator and co-analyst read and analyzed the interview material separately and then together, and talked through discrepancies in their interpretations of the interview materials during the analytic process.

Following the completion of all interviews, the interview data were transcribed by the principal investigator and a professional transcriptionist. Once all of the interviews were transcribed, the principal investigator and the co-analyst bracketed their expectations and preconceived notions specific to the data analysis process by documenting a list of such preconceptions prior to the analytic process. These preconceptions were previously identified by the principal investigator prior to the data collection process, and the preconceptions of the co-analyst were added prior to the analytic process. In addition, these preconceptions were deliberately set aside during the data analysis process so that the data was analyzed in an unbiased manner. Following the bracketing process the analysis of the data was undertaken by the principal investigator and co-analyst.
Horizonalizing the Interview Data

The goal of the analysis was to capture the meanings and essences of the lived experiences of the participants (Van Manen, 1990). That is, the principal investigator and co-analyst attempted to reduce the interview data down to the essential meanings of what these individuals experienced as recovering substance abuse counselors who were working with clients on issues related to substance abuse. First, the principal investigator and co-analyst thoroughly read and studied the interview material separately in order to become very familiar with the responses. The first read of the interview data was done without the research questions in mind, so that the participants' meanings and expressions were comprehended in a broad context (Wertz, 2005). Next, the principal investigator and co-analyst separately utilized the process of horizonalizing the interview data, and then met to compare and integrate their findings.

Horizonalizing involves regarding every horizon or statement germane to the topic as an equal statement (Moustakas, 1994). A horizon or statement was defined in this study as a meaningful phrase that may consist of a partial or whole sentence, and that conveys some type of meaning on the part of the participant. This process is similar to "coding" in other qualitative traditions, and precedes a more in-depth eidetic analysis (Wertz, 2005). In this study, the process of horizonalizing the data involved a listing of each meaningful phrase or statement for later consideration of inclusion or exclusion.

The Phenomenological Reductions

Formulation of Meaning Units

After the horizonalized statements had been listed, the psychological phenomenological and eidetic reductions were executed. During this process, statements that were relative to the phenomena were extracted and listed as separate from extraneous statements, and the meaning
units were extracted and compiled separately by the principal investigator and co-analyst. Meaning units were chosen based on the analysts’ judgments as to whether the phrase was meaningful to one of the constructs at hand, and when there was some discrepancy not resolvable through dialogue between the analysts, the decision was made to err on the side of inclusion. The extraction of meaning units began with the process of reducing the data to a manageable size. Wertz (2005) explained, “The contours of the phenomenon of interest are distinguished from its baseline—the lived experiences prior to the subject matter of interest” (p. 172). In other words, this phase of the data analysis attempted to distinguish the core features of the experienced phenomena from the extraneous features, by examining which features were central to the participant’s experience and which are more idiosyncratic in nature. This was a subjective process on the part of the researchers, and involved extracting the essential meaning units from the data that together represent the respondent’s lived experience of the phenomenon.

In reducing the interview data, the researchers encountered redundancy in the interview responses, and such redundancy was eliminated by condensing the data. In this study, the meaning units were made up of a combination of horizontalized statements, which together formed more complete descriptions of experience, or a constellation of statements into a more coherent idea. For example, if a participant was describing an instance when she or he used self-disclosure in an effective manner with a client, the numerous meaningful statements or horizons that described this experience were grouped together during the data analysis phase to form a meaning unit, while superfluous or redundant statements were eliminated. The meaning unit in this example would have been coded “self-disclosure – example.” Additionally, if after describing the experience the participant gave an interpretation of why the disclosure was effective (i.e., to build client trust), then this interpretation was listed as a separate meaning unit.
**Thematic Clustering**

After the meaning units had been formulated, they were clustered into common categories or thematic categories by the principal investigator and co-analyst together. This process was also carried out within each construct response (i.e., overall meaning, self-disclosure, countertransference, spirituality) and the result was the formulation of the participants’ experiences associated with each construct, separated from extraneous and redundant information. Thematic clustering in this study involved the combination of numerous meaning units to formulate a more holistic communication of an experience on the part of the research participant in regard to each construct. Using the example noted above for the formulation of meaning units, if a participant gave two different examples of using self-disclosure in an effective manner with clients and both were to demonstrate that it helped to build trust with that particular client, both experiences were then clustered in this process and coded as “self disclosure – client trust.” If only one experience was described by the participant, but was followed by an interpretation, the example and the interpretation (2 different meaning units) were combined to form one thematic cluster.

**Development of Textual Descriptions**

Next, the thematic clusters were grouped and woven together using *thick description* to construct textual descriptions of the individual participants’ experience of each construct. Thick description presents detail, context, emotion, and social interaction to describe the overall experience of the individual (Patton, 2002). In this study, the incorporation of thick description to develop textual descriptions involved an exploration of the participants’ reported experience in context and the researchers’ interpretations, blended with the participants’ voices, in order to better understand their experience from their own perspective. For example, if a participant
discussed two examples of using self-disclosure effectively, one example of when it was not effective, and two different interpretations as to why they were or were not effective, and if they further described the changes in how they have used self-disclosure over the years, and the data analysis process yielded no other thematic clusters associated with self-disclosure, then these thematic clusters were woven together using participants’ voices and experiences blended with the researchers’ interpretations to form textual descriptions. These textual descriptions make up much of the “participant profiles” in the presentation of results.

**Participant Profiles**

The participant profiles incorporated textual descriptions in conjunction with demographic data to describe participants in terms of their background, circumstances, experiences, attitudes, and beliefs concerning the constructs under investigation. The participant profiles are presented in the first section of the presentation of results, and are followed by the structural descriptions, which collectively are termed the “construct analyses.”

**Structural Descriptions**

Finally, the textual descriptions were used to develop structural descriptions, or what are collectively termed “construct analyses” in the presentation of results, which identified themes, patterns, and associations within the data and *between* participants. In this study, the formulation of structural descriptions was accomplished through listing all pertinent participant thematic clusters within each construct, and through connecting these together between participants to formulate thematic cluster categories that were shared between participants. These thematic cluster categories were then blended with the participants’ voices, researchers’ interpretations, and thick description to construct structural descriptions. These structural descriptions describe
the findings of the analytic process for each construct under investigation, and as noted above, are therefore referred to collectively as the “construct analyses” in the presentation of results.

**Data Checks**

Patton (2002) discussed the use of analytical triangulation to increase the validity and accuracy of qualitative interview data collection and analysis. The use of *triangulation with multiple analysts* involves the use of two or more persons in the data analysis process to avoid the potential biases associated with analysis by only one person. That is, although the researcher has bracketed her or his preconceived expectations or biases, these biases may emerge unconsciously through the data analysis process (Patton, 2002). In this study, the addition of a co-analyst in the data analysis process served to increase the validity of the analysis process through triangulation with multiple analysts. The co-analyst in this study took part in the entire data analysis process, from horizontalization to the formulation of structural descriptions, and separately analyzed the interview data in the horizontalization and formulation of meaning units phases prior to meeting with the principal investigator to compare and reconcile findings. This process served to increase the overall validity and accuracy of the data analysis process in this study.

A second method of analytical triangulation discussed by Patton (2002) is called *review by inquiry participants*, and involves contacting the participants to gather their reactions of the data analysis findings, and to reconcile discrepancies between the findings and their reactions. In this study, the interview transcripts and extracted meanings were sent via email attachment to the participants for review and approval. That is, each participant received the transcript and analysis of the interview material for their particular interview only, so that confidentiality was maintained for each participant. This process served as a validity check for the representations
of respondents' lived experiences of the constructs under investigation (Morrow, 2005). Participants were asked to read the interview transcript, description of the analytic procedure, and the resulting descriptions, extracted meanings, and inferences, and to comment on the accuracy of these descriptions and meanings. In cases of a discrepancy in the interview transcripts, extracted meanings, or other materials, the principal investigator collaborated with the appropriate participant to correct the discrepancy. The transcripts or extracted meanings were then revised to be consistent with participants' understandings of their own experiences prior to preparation of the final representation (Patton, 2002).

Only three participants in this study responded and offered clarification or changes in their interview material or meanings, and these changes were incorporated into the final presentation of results. Three other research participants responded and indicated that no changes should be made, while four participants did not respond to the researcher’s communication, and therefore the assumption was made that no changes were in order for those participants (participants were informed that if they did not respond within 2 weeks that the assumption would be made that there should be no changes). Through this verification process, the principal investigator sought to maintain rigor and credibility in the research process. The final representation of the data will present thick description of the lived experiences, essential meanings, similarities, differences, and patterns among and between the participants concerning the constructs under investigation in the following chapter.
Chapter 4: Results

Introduction

The study results will be presented in a way in which the participant's experience will emerge through the development of descriptive participant profiles. This section will include an exploration of individual experience in relation to the constructs of self-disclosure, countertransference, and spirituality, as well as their self-perceived overall meaning or essence connected with being a recovering counselor and the influence of their recovery status in their work with clients. Participant names have been changed in the following sections to protect their confidentiality. The participant profiles will be followed by a more in-depth analysis of the constructs noted above, including patterns, themes, and other variations or discrepancies in the interview data that emerged from the phenomenological reductions and resulting structural and textual descriptions. An important aspect of the participant profiles and exploration of constructs under investigation will include substantial use of the voices of the participants themselves. The use of participant voices will allow the presentation of results to communicate the participants' experiences from their own perspectives. That is, participant quotes taken directly from the interview material will be blended with thick description and presented in context to give the reader a better understanding of the lived experiences of the participants.

Participant Profiles

Interview 1

Charles is a 39-year old European-American man who has been in recovery for 19 years. He holds a bachelor's degree in psychology with a concentration in substance abuse and has 13 years of counseling experience. His theoretical orientation in working with substance abuse
clients is motivational interviewing combined with the 12-step recovery model. Charles currently works in the field of mental health with dual diagnosis clients.

**Overall Meaning and Essence**

The experience for Charles of being a recovering counselor is that his work with clients comes naturally to him. In other words, there is an effortless quality to counseling clients that is facilitated by his own recovery history. At the very beginning of the interview, Charles stated that he enjoys being a recovering counselor because his work as a counselor does not feel like actual work. Specifically he said, “I want to live a life where I enjoy what I do for a living, where work doesn’t seem to be work.” Furthermore, Charles explained that he does not have to “work hard” to understand and counsel clients: "If I do need to dip back into my knowledge base either professionally or personally, I don't have to dip very far…the tools are already there." The personal "tools" he refers to are his own experiences of addiction and recovery.

For Charles, the meaning of being a recovering counselor involves a deep, personal understanding of treatment and recovery that gives him the ability to be empathetically attuned with clients. With regard to substance abuse clients, he stated emphatically, "I know where they are coming from." Thus, Charles believes that his personal experience of recovery, what he terms his "street knowledge," allows him to reach out and connect with clients more quickly than a non-recovering counselor. According to Charles, a therapeutic advantage of being a recovering counselor is that clients are less defensive with him because they know he personally understands addiction.

What happens is that immediately it disarms a lot of the defense mechanisms a client would use…It is just the fact that they know that I know. Automatically they drop a whole set of defenses that they would have been able to utilize with a non-recovering person.
Armed with "street" or "insider" knowledge, Charles sees himself as able to understand and appreciate clients' experiences, particularly their initial confusion about "wanting to change and they just have no clue where to start." He stated that "unless you have been that confused it is really hard to know what it is like, with every part of you wanting to change something and just having no idea where to start."

Although counseling substance abuse clients comes naturally to Charles, his recovery history and "insider" knowledge can create anxiety for him in the process of treating clients. He sometimes experiences a subtle tension in therapy between his personal knowledge of addiction, including the path to recovery, and his anxiety and impatience with people resistant or blocked on that path. For example, prior to recovery his drug of choice was Xanax. He stated that he has had "the most success and the most failures, really black and white, with folks with that history." The basic challenge for Charles in treating a client with a Xanax addiction is to help clients see that withdrawal symptoms often mimic panic attacks. Charles feels that his personal experience with Xanax forges a closer connection with a client and provides a powerful therapeutic intervention.

When I can connect with somebody on that and hold their hands through the 10 or 15 days of ongoing withdraw symptoms and then the panic attacks stop. When I can connect with them it is really powerful. You know, and that comes from personal experience.

However, Charles has treated Xanax addicted clients who are unwilling to consider that their panic attacks are connected to withdrawal symptoms. He explained that he does not "know what to do with the resistance," which leaves him feeling frustrated.

You know because then the countertransference comes in when I know where they are at. I know what is going on here and I know the answer. I know the solution and they just can’t get there, they are not there yet. So it is not really a negative frustration but more of an anxiety for them, you know.
He stated that he experiences more frustration with "Xanax" clients than those who use other types of substances because he knows the "solution" to their problem. Charles indicated that he will give clients "answers that they actually need to find on their own." He labeled this behavior, "rescuing clients." Charles believes that "rescuing clients" is a common mistake among recovering counselors because they have already solved the problem of addiction, and thus there is a tendency to "push" clients rather than letting them "sit there and struggle with it themselves." "Rescuing clients" has receded over the years as Charles adopted a new approach to counseling substance abuse clients.

Charles's therapeutic approach has changed over the course of his career from a 12-step model of recovery to motivational interviewing in the treatment of addiction. He deemed this shift in treatment modes as a "powerful transformation" because he is less inclined to use his own recovery as a "backdrop" for doing therapy, and thus is more understanding and patient with resistance in clients. He realized that his work with clients using the 12-step approach was problematic: "I would create the resistance from the client and then because I had no other resources to fall back on, then it would create frustration on my part, because I didn’t have any other avenues."

Charles stated that the impetus for his work is to help clients "get to be able to experience what I have experienced" and "to help people make change and, live fuller, happier lives." The "powerful transformation" in his work came from realizing that he had to "back away" from his recovery. Specifically, he realized that if his recovery was at the forefront of his counseling it impaired his ability as a counselor.

I’m losing as many people as I am gaining, then I am not really meeting my goal. If my goal is to help as many people as possible and my style is keeping me from helping people, then I need to amend my style [and embrace other treatment modalities such as motivational interviewing].
In transforming his therapeutic approach and style, Charles distanced himself professionally from his own personal recovery. Charles said, "From the get go I did not want to be stuck in the 'I'm a recovering counselor' mode" that he associates with the 12-step recovery model. He stated that "I’m a clinically educated trained professional who happens to be in recovery." Charles often feels like he is "stereotyped as a recovering counselor" and that it undermines his credibility with non-recovering counselors.

It limits even people’s perspective on what I bring to the table. But vice versa, I do wish that the recovering counselor community would be able to kind of get to the point where they are practicing a more motivational approach.

In other words, he believes that if recovering counselors utilized a motivational approach that they would benefit professionally.

Charles is very aware of people's perceptions of recovering counselors, especially the negative stereotypes, and thus works to shatter those perceptions in various ways. For example, much to the surprise of colleagues and clients he will condone client behavior that challenges the abstinence model of recovery.

I'll say, "Well, it’s just a little weed and dude has got an anxiety disorder, you know, maybe he ought to smoke weed" and people will respond, "What are you talking about, you are supposed to be abstinent based" and da da da.

Charles said that his own views on abstinence are "a little bit abnormal" for a recovering counselor because he doesn't believe that abstinence is the "right thing" for all people in recovery. In breaking through recovering counselor stereotypes, Charles is likely seeking acceptance from his non-recovering counterparts. In addition, he is attempting to reach clients who may be suspicious of recovering counselors. He said that clients often "already know what they are going to hear from those folks, so they can go ahead and shut off their ears." Thus,
according to Charles, overturning client expectations about recovering counselors increases the likelihood clients will be willing to listen to him.

In conclusion, Charles both embraces and distances himself from his recovery in his work with clients. He clearly recognizes the strengths and benefits of being a recovering counselor. For example, his work comes "naturally" to him because he can easily understand a client's perspective and empathize with them. However, Charles also observes that there is a downside to being a recovering counselor, primarily with countertransference issues and the prevalence of recovering counselor stereotypes in the addictions field. As a result, Charles replaced his early use of the 12-step recovery model with motivational interviewing, to overcome what he perceives are his shortcomings as a recovery counselor, and perhaps to earn the respect of non-recovering colleagues.

Self-disclosure

During the interview, Charles differentiated between types of self-disclosure (i.e., specific/detailed and brief/indirect) and the degree of personal information revealed to clients. Initially upon meeting a client, Charles reveals that he is in recovery, but does not provide the client with specific details about his recovery. His intent behind self-disclosing his recovery is to "establish a baseline" with clients, so they are aware that his understanding of addiction comes from more than just "a textbook." By initially self-disclosing his recovery to clients, Charles is enhancing his credibility and trustworthiness with clients. He is someone who has been an addict and is now in recovery. Thus, he believes that clients are more likely to see him as a credible counselor with both personal and practical knowledge in treating addictions.

In addition to self-disclosing his recovery status to clients, Charles uses what he terms "indirect self-disclosure" with clients. Using indirect self-disclosure, Charles draws on his own
personal knowledge of substance use to empathize with clients. Examples of how Charles indirectly self-discloses with clients include the following hypothetical statements to clients: "Well, you know you are probably feeling like this," or "I know what it is like." Charles is indirectly communicating to clients his personal knowledge and experience with recovery, without revealing to them the specifics of his own recovery.

Charles self-discloses detailed and specific personal information to clients "very seldom," generally as a "last resort" when a client is emotionally overwhelmed and close to relapse. In such instances, when a clients are experiencing something that is common in the recovery process or their struggles are connected to Charles’s particular "drug of choice," Charles will reveal detailed information about his own history of recovery. For example, he had a client who he felt was "hitting the bottom" and it was clear to him that the client was psychologically troubled. Charles self-disclosed to the client: “You know, when I was trying to get clean, yeah, everybody I knew got high, and the only way that I was able to change that was I went to meetings.” In this instance, Charles, through self-disclosure, was helping his client problem-solve and to consider options in lieu of letting the client "hit rock bottom."

Charles weighs revealing his personal information with the needs and the characteristics of clients and the potential therapeutic benefit of self-disclosure. He generally uses self-disclosure with substance abuse clients without a "severe mental health diagnosis." He stated that clients without severe pathology are "the most effective to self-disclose with and also the most comfortable to self-disclose with." Charles also does not use self-disclosure with Driving While under the Influence (DWI) groups because he said, "They’ve actually probably not experienced some of the depths that I’ve experienced. So it wouldn’t be useful at all. It just wouldn’t be effective." In other words, his personal tales of recovery he believes would not help
these particular clients, many of whom do not have a full-blown addiction. In discussing the client characteristics that encourage or negate self-disclosure, Charles emphasized the pitfalls of self-disclosure with certain clients. He avoids self-disclosure with clients who have borderline features or "pathological manipulative factors" because, as he stated, "It would be used as ammunition later, so I just don’t." According to Charles, clients with those features would be more likely to turn one's self-disclosure into "ammunition" that could harm the therapeutic alliance and ultimately the goals of therapy.

In reflecting over the course of his counseling career, Charles said that he self-discloses with clients less today than he did early in his career. This shift in his rate of self-disclosure is not due to his years and experience in the field, but to a change in his therapeutic approach from being confrontational to a motivational interviewing style. He stated, "Had I not changed my philosophy, I’d still be self-disclosing at the same rate." His change in treatment philosophy has given him a different perspective on self-disclosure and the problems that can arise in motivational interviewing when a therapist takes the position of "expert." He believes that self-disclosure sometimes may not benefit clients because the counselor becomes "somebody who has been there," an "expert" to the client, rather than simply being a helping professional. According to Charles, when counselors self-disclose their recovery to clients, obliquely they are putting themselves in a position above a client as the person "in the know" about addiction. Charles believes that the counselor as expert dynamic can lead to "power struggles" between the counselor and client, harming the therapeutic relationship.

At the end of the conversation about self-disclosure, Charles summarized his position on self-disclosure by stating, "That’s why I think I shy away from it. It’s not really because of any fear…I’m an open book, you know especially my personal life." He exercises caution in self-
disclosing with certain clients, especially those who would unlikely benefit from knowledge of his recovery history. A shift in his therapeutic approach, from confrontation to a motivational style, has also changed his perspective and practice of doing counseling. He self-discloses less today than in the past because he is concerned about how his recovery status may position him as an "expert" with clients, thereby clients may conclude "Oh, you are so much better than me because you have gotten to the other side of this." He concluded that self-disclosure is not necessarily negative or problematic in counseling, stating that his position does not stem from the perspective that "it's not good to self-disclose." His reservations about self-disclosure stem from his understanding of motivational interviewing, and the potential for self-disclosure to impede or undermine his work with clients.

Countertransference

As stated above, Charles experiences anxiety when clients are not progressing in treatment or are on the verge of reaching a new insight about their addiction without yet arriving at that insight. He becomes impatient in these situations and his initial impulse is to give clients answers, or as he terms "rescuing them" or "helping them over that hump." According to Charles, rarely does his attempt to rescue clients actually undermine client growth or treatment. He stated, however, that sometimes clients " Didn’t internalize whatever it was because I gave it to them, it wasn’t theirs. They didn’t take ownership of that concept."

Charles is aware that countertransference generally arises in the treatment setting when he is working with clients who like himself used substances as a way to self-medicate and manage anxiety. With these clients, he has less tolerance and patience, interpreting their behavior through his own previous "drug seeking behavior."
I know all the tricks…it is hard for me to interpret their behavior any other way…and that is the draw back, you know, that’s where countertransference may be keeping me from seeing something that I would’ve seen otherwise.

Charles recognizes that his own history of addiction can color how he interprets a client's behavior. He manages countertransference and resists the impulse to "rescue" clients through self-talk and reminding himself to be patient and wait for clients to come to their own insights and realizations. He also resists rescuing clients through what he terms "redirecting myself” or approaching a client's issue through a "different angle" and asking different questions.

Charles experiences less countertransference with clients today than in the past because of his shift to a motivational interviewing approach. Using this approach, he believes, keeps his personal issues at bay to some extent, especially with clients who use substances to reduce anxiety. Charles indicated that motivational interviewing allows him to be less personally invested in client behavior and outcomes, and thus more relaxed, tolerant, and patient with clients.

**Spirituality**

Charles stated that he does not use spirituality in treatment as a general approach with all clients because of client resistance, especially to 12-step concepts. For example, in working with therapy groups he will disguise 12-step concepts, teaching the specific ideas without labeling the concept or source. Only after group members have fully grasped and internalized the idea will he relate it to a specific step in the 12-step program.

Charles's approach to spirituality in substance abuse treatment is "non-religious," "client-specific," and "individualized," depending on whether clients are open to discussing spirituality. Charles responds to the client’s "needs in the moment" and when "it seems in the client's presentation…that they have a lack of connectedness, a lack of hopefulness, a lack of spiritual
connection," then he will discuss spirituality with the client. If a client has had negative spiritual experiences or is an atheist, then Charles "just stays away from it," because a spiritual approach would not be helpful to the client. Charles often, however, addresses spirituality indirectly with all clients because of the personality traits he associates with addiction such as selfishness and self-centeredness. He uses spiritual concepts to expand clients’ thinking beyond themselves.

I do use some spiritual concepts that point out how through substance abuse, they’ve [clients] developed a “me-centered” world as opposed to an “anything-but-me-centered” world. You know, then you kind of end up being forced to use spirituality in that sense.

Charles sees the nature of addiction and spirituality as intertwined in treatment because a counselor is "forced" to help an addict shift her or his self-focused reality, which fueled their addiction, to a broader reality. Although Charles believes hypothetically that people can be clean and stay clean without having a solid, identifiable spirituality, practically he believes that the capacity for hope is connected to successful recovery, and for some clients that hope is developed through spiritual practice.

I think that hope is required for recovery, and if a person can sustain hope without having specific spirituality, or identifiable praying to something, if they can sustain hope without that, then it’s not necessary. But it’s really hard to sustain any form of overall hope or hopefulness.

Ultimately, Charles believes that a client's growth in recovery is undermined without hope and some form of sustained spirituality.

I do think that a person’s potential for growth and achievement is limited if they don’t have some form of spiritual connections or some form of spiritual direction. I don’t think it has to be defined, but again, I think their growth potential is only determined by their hope potential.

As stated, Charles takes a client-specific approach to spirituality in treatment, evaluating a client's attitudes about spirituality, and then broaching the subject if it appears that the client is open and amenable to it. Charles also stated, however, that he often addresses spirituality
indirectly with all clients because of the nature of addiction, and the characteristics of self-centeredness and isolation that result. Ultimately, Charles believes that most clients in recovery would benefit from cultivating a spiritual life. He believes that a client's progress in recovery stems from her or his capacity to sustain hope and faith, especially when recovery is slow and difficult.

Interview 2

Jack is a 60-year old European-American male who has been in recovery for over 25 years. He holds a master's degree in counseling and is a licensed professional counselor who has 15 years of experience in the field. He did not specify his theoretical orientation on the demographic survey. Jack currently practices in an outpatient facility with a primary focus on substance abuse treatment. Jack became sober through a 12-step program, and it was his affiliation with this program that began his career as a substance abuse counselor. A fellow AA person offered him a job. At the time, he held a bachelor’s degree and had worked for a few years in a "social work type" position.

Overall Meaning and Essence

When Jack began working with substance abuse clients, he said his employer provided him with little training.

They threw me a book. They threw me Yalom’s book on group therapy and said, "Go run groups." I had no group experience, and was like, "What?" And so, that was sorta how it started, and I truly liked it. I liked the clientele.

In retrospect, Jack said that he didn't like the therapeutic techniques that were in vogue early in his career because they were highly confrontative. Additionally, Jack’s early experience in recovery with a non-recovering, female counselor shaped his work with clients.

I got in recovery and met this very nice woman…she was trying to form a therapeutic relationship with me and she puts her arm on my shoulder and she said, "I think we’ll be
able to work together really well. I have a whole bunch of things I can teach you about addiction."

In response to the "nice" woman's earnestness to help him, Jack remembers thinking to himself that this woman had very little to teach him about addiction, especially because she had never been addicted. For Jack, it was an important realization that his counselor had an intellectual process and she understood much of the concept of addiction, but didn’t have the personal experience of recovery. Thus, for Jack, being a recovering substance abuse counselor comes from “a very personal” experience of addiction and recovery.

I believed as a counselor that I could take part of my experiences plus the way I interact with people and that I could turn that into something that would be beneficial to a bunch of other people. And so it was really coming from a very personal perspective.

The importance of having experiential knowledge of recovery (rather than “textbook” knowledge) is illustrated in Jack’s work with substance abuse clients. First, as a recovering counselor, Jack identifies with his clients: “I don’t view myself as being particularly different than my clients.” Jack identifies with his clients from the "personal" place of his own recovery, thus he has no need or desire to embrace the role of a professional "expert” treating addiction. Jack attempts to establish egalitarian relationships with clients.

I believe that counseling is a face-to-face, as close to equals as possible experience. I don’t want to be placing myself way above the client, with the client populations that I work with.

Although Jack emphasizes his personal experience of recovery, he does not devalue the importance of education and applying professional training to the treatment of addiction.

I was glad that there were a couple years of some kind of experience as a counselor. I was glad that at least there was a degree behind me to remind me and teach me a little bit of what ethics were, because the drug and alcohol field back then was pretty loose.

Jack talked about his early recovery by stating, “I really bought the hook, line, and sinker of the 12-step program.” A basic premise of the 12-step program is that if a person works with
those who have drug and alcohol problems, he or she needs to understand drug and alcohol problems through personal experience. Jack now realizes that education and professional training are as valuable to him as having been through recovery.

Jack, however, still strongly believes that “there still seems to be a value in having some kind of a personal experience with addiction and working in the addiction field.” He considers personal experience to be the “selling point” with clients because “it’s one more experience that you can use positively with the client” that creates a bond with the client. Jack also suggested that one’s personal experience of recovery can “be used negatively with a client” if one resorts to telling the client “war stories.” According to Jack, “That’s not therapy. That’s not counseling. That’s me at that client’s expense and I think that’s a thing that the counseling field has been so nervous of for so many years.”

Jack has observed that the counseling field has “gotten far away” from the use of personal experience with clients because of “psychiatric influences.” According to Jack,

Psychologists have been in a special position for a number of years in that they can treat clients with chemical dependency issues but they don’t have to get certified. The assumption is that they’ve learned enough through just their formal education.

Jack contrasted the treatment perspective of psychologists to that of counselors, obviously preferring what he deems the perspective of counselors.

There’s a different perception. I have never had a desire to be a psychologist. I see them as being a lot more formal, a lot more removed from the client…and dealing a lot more with an intellectual process as opposed to what I would loosely term as a recovery process.

In working with recovering people, Jack makes use in counseling of his recovery experience and professional training: “When I got involved in starting to work with recovering people, there was both a personal kind of bond and an ability to, I think, take what I had learned professionally in school and use it.” Over the years in working with both “blue collar people”
and professionals, Jack has discovered that “people are people, basically, and they’re not particularly different, and yes, they’re very workable.” He currently works with many clients who are court ordered into therapy. When these clients walk into his office, he stated that their goals are not the same as his.

   My goal is to try and encourage them toward abstinence. To try to develop some different mechanisms for coping with life and their goal is to get the legal system off their back or their wife off their back or whatever.

In such instances, establishing a therapeutic alliance according to Jack is critical with resistant clients, so that one can find common ground with them.

   In addition, Jack stated that he enjoys the work of a counselor because it is something that he can’t “master.”

I never found anything that I couldn’t master. I ran restaurants. I ran some businesses. As soon as I learned what I thought all there was to learn about that and there wasn’t anything else to learn, I got really bored with it, and rapidly just ended it. One of the things I’ve discovered about counseling is you never master it.

The challenging work of counseling Jack experiences as “exhilarating” and a “motivating” force in his life for “good.” One of the primary reasons Jack has remained in the counseling field over many years is that he gets to see people recover and go on to live fulfilling lives. The hope that clients can actually recover from an addiction has sustained Jack in his role as a recovering counselor.

   And I think, maybe the important thing about it, that has kept me in the field, is that people with addictive disorders can actually recover, then go on, and have really great lives. It’s different than if you’re a schizophrenic. It’s different than many other diagnoses for people.

In conclusion, Jack stated that being a recovering counselor comes from a "very personal perspective" of addiction and recovery. Jack values having a personal connection with recovery and readily draws from his experiences to benefit others. Early in his recovery, Jack realized that
non-recovering counselors had an intellectual understanding of addiction and what was missing for him in their counseling was the lived experience of addiction. Jack's lived experience of addiction and recovery provides him with the tools to understand, identify with, and empathize with clients. As Jack said, his recovery is "the selling point" with clients and it is something he readily draws upon to establish trusting, productive relationships with clients.

In discussing the meaning of being a recovering counselor, Jack also gave voice to tensions in the substance abuse field between non-recovering and recovering counselors. He feels that the "personal experience" component of addiction counseling embodied in the recovering counselor is being replaced in the field with a formal, highly professional approach to substance abuse treatment. Jack feels at odds with this "new" approach as a person with a recovery history because this "new" approach negates the need for recovering counselors in the field. Although Jack recognizes the importance of education and training for substance abuse counselors, especially in terms of ethics, he believes that having firsthand knowledge of addiction and recovery is valuable for both counselors and clients.

Self-disclosure

Jack identifies his recovery status to clients in the beginning of treatment so clients have a choice to work with him or not. He is uncertain about whether self-disclosing one’s recovery history to clients is an advantage for counselors or is an advantage for a client. He believes, however, that it “opens up the possibility of forming a therapeutic relationship on other than just knowledge, but the experience also.” Jack attempts to build an “as-close-to-equals” relationship with clients "judiciously" using his own experiences, especially when it could be helpful to the client. His intent is to "normalize the process" for the client and "move it away from being a
textbook issue.” Jack’s attempts to normalize client experiences may involve referencing his past.

Oh, I’ve been there and it was directly as a result of being drunk all the time and being out of control, and whatever, and strangely enough, in 25 years of not drinking or whatever, the police don’t come to my house…and because of that, because you and I aren’t different, the difference between us is I’m not drinking right now.

Jack’s use of self-disclosure has changed over the course of his counseling career. At the beginning of his career, he said there “weren’t any limits” in self-disclosure because his “boundaries were probably very bad.” Working at inpatient facilities, he said that it was common practice for counselors to self-disclose “a chunk of your life story at a focus group and then to see what kind of discussions it would prompt. And if I remember correctly, it actually did prompt a lot of discussions.” In reflecting on these events, Jack stated that self-disclosure “was not the potentially very negative thing that it has been made out to be,” but concedes that it was unfortunately “overused” by counselors.

Currently, Jack uses self-disclosure “a lot less” than he did early in his career. If he self-discloses with a client, he stated, “It might be a minute sound-bite or something, or two-minute sound bite out of a 55 minute hour. And that would generally be it.” Jack uses self-disclosure “to remind them that I’ve been there,” which he believes is sufficient information to earn the client’s trust. Jack believes that trust in the therapeutic relationship is built on what he termed “the common thread of experience,” that is addiction, and which both counselor and client share. He bemoaned that this “common thread of experience” is “the part being pulled out of the drug and alcohol system at this point” because the field has become less supportive of self-disclosure.

Jack’s use of self-disclosure involves communicating to clients that he personally understands and has experienced addiction and recovery. For example, if a client asks him, “What would you know about being drunk?” Jack, “without getting totally carried away,” would
say, “Well gee, I probably spent about 11 years in that state.” If his client asked for a specific example of a time he got drunk, Jack said, “I might give them a specific example, but I really, truly would try not to.” Generally, Jack self-discloses enough information so that the client is aware that he is in recovery, without revealing specific details and events of his past. He said, “Unless there was some kind of a reason to do that, they don’t need to know all of the details of my life and they’re probably not interested.” And in some cases, the status of his recovery would be irrelevant. For example, if he were counseling a couple, their marital issues “may have nothing at all to do with the fact that I do a lot of addiction counseling or that I’m a recovering person.”

The main question Jack asks himself in determining whether to self-disclose is, “Is it going to be helpful for a client?” As a recovering person, he said the he could “get into telling stories without any problem for days and days and days.” According to Jack, “storytelling” in this sense is neither productive nor beneficial to the client: “Because it’s their time. And because although it’s possible that they can learn from my experiences, it’s still not their experiences and they’re the ones that are paying.”

Jack reported that he has given clients more than a "sound bite" about his life when he felt it was warranted with a client. In the case example below, Jack disclosed more detailed information about his past, hoping his revelation would be beneficial to the client. This particular male client was “testing” Jack for months, revealing many “dark” secrets to see if he "was going to be horrified by what they were telling me about.” Jack suspected that his client was waiting to see if he “would dump him” as a client after learning all of his dark secrets. Jack reassured the client that: " All of us, everyone in the world has a dark side, everyone has those
things that they don’t disclose to anybody else.” One particular issue for the client involved domestic violence. Jack told the client a personal story about the “very end” of his addiction.

I was just furious raging all of the time. And a lot of that was directed at my wife. And one of the things that finally drove her out of the home was, in the midst of one of our many arguments, I started chasing her around the house and she ended up with a broken toe in the process.

Jack said that his self-disclosure "really seemed to make a difference" with this client, as it helped the client by normalizing his experience and helping him to "figure out how to deal with it.” One of the primary reasons that Jack may share more details about his life with a client is to help the client feel a sense of universality connected with their own behavior.

In sum, Jack self-discloses less often to clients about his recovery than he did in the past, perhaps giving them a "sound bite" that he's in recovery. In self-disclosing, Jack draws on the common thread of experience he has with the client to earn their trust. Although Jack generally gives clients a "sound bite" about his recovery, he is aware that other counselors may view his self-disclosures as inappropriate or excessive, “perhaps using it too much in various people’s opinions.” In regard to other people’s opinions, he says, “I sorta really don’t care about that. I care about working with clients.” Jack's words suggest a tension between other counselor’s perspectives on self-disclosure and his own actual work with clients. Ultimately for Jack, working with clients involves: “Trying to tune to whatever’s going on with the client so that they can get the best out of what is being offered. If that means self-disclosure then that’s fine.”

Countertransference

Jack said that the reality of being of substance abuse counselor is that “a portion of my clients will go and die.” For Jack this reality often leads him to want to overwork: "to want to do too much, push too hard, do whatever with clients. And mostly they’re pretty good about
reminding me that they will work at their own pace.” Jack stated that he “reacts kind of strongly” to clients who perpetrate abuse on their spouse or children: “A fair number of people under the influence that have children, abuse them…I say to them that I have a really low tolerance for any kind of abuse.” Jack tries to not bring “his personal stuff” into therapy with clients, but acknowledges that his own personal issues, in this case his relationship with his son, may surface with abusive clients. Jack was using substances for the first seven years of his son’s life and as a result: “There was emotional abuse that went on in the home. I don’t believe that it was physical. I’ve never had any verification from my wife that it was physical. But I do react kind of strongly to that.”

When a client reveals that they have abused their spouse or child, Jack becomes “upset” and “immediately kicks into problem solving mode” in an effort to manage his countertransference, which may inevitably cause him to avoid exploring these issues more deeply with clients. He stated that he might ask himself, “What am I going to do to stop that?” He usually says to the client, “Yeah, we need to keep talking about this. We also need to set up a quick plan of what’s going to happen.” To understand and manage countertransference around abuse and other issues, Jack will consult with colleagues: “I will go and get one of my colleagues and do some peer supervision right then about what’s going on and get an objective opinion.”

**Spirituality**

Jack views spirituality as separate from religion: "It is not a religious, necessarily, experience. It is just a belief in something that is greater than you, whatever it is." He believes that clients need "to be able to kinda tap into that power, because by themselves, I think addictions are more powerful than most people." According to Jack, an addict must not only come to terms with turning one's life over to a higher power, but also reach a point where
they say, “I need your help.” He stated, "Truly, one of the most significant components of addiction to me is the isolation" and the feelings of disconnection from themselves, other people, and spirituality. Thus, he encourages clients to consider that there "might be a power greater than themselves, whatever it is, that might be positive, and what have they got to lose by trying that."

Jack believes that "Spirituality is a very strong component of the counseling process." According to Jack, a spiritual practice provides people with a medium for change, recovery, and "rebuilding" their lives. He thinks that most addicts "Have so violated whatever the basic beliefs that they started out life with, that there is – for want of a better word – a moral bankruptcy." To Jack, spirituality "offers people a way of beginning to rebuild that and change it and own up to who they are."

As clients develop "a belief in something," Jack said that it often leads them "back around to some kind of religious experience." He emphasized that he does not "push" religion onto clients, and that "it is completely client driven." If a client asks him, "Do you believe in God?" he may say, "Yes, but my personal beliefs are my personal beliefs" without referencing his own religious background. However, he would not hesitate to discuss with a client his experience of how spirituality helped his own recovery process.

Although Jack thinks that ideally clients should develop a sense of spirituality, he doesn't believe that spirituality is necessary for people to be in recovery: "I think that the only thing that is necessary for people to develop a recovery process for themselves is abstinence." Anything else beyond abstinence, such as spirituality, he believes has potential for helping the process, for speeding the process of recovery.
To succinctly summarize Jack's thinking on spirituality and substance abuse treatment, he said that "Addictions are more powerful than people." He sees people in addiction as profoundly isolated, disconnected from their faith, and without a moral compass to guide them. Thus, Jack believes that clients must tap into something greater than themselves in order to recover, reclaim their moral bearing, and rebuild their lives.

Interview 3

Linda is a 52-year old European-American woman who has been in recovery for 22 years. She holds a master's degree in social work and has 9 years of counseling experience at the master's level. Her theoretical orientation includes solution-focused therapy, cognitive-behavioral therapy, and a strengths-based approach. Linda currently practices at an inpatient substance abuse facility.

Overall Meaning and Essence

In the early years of her recovery, Linda resisted becoming a substance abuse counselor because she was deeply involved in the substance abuse community at the time.

I always said I don’t want to work; I never want to work in a treatment center. Never, never, never do I want to do substance abuse counseling. I’m in recovery and my husband is in recovery. I go to meetings, you know, most of the people I deal with in my personal, my social life, are in AA and NA and I don’t want to do that.

Although she did not want to work in substance abuse counseling, she said that “My higher power had me do it.” The majority of her jobs over the years have been in the substance abuse field; a fact that she finds “entertaining” and comical given her strong resistance to the idea.

Linda's recovery influences her work with clients by giving her "A lot more understanding of the trials and tribulations that people go through." Her intimate knowledge of addiction fosters empathy towards clients and shapes her approach to treatment. Coming from a
“strengths perspective,” she firmly believes that "If I can do it, then they can too." This belief in one's own healing ability arises from her personal healing in recovery. Within a "strengths perspective," she sees clients differently than they see themselves, as successful people rather than as "failures" because "They have survived so much trauma already." From such a perspective, she "Supports them and encourages them and normalizes what they're going through." She will say to clients, "Yeah that's really tough, but you can do this" and mean it with sincerity because she "knows where they've been."

Linda expressed that her primary task as a substance abuse counselor is to "instill hope." Linda said, “And I think that’s my job, because if they can just have a little tiny glimmer of hope, then they can do something.” She said of her clients, "When they come in (to treatment) they have no hope. This is the last straw, some of them have been here multiple times." Her hope and positive outlook on recovery are often expressed in counseling through the use of laughter: “I get them to laugh a lot. I spend a lot of time encouraging them to laugh.” The use of laughter in her work with clients originated in her experience at 12-step meetings where she says, "We do a lot of laughing." Linda has discovered in the past 5 or 6 years that "there is some psychology tied in" with the use of humor and she finds that it is healthy and healing for clients in recovery. She says to clients, "You've been crying long enough. We need to laugh. We need to make sure you laugh every day at least once."

Linda indicated that she provides clients with “some ways of coping” with addiction and recovery that are practical given the time constraints of her work and having only a few weeks of counseling with clients. Her emphasis on helping clients develop coping skills she describes as mainly “psycho-educational with some process, but it is really more psycho-ed.” She explicitly tells clients:
There's no way we can resolve any of the issues that you've got. It's impossible. So what I would like to do...is give you something now that you won't get there (AA), which is some ways of coping with life.

Linda also specifically focuses on coping skills because it isn’t always addressed at meetings (AA, NA). She helps clients develop a “long laundry list” of what to do: “You go to meetings, you call somebody, you can help somebody to stay sober.” Thus, she said when clients feel “Stuck or they’re trapped, they feel like there’s no way out,” she tells them, “No, there’s a way out.”

Part of Linda’s experience as a recovering substance abuse counselor seems to involve hiding or minimizing her own recovery, except under rare circumstances discussed later in this section. She does not reveal her recovery to clients: “And I do not talk about my recovery. I don’t tell them I’m in recovery. I just don’t talk about it for multiple reasons.” Linda's experience of being a substance abuse counselor involves working with clients from two different angles, from her personal recovery and her educational background in counseling. She said, “You know, they say you have your own personal experience, but then you have all this education in substance abuse, you know, the research, the psychology.” She perceives each of these vantage points, her personal recovery and education, as helpful in the work she does. She stated, “And I think it’s good. And I think both the AA community and the substance abuse treatment community will benefit.”

In conclusion, Linda's recovery is salient in her work with clients through her treatment approach and her ability to understand and empathize with their "trials and tribulations." Linda works with clients from a strength-based approach, recognizing that they already possess the skills, strength, and resilience to recovery. As she said, "If I can do it, then they can too." Her optimism and hope that she instills in clients stems from her own success in recovery. Although
her recovery is the foundation for her treatment approach, Linda only occasionally self-discloses with clients. She views her recovery as "irrelevant" in what she is trying to accomplish with clients during their short stay in treatment, and thus keeps it hidden in most instances. Her treatment focus is "strength-based" and psycho-educational rather than 12-step oriented, which she stated lessens the necessity to make one's recovery history known.

**Self-disclosure**

Rarely does Linda self-disclose her recovery history with clients: “I really try to avoid that. I just don’t talk about it.” She feels that either way she "can't win" if clients are aware of her recovery status.

“If I say yes, then we're all gonna be talking about 12-step groups. And that’s what we’re gonna focus on, recovery. And if I say no, you all (clients) are automatically gonna say, You don’t know what I’m going through.” I can’t win, and so I don’t go there.

Linda chooses to not answer questions about her recovery status from clients, thus avoiding a "no-win" situation. She tells them that her past "is irrelevant" to the group by using the following analogy: "Ok, so, if you’ve ever broken a leg, are you gonna ask the doctor if he’s broken his leg before? You know, it’s irrelevant. You can learn things from people who have not had similar experiences."

Early in her career, Linda discussed her recovery status with clients and the result was that "Clients would try to have mini-AA meetings." Linda sees herself as "very strong on the AA tradition," and one of the tenets of AA states that people should not get paid for doing 12-step work. Linda believes that it is important to keep AA and professional counseling separate: "If I have somebody doing steps and I have them doing that, then to me, I’m blurring that line, you know, between AA and treatment." One of the primary reasons Linda refuses to self-
disclose is to maintain focus on clients' treatment goals rather than on AA steps, for which according to AA tradition she should not receive compensation.

An additional reason that Linda avoids self-disclosure of her recovery history is because early in her career she found that it would lead to "big, long war stories" about her life and addiction. She sees herself as a "storyteller…raised by storytellers" who would "sit around and tell stories." She recalled working with a group of adolescents and made the mistake of telling them about her past "war stories" rather than focusing on their own treatment.

Linda's use of self-disclosure today is much less frequent and more treatment-focused than it was early in her career. There have been occasions in her work when she chose to self-disclose to a client to facilitate the therapeutic process. On one occasion, a man became a member of her group who had eight years sobriety at AA and then he relapsed. He came into group "pushing" her to talk about the 12-steps and disrupting the group. She spoke to the client privately about his behavior.

Look, I do know what you’re talking about. I’ve been sober from alcohol for this long, so I do know what AA is about. I understand the steps, I’ve worked them multiple times, but what I want you to understand is that you’re here for 14 days. I have an opportunity and you have an opportunity to learn some specific coping skills which you know as well as I do you’re not gonna get in AA.

She further informed him that what he would be getting in group "Is a lot of the same information (as in AA), but you’re getting that from a therapeutic angle." By self-disclosing, Linda was able to diffuse the situation with this client and afterward she said that "I didn’t have any more trouble with him."

Linda has also used self-disclosure to provide clients with hope. She told the story of a male client who was pagan and who "Hated going to AA because they were too religious in his mind." She sat down privately with the client and told him about her recovery: "I just want you
know that I’m pagan and I’ve been sober for 21 years. So you can do this. I mean, I want you to know that it can work for you because it worked for me.” Linda felt that she used self-disclosure "appropriately" given that the client felt reservations about attending AA because of the religiously themed steps. Linda said that the occasions that prompt her to self-disclose involve client’s “narrowing their options” in treatment.

To me, in order to have the hope, they gotta have options, and if they start saying, "Well I can’t do it because of this, and I can’t do that because of this," and they start narrowing their options, so that’s primarily why I self-disclose.

To summarize Linda's use of self-disclosure, first, early in her career when she shared personal information with clients she found that it either led to "mini-AA meetings" or her telling "war stories" from the past. Today, she generally refrains from self-disclosure with clients because she believes it is irrelevant to her work and distracts clients from their own treatment process. On those infrequent occasions when she chooses to self-disclose with a client, she does so to facilitate treatment goals and to instill hope in the client if she or he feels "stuck" and are unable to make progress in treatment.

**Countertransference**

After her father died, Linda noticed that she became angry with certain clients: "I was getting mad. And it was coming out and I would snap at them, and it was just not therapeutic at all." She said that these clients were self-absorbed: "And they could do no wrong. And it's everybody else's problem. They were very demanding. They would put other people down. You know, they always wanted to bring conversation back to them." Linda would find herself engaging in what she termed "power struggles" with these clients, particularly with male clients who were controlling: "I was getting into power struggles with them. I was confrontational, you know, I was arguing. And part of it was, I just didn’t know any better. And I hadn’t had enough
training." At that point in her career, she felt unable to "Work with it or use humor to deflect or do redirection" and instead would get angry. She would say to the client, "Ok, this needs to stop" and then a "power struggle" would ensue.

Linda stated that she's the type of counselor who "Uses supervision if I'm doing something wrong." That is, in order to manage her countertransference reactions, Linda seeks supervision and explores with her supervisor what might be happening to cause a reaction in her. In one instance, she approached her supervisor and said, "God, you gotta help me. I can't do this. This isn't right." Her supervisor said to her, "Well, all of the people you are having trouble with are narcissist. You probably have to get a handle on this because it isn't appropriate. You are not helping them, you're creating problems." Approximately six months after talking with her supervisor, Linda became aware of where her anger originated: "All of a sudden it hit me that these guys were just like my brother and my sister…the total disregard for anybody else, total focus on themselves." Linda said that after her father died her brother and sister were unkind to her. She stated, "They were total jerks…total assholes. I mean, just horrible…it was a nightmare." Once she recognized that her anger with certain "narcissistic" clients was connected to her relationship with her brother and sister, "It wasn't an issue anymore." Over the years, she has been taught through supervision how to better manage situations with clients, and has learned that power struggles "are a waste of time." She noted, however, that "I still don't like narcissists, but I'm surrounded by them all the time."

Today, when somebody is "getting under" her skin, Linda says that, "I have to stop and say, Oh there’s something going on with this person.” Linda is fascinated that countertransference still arises for her in counseling with certain people and personalities because:
I’ve been sober for this long, I should be able to do this…I’ve been in counseling this long….I’ve got two master’s degrees. And it’s just ridiculous. I’m a human being and I’m a screw-up."

Ultimately, she recognized that counseling substance abuse clients is challenging by stating that, "It’s a learning process."

**Spirituality**

Linda developed her own spiritual practice in recovery through AA. Prior to that time, she didn't consider herself to be particularly spiritual or religious. She considers her spirituality to be non-religious: "I am a non-Christian, non-Jew, non-Muslim, which in the dictionary says I’m a pagan. More earth religions but no religion really. My favorite place to pray is out in a tree."

Her own spiritual practice allows her to be open-minded about religion and spirituality and to encourage her clients "To be very open too." Linda believes that her openness to various religious beliefs and practices stems from her past.

Because of my upbringing…and being married to a man with very strong religious beliefs…and going through my spiritual journey of learning what I believe, and how to express that belief, I can sit and listen to fundamentalist Christians talk and I can listen to pagans. I had one guy who was a Celtic shamanist, and it allows me to be supportive of all of it.

Linda has observed that when clients come for treatment that "they have pretty rigid ideas about what’s right and what’s wrong, and the way people should be." When this happens, she says that she gets close "to tripping up and self-disclosing," because she wants to quote AA literature. As stated, she encourages her clients to be open-minded about religion and other people's religious beliefs. To illustrate her point, she described a client group that consisted of three pagans and four fundamentalist Christians.

I just love challenges. It was so much fun. Because I was negotiating and navigating…And it turned out to be a really good group, you know, because it opened up
everybody’s eyes. I mean, it was a constantly, “Well wait a minute, you pagans, listen what they’re saying,” and “You Christians, listen to what they’re saying. You know, it’s a manner of learning how to respect other people’s different beliefs and ya’ll don’t do that well.”

In keeping her groups spirituality and religiously inclusive, Linda has had to limit the discussion of religion among group members. She's had clients who were "very fundamentalist" come into group stating that, “Oh, I got saved Sunday,” and then wanted to "convert" others and exclusively talk about religion and Christianity. She stated that "The more these guys would try to come talk about religion in my group, the more I would limit the discussion" by redirecting the conversation. Often such clients have found encouragement and support for their fundamentalism in the facility where she is currently employed. In reference to the facility, she says, "Unfortunately the facility [she works at] tends to be very Christian focused…and I've been jumping up and down about that." Linda believes that spirituality in treatment should be inclusive rather than religion-specific.

Linda believes that spirituality played an important role in her own recovery: "And for me, if I hadn’t had had this spiritual piece, I would’ve been in trouble." She also stated, however, that "I don't think it's [spirituality] absolutely necessary" to recovery because "Everybody does what everybody has to do in order to make it work." In other words, she believes that each person's recovery is unique and thus does not require a spiritual framework or spiritual guidance for recovery to be successful.

Overall, Linda sees spiritual exploration in recovery as a valuable process for clients, but not "absolutely necessary" to actual recovery. She admits that she would have been unable to sustain recovery without it. Her approach to spirituality with clients is to foster open-mindedness and tolerance for different spiritual perspectives. Essentially, she hopes that clients,
if they are open-minded, can draw upon spiritual principles from various traditions to support their recovery.

Interview 4

Paula is a 55-year old European-American female who has been in recovery for 27 years. She holds a bachelor's degree in psychology and has 23 years of experience in the counseling field. Her theoretical orientation is solution-focused therapy combined with narrative therapy. She currently works in an outpatient substance abuse facility.

Overall Meaning and Essence

After recovery, Paula was not interested in working in the substance abuse field, however, she majored in psychology because the person who helped her the most in recovery was a non-recovering psychologist who she "wanted to be like." She stated that substance abuse counseling is something she just "fell into," reiterating that: "It wasn’t something that I really wanted to do. And I avoided it for five years after I got my bachelor’s degree." Her initial ambivalence about becoming a substance abuse counselor has continued, as today Paula seems to feel somewhat conflicted about the significance of her recovery to counseling clients.

Paula minimized the importance of her own substance abuse history in working with clients.

For me it would be like if I was a doctor, if I were recovering from any type of medical disease and working with people. I don’t really attach that much importance to my own recovery history to what I’m doing.

The "doctor" analogy Paula used to describe her role as a recovering substance abuse counselor implies that a doctor treating a sick patient is simply a doctor. She does not need to have suffered from the patient's medical condition to successfully treat that condition.
Although Paula downplayed the importance of her own recovery in working with substance abuse clients, she also recognized how her recovery has benefited her work with clients: "I have been working with addicts and alcoholics for about 20 years… and my personal history of addiction has helped me out tremendously and helped them [clients]." Paula stated that her own history of addiction has helped her to develop more understanding and patience with addicts and alcoholics: "Helping them to find a way out of the turmoil they keep repeating for themselves, because I’ve been there and I’ve done that." Paula has been an addict; therefore she intimately understands addiction and is able to identify with clients, connecting their turmoil to her own. She knows "The type of guilt and shame, the internal conflicts, that addicts and alcoholics generally experience, as well the denial and all those defense mechanisms that are employed to keep the addiction going."

In discussing how her recovery history has enabled her to compassionately understand and empathize with clients, Paula returned to minimizing the significance of her recovery by stating that she doesn’t have "complete understanding" of addiction and recovery. She compared herself to non-recovering counselors: "I've worked with some wonderfully gifted people who are not recovering from any type of addiction who work with addicts and alcoholics and I don't really see any difference in the work that we do." In praising non-recovering counselors, she denounced certain recovering counselors: "I've seen some very detached, harsh, cruel recovering substance abuse counselors." In her statements, the "doctor analogy" is evident as she asserts that "recovery" from an addiction is not a necessary precondition to work with clients.

Paula's recovery facilitates a greater willingness in clients to open themselves up and reveal the most intimate details of their lives to her. Paula has observed that clients "Seem to feel more at ease in self-disclosing some really difficult issues, like sexual abuse or prostitution,
even in homicides they’ve been involved with.” She stated that clients working with recovering counselors "Assume that you've done the same things…so they feel, sometimes more at ease, I believe, in disclosing very intimate details of things that have happened to them."

Paula believes that substance abuse clients quickly connect with counselors "that appear to be caring and listen with an open heart." She stated that these therapist qualities are crucial in working with substance abuse clients: "Addicted folks have just been so wounded in their lives and have so much shame and hopelessness at times, especially when they first enter treatment, that they immediately, kind of, connect with an open heart." Paula believes that any counselor can have an "open heart" with substance abuse clients (not just those in recovery), however she has observed that clients seem to feel more at ease in self-disclosing highly personal information to recovering counselors. During the interview, Paula told the story of a female client who she helped by having an open heart and being in recovery.

It was because I understood where she was coming from with guilt and shame and being a woman and being addicted to drugs, and that she felt like it had helped her maintain abstinence, even in between those times that she relapsed.

It is interesting to note that in the interview Paula seemed to distance herself from being a recovering counselor, but then also subsequently embraced it in stating that her recovery is helpful in working with substance abuse clients. It seems as though for Paula both recovering and non-recovering counselors can work with clients on substance abuse issues in effective ways, which involves having an open heart and connecting with them on a personal level, but perhaps that recovering counselors have a slight edge in that substance abuse clients tend to more easily trust recovering counselors. Paula also indicated that her personal history of addiction helps her to have more "understanding and patience" in her work with addicted clients. In conclusion, there seems to be a degree of ambivalence for Paula regarding the importance and
impact of her own personal history of addiction on her work with substance abuse clients, and
this ambivalence seems to permeate the overall meaning and essence of her experience as a
recovering counselor.

Self-disclosure

Early in her career, Paula used self-disclosure frequently because, as she stated, "I used it
as a way of not knowing how to do anything else." She recalled that self-disclosure was a
common practice in the recovery field 20 or more years ago: "That was the only thing we had,
was our recovery history, because of a lot of us didn't go to school, we didn't know what
techniques were in those days. That was the technique." Self-disclosure was both a tool and
method of counseling clients when Paula entered the field, and thus she relied on it for lack of
professional counseling training.

Currently, Paula uses self-disclosure sparingly. She primarily uses it as a therapeutic
strategy.

I'm very choosy about the times I use disclosure. I want to use it as a therapeutic
strategy, and not just a – and I’ll think about it, and I say, “Oh what’s this going to do for
impact?” And sometimes I use disclosure as just my last kind of tool in the toolbox.

The temporal shift in relying less on self-disclosure today occurred for Paula because of
pursuing additional education and training in counseling, and because of negative self-disclosure
experiences she had with clients, especially male clients.

The problems that arose early in Paula's career with the use of self-disclosure were that
inpatient male clients used her personal information as a tactic of "manipulation," discounting
her authority in the role of a counselor, and making negative assumptions about her identity as a
woman in recovery.

Certain clients [men] get the wrong idea about recovering women and recovering women
counselors. The recovering women they know have been involved with prostitution,
have been involved in an assortment of things, so they just assume that any female in recovery is easy game, for later, whatever games they want to play.

Thus, for Paula, part of the problem in self-disclosure was that male clients construed false assumptions about her as a woman and her sexual availability. In addition, Paula experienced dismissive treatment and direct hostility from male clients because of her recovery.

They used that as a reason in the group to discount everything I said, basically with the attitude, that well, “You’re just like us. What do you know? You don’t know anything.” But they even got a little more hostile as the process went on and I literally had to leave the group because I was feeling so threatened.

Paula concluded from these experiences that it was not safe to self-disclose with clients, especially male clients: "And I don't think it's safe, especially for women, to self-disclose in a group in a building where there's no protection." Avoiding self-disclosure became Paula's strategy of self-protection and feeling safe in her work. At one time, she primarily worked with dual-diagnosis clients, including anti-social personality disorder, in inpatient treatment. She did not use self-disclosure with this client population.

In order to protect myself and to protect the client, and not get into too much countertransference, I’ve learned that using self-disclosure with my recovery history has not been a really positive thing. It’s harmed, I think, the therapeutic process, more than it has helped it.

In the past, when Paula self-disclosed her recovery history to clients, she stated that, "It would end up being somehow manipulated by the clients to meet their own needs. They would remind me of something I had said about myself and it would catch me off guard."

Professionally, she realized that her clients were not benefiting from self-disclosure, but instead were "learning how to use it to manipulate, to get their needs met." Personally, Paula felt uncomfortable with self-disclosure because, "It felt too much like being known as a counselor on such an intimate level" with clients. From those experiences, she became more self-protective and private about her past life, and selective in the clients to whom she self-discloses.
Paula will therapeutically use self-disclosure on occasion with clients whom she feels safe with, such as clients with professional occupations who are primarily female without a clear history of pathology. She currently runs an outpatient group, primarily with female professionals and will sometimes use self-disclosure to connect with the clients and normalize their experiences. For example, if a client complains about working in a department store because they can't practice their profession, Paula will say, "Oh yeah, when I first got into recovery, I had to work at a clothing store and I worked at a flea market and I cleaned houses…” Through self-disclosure, Paula instills hope in her clients.

“It’s OK, it’ll pass. You’ll get back into your field again if you stay clean.” So I use it to give them hope that their lives will change. And I think that’s how I use self-disclosure now, as to say, “Ok, look at me, I went through that, and it’s different now. It’s better.”

To briefly review Paula's use of self-disclosure, early in her career she frequently self-disclosed with clients. She did so for two reasons. First, because self-disclosing was a "common practice" among recovering counselors at that time. Second, Paula self-disclosed often with clients because she didn't know what else to do in counseling sessions because of a lack of training in professional counseling. Paula learned over time that self-disclosure was particularly problematic with male clients who were overtly sexist in attitude and behavior toward her. Specifically, male clients were disrespectful toward her in challenging the legitimacy of her knowledge and authority as counselor, and at times were outright hostile and threatening because of her recovery status.

Today, Paula uses self-disclosure much less frequently with clients, considering it to be the last "tool in her toolbox." Her strategic use of self-disclosure is generally with professional women in recovery. In self-disclosing with these women, Paula attempts to reduce the shame professional women feel about their lives, for example, being unemployed or working at a dead
end job. As a final point, Paula's self-disclosure of her recovery is a statement of hope to women that they too can successfully recover.

*Countertransference*

Paula experienced what she termed countertransference with a female client who fought chickens against other chickens. Paula stated that the client "did not like me from day one" because of Paula's judgmental attitude toward her.

I’m sure she could see that my judgment was coming out, because I’ve always kind of seen myself as an animal activist. And I hate dog fighting. I hate chicken fighting. I hate bull fighting. I hate anything like that. I hate it.

Paula asked her supervisor to take this client off her caseload but her supervisor said “no" and instead encouraged Paula to keep working with the client to "figure this stuff out." Paula thought that she needed to get out of counseling because, as she said, "Why should I be working with these types of people who are mean and hateful and cruel and working my own stuff out with them?"

Paula recounted one particular experience with this female client that changed the nature of their relationship. The client became angry with Paula for suggesting that she would not be able to recover from her addiction until she stopped fighting chickens. Paula said to the client,

I don’t see how you’re going to stay sober and fight chickens at the same time, because there’s always a lot of drinking at the place where you’re fighting chickens, that’s what you said. And there’s a lot of dealing of cocaine and using cocaine, amphetamines.

According to Paula, the client retorted “You’re just a hypocrite, you’re just a hypocrite. How dare you kind of judge me for fighting chickens and you eat chicken, and the way those chickens die, it’s just horrible." Paula realized in this encounter that her judgment of this client was a barrier to productive counseling and eventually discovered common ground with the client.
Yeah she’s right. I mean, there’s something wrong, there’s something wrong here, there’s something wrong because I eat chicken that are killed in a factory horribly, and she fights them, so we’re doing the same thing on a level. On some kind of level, I’m engaging in some type of chicken-killing process, and so is she.

Paula apologized to the client, concluding afterwards that her interactions with this woman helped her to grow as a counselor: "It was very good because at that time in my career I didn’t want to think of myself as being wrong as much with clients." As a person in recovery, Paula often saw herself as superior to substance abusing clients.

Even with the bottom line, with my image as a recovering counselor who could really join with the client, I always had this, still, kind of one-upmanship with the clients that was there. Like, I am at least two steps ahead of you guys. I’m right, you’re wrong.

Paula felt that she didn’t know how to ethically work through the "one-upmanship with clients," because she did not have good clinical supervision.

In the instance described above, Paula attempted to manage her countertransference with this client by first asking her supervisor to re-assign the client to another counselor. After her supervisor refused, however, Paula was forced to work through her reaction by directly interacting with the client, and to the extent possible, resolve their differences. She also used self-reflection and self-evaluation to examine her own belief system in the context of her relationship with this client, and this allowed her to be more understanding and flexible, thus allowing her to reduce her level of reactivity in relating to the client.

Spirituality

Paula identified her spiritual beliefs and practices as a "mixture of Christianity and Buddhism." She stated that "the older I become, the more it plays a role" in counseling clients. Paula believes that spirituality is an important component of recovery. She believes it is difficult to work with clients without a sense of connection to people or things outside of themselves.
It’s a challenge to work with someone who doesn’t have any sense of spirituality, any sense of spirit within them, because they are so isolated sometimes within themselves that they’re just not connected to other people, animals, the world…It’s real hard to get them connected to something when there’s an absence of spirit, of some type of human spirit within them.

Paula views addiction as a manifestation of a lack of spirituality. She stated that she has a difficult time reaching clients who lack spirituality: "Some of the folks don't see any reason to get better or to change. When they stop existing then life stops existing. So why not drink and drug right now. There's no reason to get clean." According to Paula, clients without faith in something larger than themselves lack meaning and hope in their lives, which would provide the impetus for change and recovery.

Paula is currently working on how to assess spirituality with clients and broach the subject "without scaring them or without insulting them," because the 12-step program is "all about spirit, connecting, spirit and faith and hope and meditation and prayer and believing in something that you can't see." In her current employment setting, she doesn't have the time to fully address or explore spirituality with clients.

We talk about it, but it’s something that has to compete with techniques and cognitive types of practices that tend to be more scientific in nature, I guess, and methodical, than trusting something like the human spirit, or God, or something like that.

Within Paula's employment setting, the emphasis in treatment is on changing a client's thoughts and behavior rather than examining more humanist-existential concerns of life's meaning and purpose.

In conclusion, Paula views spirituality as vital in recovery, as the means by which substance abuse clients heal through finding a new engagement with life and a greater sense of connection to the world around them. Although Paula verbalizes a strong commitment to client spiritual development, the treatment goals where she works and time constraints undermine her
efforts in this realm. In the end, she wishes she had more time and freedom at work to encourage and support client exploration of spirituality.

Interview 5

Lance is a 54-year old European-American male who has been in recovery for 28 years and 10 months. He holds a bachelor's degree in English literature, is completing a master's degree in counseling, and has 23 years of counseling experience. His primary theoretical orientation is cognitive-behavioral therapy. He currently works at an inpatient substance abuse facility.

Overall Meaning and Essence

Lance's experience as a patient in an inpatient treatment facility where he was subjected to "excessively harsh" and "essentially dehumanizing" treatment has informed his work with substance abuse clients.

I really felt almost like a human rights victim. There was very little warmth, very little genuine personal concern…They were excessively harsh, excessively contrived and essentially dehumanizing in how they treated people…And I was so fragile at that time that I actually had a nervous breakdown and had to be sent to a psychiatric hospital.

Lance interprets this experience as "a gift from a higher power" that showed him if one is going "to treat human beings for human psychopathology, you really ought to try to be humane about it and not try to subject them to systemic requirements that don’t take into account how they feel or respond." He stated that this experience, "Definitely affected my approach, in that I would never dream of treating anyone that way if I could possibly avoid it." For Lance, one of the major issues in working with clients for a substance abuse counselor is "to engage in treatment in ways that are warm and genuine and caring without being, you know, sorta naïve victims of these people when they get manipulative at times."
The meaning of being a substance abuse counselor for Lance has changed over the years. He stated that, "Initially the meaning of it was really substantial to me in the sense that it meant I was pursuing a vocational calling that had a lot of spiritual meaning." He views the early years of substance abuse counseling as a "spiritual experience" especially because of his involvement in "AA, the 12-steps, and the AA community," which for Lance was akin to being "a passionate member of a church or a faith." During these early years he was able to "enjoy the experiences of recovery while making a living doing what he liked most." In retrospect, he believes that he had a "naïve enthusiasm about it earlier in life," which later gave way to "a bit more cynical edge as a middle aged man, and as somebody who has probably lost more fights than he has won."

Lance's past experience in managing an addiction rehabilitation facility changed the meaning and experience of being a substance abuse counselor. He became more cynical about the substance abuse field and doing substance abuse work as a result of this position.

It really sorta lurched away from any kind of sense of spiritual meaning into more, kind of a socioeconomic combat. It became a different kind of experience altogether for me. It became more of a competitive business practice. It became more of a ‘let’s be better than the other guy, let’s do better than this other center, let’s evaluate people according to some kind of hierarchical standard.’

In the process of managing a rehabilitation facility, Lance lost touch with why he became a substance abuse counselor and the spiritual meaning he attached to this vocation because his new position required more focus on the financial aspects of running a successful treatment facility.

Lance was eventually fired from this position due to internal conflict among staff and as he stated, "making enemies." He used words such as a "bit devastating," "difficult for me," and "a major loss" to describe his reaction to being fired. He believes that the reason he lost the position was due to "not having either the credentials or the training to do that, and as crises
began to develop…” He believes that he would have been more successful in the position if he had formal education in addictions counseling and treatment.

And I’ve always felt that if I had done the professional education thing, rather than the personal recovery thing…If I had more academic and intellectual backbone, less in the way of openness of heart and spirit, that I actually may have done better managing those types of situations.

In his comments, Lance identified a split in the addiction field between formally educated (non-recovering) counselors and less-educated (recovering counselors), with the latter having stigma attached. He feels that his recovery and having what he calls "openness of heart and spirit" was in part a professional liability that led to losing his job.

A reoccurring theme throughout the interview with Lance was his feelings of self-doubt and ambivalence attached to being a substance abuse counselor.

Well, I have to confess to a certain element of self doubt, that sometimes, I think in my career as a recovering counselor, is a consolation prize, that I could’ve been more and better, and should in fact now be even more and better than I am.

Lance feels the stigma of being a substance abuse counselor, as perhaps a position lacking professional clout in his mind and a position below his aspirations. For Lance, the discrepancy between his self-image as a substance abuse counselor and his ideal/desired self results in feelings of self-doubt and failure.

Lance has also experienced a shift in the meaning of being a recovering counselor in his attitudes about abstinence.

My personal history of addiction, it has always been about complete abstinence and that I have pretty particular allegiance to a complete abstinence model in my own recovery. I'm not so enthralled with that professionally anymore, though, and I think there are exceptions that can and should be made for people with pain problems, chronic pain problems or people suffering medical emergencies, or people who have psychiatric complications that really are tangible and measurable.
Lance went on to state, “So I'm not a complete abstinence Nazi by any stretch of the imagination. I think a lot of people probably coming from the origins that I do, are.” In this final phrase, Lance pointed out that most recovering counselors would hold very strongly to the abstinence model of recovery, but that his beliefs are different. Again, he seemed to be expressing some ambivalence about his identity as a recovering counselor and was distancing himself from the commonly held stereotypes of that group.

Part of Lance’s experience as a recovering counselor involves an awareness of his physical and spiritual energies and how they have somewhat diminished over time, as well as currently varying when working with clients.

There's always been a kind of attitudinal zest that I have when I'm feeling spiritually enlivened. And when that comes across, I think the clients have a lot of respect for me and interest in me and join well with me.

He believes that there is something "real" about the use of spirituality in counseling even thought he can't "Measure or quantify it or subject it to any kind of positivist measures. It's an important aspect in how I feel about myself and how I see clients." Lances reported that in the past 10 to 15 years that experiences of true connection with clients “have been less intense and probably more rare,” because he has used more “skilled clinical interventions” with clients.

I do think as one becomes, sort of, more professional in one’s orientation, something of your ability to kind of have raw, human connections gets lost. And I think that those (in the past) were probably more raw human connections than skilled clinical interventions.

Lance told the story of working with a young male client early in his career and literally holding him in his arms while the client wept in his office. He said of the client "I think he just needed someone to hold him like a child for about 15 minutes and let him weep about his parents and his family." Lance discussed his more effective work with clients by stating,

With people that I understand their dependence and their personality and their character structure, it's really a matter of eliciting from them the motivation to make changes and
helping them recognize that they have that, and encouraging it once it begins to sort of unfold and embody itself, encourage that, support it, reinforce it.

In conclusion, the meaning of being a substance abuse counselor for Lance is complex, fraught with disillusionment and ambivalence. Early in his career, Lance felt vibrant and enthusiastic about his work, viewing it from the 12-step paradigm as a "spiritual" endeavor. Over time, Lance became more realistic and eventually more cynical about his profession because of the reality of treatment centers that operate according to a business rather than "human" model of treatment. He believes that he lost a job as director of a treatment center because of being oriented to the "human" model of treatment as a recovering counselor with an "openness of heart and spirit." Lances seems to think that his personal recovery is detrimental professionally, especially without advanced education and training. However, Lance observes that as a counselor becomes more skilled in human interventions through education, and ostensibly more successful in the field, that therapeutic relationships lose "spirit" and depth of human connection.

What is the most striking about Lance's interview is his feeling that being a recovering counselor is a "consolation prize" in life. Lance believes that he should have accomplished more in his life professionally. Being a recovering counselor is not what he intended or imagined for himself, and is certainly not the top "prize." And yet, his personal recovery set him on this professional path, and at least early in his career he was passionate about his work. Having been in the substance abuse field for over 23 years, Lance seems somewhat soured on the profession of being a counselor.

Self-disclosure

Lance primarily uses self-disclosure to provide clients with information about solving problems, specifically using his own life to illustrate how you can apply basic recovery skills to
situationally manage events and conflicts and experiences.” According to Lance, “Ninety-nine percent” of his self-disclosures involve giving clients information on how he solved problems in his life using basic recovery skills. He stated that “Those are the narratives I tend to use in my counseling. That’s the kind of storytelling I want to do, evidence of solving problems.” Examples of the content of Lance's self-disclosures for the purpose of problem-solving include:

This is what I did when my girlfriend walked out on me. This is what I did when my boss said I wasn't working hard enough and humiliated me in front of my colleagues or this is what I did when I really wanted to do things that sober people don't ordinarily do.

Lance is willing to reveal intimate, detailed experiences from his past as illustrations for how clients can cope with their recovery and make changes in their lives. In addition, Lance is aware that there are "varying degrees of usefulness" in self-disclosure, stating that it is more useful with adults rather than adolescent populations.

In reflecting on his counseling career, Lance stated that he self-disclosed to clients "with a certain amount of pride" in the sense of "Yeah, I solved that problem and if you want to know how I did it, I'd be happy to tell you.” He believes that clients prefer to work with a counselor who has solved the problem of addiction through recovery. He stated that, "Clients are not looking for expertise, they’re looking for an alliance with someone whose confidence is practical and that they can trust on the recovery level.” Thus, Lance believes that substance clients value counselors not for their expertise and training per say, but for their practical and personal knowledge of recovery.

Lance emphasized the "terrific clinical impact" of self-disclosure with a client because "A client knows you've been through what you are trying to help them get through." Thus, there’s an automatic deeper level of trust the client places in the counselor because of their self-disclosed recovery. Lance has observed this phenomenon in treatment facilities where
recovering counselors had a therapeutic advantage over their non-recovering counterparts. He said that the clients at this facility “Had this sort of instantaneous trust for you, whereas if they knew you weren’t recovering, they had this sort of instantaneous suspicion of you.” Thus, according to Lance, self-disclosure of one's recovery can provide the therapist with “clinical capital that shouldn’t be wasted.” Lance cautions that a recovering counselor should “Have a sense of discretion and judgment because it’s not something you want to wear on your sleeve,” suggesting that one must consider the therapeutic impact of self-disclosure. He said that self-disclosure should not be "a matter of show or demonstration," because clients do not "universally approve of or accept" recovering counselors. Thus, self-disclosure, according to Lance, should be used with discretion as a "key" to reaching a client and helping them problem-solve.

Lance's use of self-disclosure has “changed contextually more than chronologically” over the course of his career, depending on where he was employed. For example, he has worked in treatment centers who only hired recovering counselors: "Everybody already knew that if you were their counselor, you were in recovery…So there wasn't a lot of point" in identifying one's recovery. In other employment settings, Lance said that self-disclosure was “expected.”

They want to know how long and they want to know for what, so it’s not just a matter of disclosing that you’re in recovery…It's like, ‘Are you in AA or NA? Have you been sober for 3 years or 12 years?’

In contrast, Lance has worked at treatment facilities that discouraged or didn't permit self-disclosure with clients. Lance firmly objects to these policies: "If the client asks me a question, I feel like I should be able to answer it generally speaking.”

Lance believes that his non-recovering co-workers may view his use of self-disclosure “As an unfair advantage of some kind, and they may be right for all I know.” Although being a
recovering counselor brings with it clinical capital, Lance made the point that being in recovery is not necessary to the work of counseling addicts.

You know, I have never felt that, you know if I was going to have brain surgery that I would want the surgeon to have had a tumor just to do the brain surgery, which is kind of a common refrain.

He stated that he does not "have any value judgments about it one way or the other" as to whether recovering counselors work more successfully with addicts than non-recovering counselors. Thus, he believes that both recovering and non-recovering counselors can work effectively with addicted individuals, but seems to believe that recovering counselors may have a slight edge in being able to establish trust with substance abuse clients.

Lance generally refrains from self-disclosure with "Anti-socials, borderlines, or people who are somewhat suicidal." With these clients, Lance said that self-disclosure "isn't about recovery," it is about the therapist and he personally does not want counseling "to turn into a biographical questionnaire about" himself. He views self-disclosure as "irrelevant" with these clients and as not useful "to the level of care that the person clearly needs."

In citing an example of when self-disclosure has been effective, Lance told the story of a client with whom he formed a close relationship: “We became so close in fact…maybe some ethical red flags went up, because I was his age and I’d been sober 27 years and he was my age and had been sober like 7 days.” Lance revealed intimate details of his life with this client because “There was almost a generative quality for his knowing that I was in long-term recovery.” Lance believed his main strength in the therapeutic relationship was his long-term recovery. In the therapeutic relationship with this client, he perceived it to be one of equals.

We really helped each other as equals in the therapeutic relationship…He had really achieved some substantive things in his life. But he hadn’t achieved any sobriety. And I kinda helped him move along that path. And he actually, in some ways, was encouraging
me to do the things like going back to school, which I subsequently graduated from and got into graduate school.

Lance stated that he had resigned from his position at the treatment facility with the encouragement of the client who was still in treatment.

In conclusion, Lance seems to see self-disclosure as a powerful tool that should be used by recovering counselors, but in a judicious manner. He indicated that he has used self-disclosure throughout his career in order to help build trust and a strong working alliance with clients, as well as to help give them coping strategies for obstacles they may face in their own recovery. Lance seemed to feel that self-disclosure should be reserved for clients who do not demonstrate Axis II pathology or suicidal behavior, as such disclosures will be useless and potentially counterproductive.

Countertransference

Lance stated that countertransference arises when he makes judgments about clients before having assessed them.

It is possible actually to start building a litany of complaints about these clients because they’re poor, or because they’re uneducated, or because they have spent so much time in jail, or because they can’t tell the truth to anybody.

Lance connects the judgments he makes of clients to his own family-of-origin dynamics and addiction experiences.

It has to do with, you know, a lot of experiences in my own family system, which were just really dysfunctional parental behavior. But I also think it has to do with countertransference from my own drinking history and being around people, who not only they were bums, but took pride in it.

Lance manages countertransference with clients, in particular those who reveal information that is “painful” or “painfully offensive,” by remaining “therapeutically neutral.”
His practice of neutrality in therapy he views as akin to the work of the Truth and Reconciliation Commission in South Africa.

When you’re listening to people who are talking about mass torture and mass murder. But they did that knowing that, if that truth wasn’t told, that those horrors were gonna be repeated, and they were really trying to put an end to them. And so, I mean, I guess that’s a place I have built in my listening self that I can go to, to witness the atrocities as a way of giving them witness, bearing witness.

For Lance, therapeutic neutrality is built into his practice of listening, as a way to allow the truth to be told without judgment by simply “bearing witness.”

Lance stated that countertransference over the years has “strangely become kinda like a positive thing” because he experiences “human reaction to these human beings.” For Lance his own reactions give way to what he terms a "deeply human place."

There’s a more human or deeply human place underneath us that bears witness to their demands, whether it’s the unabated criminal depravity of human beings, thinking we’re out to slaughter each other, or whether it’s the sort of, miracle of surviving the madness.

He concluded that when he is having a “positive countertransference reaction” that he is, Helping history to prepare its battlegrounds and slaughterhouses by being in that and listening to the right ear and bearing witness to a point now that people have gotten through it. And breathing today, let us be grateful for all.

Here Lance seems to be equating witnessing human suffering with neutrality and “positive countertransference reactions,” and seems to be communicating that simply offering a space to share painful experience can and is healing in and of itself.

Lance identified positive countertransference as “Rare in addiction recovery, but when they occur they’re prominent. And I’ve noticed that in inpatient settings, they’re shared.” He equates this experience with someone “biting your gut.”

Because the client has suffered something so similar to what you’ve experienced…and I have felt myself, in listening to men confess about humiliating things that have happened to them, either through sexual abuse or physical abuse…just sitting there, cringing at the humiliation, remembering something like that from the past.
Lance’s spirituality underwent a change similar to the shift in his career. He said, "In the beginning, in my 20s and 30s, there was kind of a naïve enthusiasm about God. And, that’s deepened, as I’ve gotten older, especially in my 40s.” Today, his spiritual approach is about “deepening” his humanness and “trying to connect with other humans in that, in that depth of humanness.”

This “shift” in spiritual perception and practice affects his work with clients by reminding him that “addiction is a human problem.” His view of addiction in the spiritual sense is that addicts are profoundly suffering.

These are all human beings suffering, regardless of some pathologically insane things that they may have done or may be thinking about doing or might be doing openly. That they’re usually humans that have lost contact with the core, and aren’t about to get it back without someone caring about them.

Lance views human connection on a spiritual level as a key ingredient in treating addiction and bringing people back in touch with the core of their being. Furthermore, he believes that when he feels “spiritually enlivened” then “clients have a lot of respect for me and interest in me and join well with me.”

Lance stated that spirituality is a complex issue for him in recovery in part because of his own personal and intellectual complexity: “So I guess my spirituality is kind of hooked up to an almost intellectual complexity and I know a lot of people discourage that, but that’s just who I am and how I do things.” He stated that most clients who know him “Would tell you that, that it has been very difficult for me to keep it simple. So I don’t. I keep it complex. But that has made life interesting for me.” Lance stated that on occasion he has “Opened up to clients intellectually, and let them see what’s behind this sort of substance abuse counselor” revealing the depths of his spiritual thinking.
Interview 6

Jim is a 51-year old European-American male who has been in recovery for 18 years and 6 months. He holds a bachelor's degree in social psychology and has 16 years of counseling experience. His primary theoretical orientation is client-centered therapy. He currently works at an outpatient substance abuse facility.

Overall Meaning and Essence

Jim views his own experience with addiction as the catalyst for his work with substance abuse clients.

If it wasn’t for my own experiences with my own addiction, I probably would’ve never ever been in the field to begin with…I was trying to get out of something and the only thing I had other than my own technical experience that I could fall back on at that particular time in my life was my own recovery.

Jim’s entrance in the substance abuse counseling field came about because of his substance use, and having recovery as the only other experience he could use to build a career apart from the profession he left.

Jim experiences a conflict in his role as a recovering counselor in that he sees his recovery status as helpful clinically, but as a complicating factor in dealing with other professionals. Jim succinctly identified the conflicting experience of being substance abuse counselor by stating, “I see it as a plus when working with patients. Unfortunately, it is still a negative when I’m dealing with other professionals.” Personally, Jim views his recovery overall as being helpful in treatment: “My own recovery issues have helped me more than it has hindered me. But I have to use it as a tool, just like any other tool.” He uses the “tool” of his recovery primarily to build relationships with clients: “The way that I’ve used it effectively is to connect with the individual.” He stated that substance abuse clients are often “shame-based and
on top of that, they’re scared” and thus rapport building is critical to therapeutic success. Thus, Jim sees his tool of recovery as therapeutically effective:

> Any tool that I could have, plus or minus to where I can connect to a person, to kind of get them to either hear what I’m saying and integrate it, even if they’re just as rigid and angry as they can be, you know, is an effective tool.

In essence, Jim’s recovery experience has enabled him to “meet the patient where they are at,” and discern the needs of the client in the moment. In this process Jim identifies with what the client is experiencing.

> Having gone through the experience myself it is easier for me to identify most of the time…where that particular person is in receiving whatever it is that he or she is supposed to be receiving at that particular point in time.

> In other words, his recovery provides a reference for how to respond to the client and facilitate change. He may use self-disclosure in “meeting the client where they are at,” especially if a client is “struggling” in recovery.

> When I look at an individual and see them struggling, it is sometimes very helpful for me to relate it back to something that happened in my recovery, to say, "Yeah, you know, I had an anger problem early on and I couldn’t see it, you know, and until I was ready to see my anger issues, there was no amount of individuals beating me up about my anger issues that was gonna get me to take a look at it."

> Although Jim views his recovery positively as an asset in working with clients, he concedes that “Unfortunately, it is still a negative when I’m dealing with other professionals.” At the time he entered the counseling profession, he found that “Recovering therapists were kinda frowned upon” and the “party line” from the field was that “You can’t teach them anything.” Jim stated that the “learned guy” (non-recovering counselors) perceives recovering counselors negatively, asserting that, “Them recovering guys, you can’t train them. They think they know everything already. They don’t listen to any of this stuff. They’ve got no formal education.” Such narratives about recovering counselors likely leave Jim feeling at odds with his
profession, which he feels devalues and stereotypes those counselors in recovery. Furthermore, Jim expressed concern that people like him, recovering counselors, are a “dying breed.” He believes that, “Substance abuse treatment is probably on its way out, that somehow it’s going to be turned into behavioral therapy, it’s gonna be normalized and be more clinical than it is.”

Jim discussed the tension between recovering and non-recovering counselors that stems from philosophical differences in how to best serve and treat substance abuse clients. He said that in actuality the effectiveness of non-recovering and recovering counselors is the same, although each asserts differently

The recovering counselors were saying, "You can’t possibly be as good as me. You’re not in recovery. You haven’t been in my shoes. You don’t know where I’m coming from. You guys get this stuff from a book.” The textbook guys are saying, “But I’ve got all this training. I’m a real live therapist. You can’t possibly be doing any of this stuff. You know, you don’t know the fancy words and you can’t give me the people that invented it and all the other stuff that goes along with academia.”

It seems for Jim that part of his experience as a recovering counselor involves a focus on the tension between recovering and non-recovering counselors and a slight ambivalence about being a recovering counselor, which originates from this tension within the field. Aside from the politics of the substance abuse field, Jim believes that his recovery is a "plus" in working with clients. He uses his recovery as a "tool" to build rapport with clients who are willing to listen to him and trust him because of his recovery status.

Self-disclosure

As stated, Jim became a therapist in the midst of heightened tension between non-recovering and recovering counselors, at a time when self-disclosure was discouraged.

Self-disclosure, if used at all, was used at a very, very minimum...Generally it was a no-no. It was just something that therapists didn’t do. And if you did it, it was like, your motivation was called into question by other counselors.
Early in his career, Jim rarely self-disclosed to clients “Because it was seen as a sin. I mean, it was literally.” When he did self-disclose, he soon realized that “It didn’t seem to hurt anything in the therapeutic process,” but instead, “It just got the staff all worked up because it was us against them kinda stuff that was going on, back and forth.”

In retrospect, Jim “never regretted” self-disclosing with past clients and believes advocacy of non-disclosure is an issue that is “More of the therapeutic staff’s issue than the patient or client’s issue.” For example, when he would self-disclose, for whatever reason, it was not uncommon for a "Non-recovering clinician to come to me afterwards and say, thanks for sabotaging my therapeutic alliance with that particular group or person.” He said, “To this day, you know, whenever it comes up, it’s the us against them…It seems to be more of a professional issue than it does to be a therapeutic issue, at least to me anyways.”

If clients ask Jim a question about his recovery, Jim is cautious in self-disclosure. He stated that he often follows up a client’s inquiry with his own question: “And what’s your need to know?” He seeks to understand the client’s motivation for asking the question. If a client has what he believes to be a “preconceived notion” of a recovering counselor, he says that it “really isn’t in my particular best interest at that particular moment in time” to self-disclose. Thus, based on a client’s response, he decides whether to self-disclose or not.

I’ll make the decision on whether or not I will answer the question. I’ll make the decision on how I should answer the question. But I always base it on what I’m getting back from the particular patient or the group itself.

Jim uses self-disclosure if clients are asking him “healthy questions, and they’re inquisitive kinds of questions” or if he’s discussing a particular issue and wants to illustrate a particular point using his own experience to help clients problem-solve.

If I’m giving a workshop on shame or if I’m giving one on fear or if I’m giving something on picking a sponsor I might say, “This is what the process was like for me,
and here’s my stuck points, and this is the problems that I had. Maybe you’re having some of the same kind of problems.”

When Jim self-discloses with clients about his recovery, it generally involves an effort to build rapport, open-up dialogue with clients, and help clients problem-solve.

In noting an instance when self-disclosure was particularly helpful, Jim told the story of an affluent, well-educated client who was in his office because of a second DWI “with a very significant BAC.” The client was uninterested in counseling and gave Jim very little to work with therapeutically. At the end of the client’s mandated assessment, Jim says he self-disclosed to the client about his own personal history and also confronted the client by stating:

Look, here is what my gut tells me. I think that you have a significant problem and I think that your intelligence is getting in the way. You are rationalizing it, you’re minimizing it, and I’m used to minimizing it.

Then, three months later the man returned with another DWI asking for Jim’s help:

“Please help me. I can’t do this anymore. I’ve been lying. I lied to you.” Later, Jim asked the client why he returned to his office and the man said, “Because of that little thing you told me at the end…I sensed that you really cared because you’d been there.” Jim’s use of self-disclosure became what he termed “the bridge” for the client’s willingness to engage in therapy.

Jim said that often self-disclosure of his recovery history is unnecessary with clients because he lives in a small town: “I include 12-step facilitation and encourage folks to go to AA meetings and NA meetings…I’m in a really small town, really small…it’s just a matter of time before they run into me.” In addition, Jim said that half of his clients “when they walk in the door, know me.” He said that he can tell very quickly if a client recognizes him.

You can see it in their eyes. I can instantly tell that of the 50% that walk in the door, 50% of them are actually relieved because they recognize me and it’s like, “Ok, I know Jim. I’ve seen him around. I like his recovery. I’m in a safe place.” Others will go, “Oh man.” They’ll do exactly the opposite.
In conclusion, Jim is guarded in his use of self-disclosure with clients for two primary reasons. First, Jim said that he became a counselor at a time in the substance abuse field when self-disclosure was basically forbidden. Jim disagrees with this pronouncement against self-disclosure and has been admonished for self-disclosing to clients by other non-recovering counselors. Jim has observed and been a part of ongoing tensions and disagreements between recovering and non-recovering counselors over this issue. Second, Jim is cautious in self-disclosing his recovery history because clients may hold negative stereotypes of recovering counselors and thus would not be amenable to treatment with him. Although exercising restraint in self-disclosure, Jim follows his own internal guide using self-disclosure at appropriate times to build relationships with clients and to help them problem solve in recovery.

Countertransference

With regard to countertransference, Jim said, “It has been a long time that I’ve had anything that actually, cognitively has come up for me to say, ‘Oh that’s my particular issue.’” In looking back through his career, he recounted the story of a male client who reminded him of a past client who had committed suicide: “This particular client in group was doing the same kinds of stuff and saying the same sorts of things that the person who earlier had committed suicide.” During a group session, the client “said something or did something…the connection was definitely there between the guy’s suicide and the verbiage that was coming out of this guy’s mouth,” and Jim “went off.”

I got in his face. I was to the point where I was literally screaming at him. This went on for a good five to ten minutes, which was clearly, “It’s my stuff now,” coming up to where I gave him a wire brush and a verbal lashing that was just as shaming and as un-therapeutic as a verbal lashing could be.

Jim watched the videotape of the group session, and realized that during the session he was completely unaware that it was his issues coming up with this client. He said that lacking
awareness for when countertransference transpires is problematic because of the potential
damage that can be done to the client and the therapeutic relationship.

For me you know, that’s the stuff that we need to be looking at. When I’m aware of it,
OK, I can use it one way or another. It’s when I’m not aware of it, that’s where it can
become damaging you know.

He eventually sought professional help to confront his issues and feelings about his
client’s suicide. He sought out the help of a recovering therapist who he says “Was older, had
lots of education, board-certified psychiatrist, board-certified addictionologist, and in recovery
himself.” Jim self-disclosed to the therapist: “I was aware it was eating my lunch. I was aware
that it was affecting my work, and I needed to do something about it, and that’s why I was
there.” The therapist “normalized” Jim’s experience by stating to him, “It’s normal, it happens
to all of us.” For Jim, things “got better from there.”

Jim said that the best way to manage countertransference is to verbalize it in the “here
and now” and “take care of it” with other professionals. When Jim is feeling frustrated with a
client, he will express it in the middle of a “process” by stating to a client, "You know, this
resistance is really, you know, part of me wants to reach out there and just smack you on top of
the head.” Jim indicated that he works with a social worker who is surprised by his directness
and honesty with clients and will say to him, “Oh my god! I can’t believe you just said that.”
And he’ll say to her, “That’s what’s going on with me.” Jim was contemplative about his ability
to be authentic: “For some reason, I can get away with that,” adding that “Most non-recovering
counselors can’t.” In addition to communicating how he attempts to manage
countertransference, in this final phrase Jim again referred to the tension between recovering and
non-recovering counselors, a pattern that permeated his interview responses.
Spirituality

Jim identified himself as “an existential kind of guy” who’s “greatest awareness has come through my struggles.” In addressing spirituality specifically, Jim said that he can’t define spirituality because it is unique to the individual. Jim stated, "I can't define it. I don't know of any two learned people in the world that if they write the same definition down will come up with the same exact answer.” For Jim, spirituality is a personal “belief system” that defies definition.

Jim believes that clinicians must have "their own sense of spirituality" or “belief system” when working with clients, even if it is simply faith in the "therapeutic approach…that in itself is a type of spirituality.” Jim’s conceptualization of spirituality involves a person, either a client or counselor, having "faith in something."

Jim believes that the therapeutic enterprise is an exercise in faith and embracing a higher power because if clients "Don't have any faith in the therapeutic process, if to them it's a bunch of hooey, chances are really good that they're not gonna make any progress with it." In other words, for Jim a component of spirituality in therapy involves clients having faith that therapy will work. Jim stated that based on, “All of the research that I’ve seen says that there is no magic wand. No magic bullet. No therapeutic approach is any more effective than any other therapeutic approach.” Thus, according to Jim the success of therapy lies in the therapeutic relationship and the faith that the client has in the counselor and the therapeutic process.

In exercising faith, whether it is in therapy or something else, Jim said that clients "Must rely on something outside of themselves. They have to take that outside thing and they have to integrate it, somehow into their life." Therapy is that “outside thing” that the client must embrace and bring into the internal realm. Jim equated faith in therapy as akin to a belief in a
higher power. Jim defined higher power as "Something outside of yourself that you have faith in."

For clients in recovery, Jim said that clients must develop "Some sort of higher power like in 12-step facilitation or God or any of that stuff. Whatever works." In this sense, clients must find the spiritual path that is "right for them," as long as it includes a belief in an entity greater than themselves or what Jim terms a "higher power." Thus, the therapist's role according to Jim becomes one of offering “As much as you can possibly offer to them” spiritually, so that they can find a belief in something outside of themselves. As Jim stated, “Whatever works for them.”

Interview 7

Thomas is a 46-year old male who has been in recovery for 22 years. He holds a bachelor's degree in rehabilitation counseling and has worked as a counselor for 12 years. He referred to his theoretical orientation as eclectic. Thomas currently works as a substance abuse counselor in a prison.

Overall Meaning and Essence

Thomas stated that the essential meaning and experience of being a substance abuse counselor is to “extract some kind of positive meaning from the wreckage of my past,” which for him involved a family history of addiction. From an early age, he experienced emotional pain related to addiction.

I witnessed that kind of suffering…experienced it as an observer, experienced it as a victim of some of the actions and behaviors that come of it, and then ultimately became a victim of addiction myself. On a lot of levels, I experienced it.

The profound suffering of addiction on many levels that Thomas experienced led to working in the substance abuse field as he sought to make amends with the past and heal its “wreckage.”
Thomas’s intent to “exact positive meaning” from his past was shaped by participating in a 12-step recovery program and what Thomas called one of the "12 Promises": “We will reach a place in our recovery, we will no longer regret the past or wish to shut the door on it, and we will see how our experiences can benefit others.” After learning this tenet of twelve-step recovery, Thomas had a “eureka moment” where it became clear to him that “This is it. I want to go in and I want to help people.” Helping people in recovery became his life path, allowing the “wreckage of his past” to bring meaning and purpose to his life, and hope and healing to the lives of others.

Thomas stated that his experience of being a recovering substance abuse counselor has changed over time. In his early career, Thomas saw himself as being idealistic and “a bit more naïve” in terms of his “abilities or the answers that I might be able to supply somebody or the advice or the direction that I might be able to offer somebody.” Thomas described feeling “profoundly connected to addiction” at this time. He stated, “Addiction was my identity. The addictive experience, and that’s what I lived and breathed. Eventually I had to move beyond that.”

Over time, Thomas believes he has become “a lot more realistic and unfortunately, probably a lot more jaded as well” in his work. This shift for Thomas in his perspective and the experience of his work with substance abuse clients involves what he termed the “tenacity of addiction” and “the way society has responded to it.” Thomas now views addiction more realistically: "It is a really frustrating, frustrating illness to work with. I think more so than so many other illnesses whether they be mental illnesses or whatever, you know, the whole concept of denial just is really gripping.” He illustrated the depth of client’s denial, telling the story of clients with multiple DUIs who continue to deny any problem with alcohol. Thomas said of these clients, “This kind of absolute clinging to this belief system…This delusion and it’s so
obvious [their addiction]. That in and of itself is really difficult.” However, Thomas pointed out that his frustrations with client denial are muted at times by positive experiences working with substance abuse clients. He stated that “Some of the joy of working with this population is beginning to find the chinks and to disarm that and breakthrough that, and get into it.”

Another frustration for Thomas as a recovering substance abuse counselor stems from “The way society has responded to it. We’re not funding treatment.” Thomas observed that society “Continues to address addiction as a criminal justice problem rather than a health problem.” He witnesses the insufficient, inadequate treatment addicts receive:

I see that stuff and I get burned out and I get disgusted with it. And I work currently in a prison and I’ll see guys and women that are, clearly, all of their criminal problems are revolving around addiction.

For Thomas, this is the reason why substance abuse counseling is frustrating, difficult work because he is witnessing:

On a daily basis the destruction on the individual level. You have the individual who is suffering from addiction and you have that person’s children or wife or parents or whatever, and then the damage to the community. And when there’s no real support by society.

Thomas said that he sometimes feels like he is “working for the enemy” because as a society we do not “Offer meaningful treatment to the person, it just becomes a dog chasing its tail.” In his statements, Thomas qualified that his frustrations are not with the clients but with society’s response to addiction. He still enjoys working with clients: “As I said, that can actually be some of the fun stuff.” Thomas feels “camaraderie” with addicts:

I still love addicts. They’re crazy. Their denial is just off the wall. Their stories are beautiful. Their humor, I mean, I feel comfortable with them. Clearly, because I lived that life, you know.
Thomas feels a close kinship with substance abuse clients, identifying with their stories and their sense of humor, and thus feeling at ease in their presence. He stated that “Only another junkie is gonna be able to find humor in some of the experiences I’ve had.”

Thomas stated that his own recovery process has benefited his ability to work with others in addiction: “I hope I have the ability to see a little clearer some of the thought processes and some of the lies and games that we tell ourselves to maintain that delusion.” According to Thomas, to see addiction “a little clearer” requires not only recovery, but “serious work in recovery.” He said that “If anybody has done serious work in recovery, they’ve done serious work on themselves, and they’ve done real heavy introspection and examined their behaviors, they’ve examined their actions.” The process of introspection and self-examination has enabled Thomas to “recognize who the old person was and who the new person is.” This symbolic rebirth Thomas framed as a “gift” because a person can “Almost step out of yourself and witness what you’re doing…and view yourself in a much more accurate way. Recovery gives you that capacity I think.”

With the capacity to see himself in a clearer, more accurate way, Thomas is able to understand his clients, thus connecting his experience of addiction to their experience.

And I can remember some of the madness that I went through, and some of the thought processes, the denials, the rationalizations, the justifications, the substitutions, all of the games that addicts play. I went through them and I remember them vividly. And I can see it in others.

The insights Thomas has related to his own thoughts and feelings during his substance use and recovery provides him with an understanding of the “madness” of his clients’ experience. He believes that this experiential connection between a counselor and client “is a really important component” to substance abuse counseling.
Thomas qualified his belief by adding that he is not one of those stereotypical substance abuse counselors who “Believes that only another addict is capable of offering or providing services to someone with addiction.” He emphatically stated, “I don’t believe that.” However, he does believe “That there is something about the experience, that, it does provide” a deeper connection between a counselor and client. He illustrated his point by using an analogy of working with a veteran with post-traumatic stress disorder from a combat situation. He said, “There’s going to be a connection between someone that has experienced combat, talking with somebody dealing with that, than someone who hasn’t.”

Thomas has observed with clients a resistance to working with non-recovering counselors. He remembered his own early experience with recovery and feeling that “I couldn’t identify or connect with someone that wasn’t in recovery.” He believes that clients are going to feel more comfortable working with someone who has experienced an addiction because of feelings of shame associated with addiction. He stated that addicts know “pain and shame and humiliation on a first name basis,” and thus are “gonna know that they’re less likely to be judged” by a recovering counselor. He believes that discussing the “cracks in their armor, discussing their weaknesses, the ramifications of their behavior” will be “too painful to share with someone who hasn’t been there.” In other words, Thomas believes that clients will ultimately be more open and trusting with those counselors in recovery, regardless of the politics in the field of substance abuse treatment and the narrative that non-recovering counselors can empathetically reach and treat clients as successfully as counselors in recovery.

In conclusion, Thomas has been painfully familiar with addiction for most of his life, as a victim, an addict, and eventually a counselor seeking to heal from the past through helping others conquer addiction. Over the course of his career, he has become "burned out" in the field,
feeling extremely frustrated when he sees individuals not receiving appropriate or adequate substance abuse treatment. In terms of his clinical work with clients, Thomas stated that his recovery gives him unique insight into the typical thoughts and feelings of an addict. Thus, he sees himself as being able "to see more clearly" into the psychological experience of addiction than a non-recovering counselor. In reference to non-recovering counselors, Thomas contradicted himself by stating that he is not the typical recovering counselor who thinks that only someone in recovery can help addicts; however, Thomas then discussed how clients are more likely to feel comfortable with a recovering counselor because of a shared experience of addiction that lessens their feelings of shame and embarrassment. Thomas's own recovery history illustrates his point. He said that during his recovery "I couldn’t identify or connect with someone that wasn’t in recovery.”

**Self-disclosure**

Thomas self-discloses his recovery history with clients. Thomas stated that there are two main reasons that he is open about his recovery with clients. One reason stems from his experience of frustration as a substance abuse client in a "sterile" therapeutic relationship.

> I understand, you know, I understand in terms of therapy that we need to maintain a professional distance… But I think there can be a sterility and a clinical air to that relationship that just really -- it drove me crazy as a recipient of that relationship -- it just reeked as inauthentic and it lacked a human connection and it added to my inability to trust someone.

For Thomas, his experience of working with overly formal, detached clinicians felt alienating and superficial. Thus, in his work with clients, self-disclosing his recovery history provides a more immediate, authentic relationship with clients, which earns their trust.

> A second reason that Thomas is open with clients about his recovery is political in nature.

> I’m pretty open with my recovery, almost as a political statement… I also believe that in order for addiction to be recognized as a much more commonplace and treatable ailment,
there has to be more people that take the risk to acknowledge that I’m a recovering addict and put a face to it.

In the use of self-disclosure, Thomas humanizes addiction and puts a public face to the disease. He feels that the addicted population doesn’t “have lobby groups” or “anybody to come to their defense.” For example, Thomas told the story of fellow counselors “deriding addicts and alcoholics” whom he defended by reminding his colleagues that he’s an addict and an alcoholic.

Thomas currently uses self-disclosure but has reduced its use over the years.

I have to be careful with self-disclosure. When I first started working with people, I remember I would use it and I would catch myself telling them my life story and I would sit there and I would have to say, you know, whose benefit is this for? Thomas believes that “talking way too much” about himself stemmed from being fairly new in recovery where “there was a lot of ego involved.” He observes this phenomenon today with “young bucks” who have come in with the attitude, “I’m a recovering addict and it’s a badge of honor.” Thomas believes that this is a phase people in recovery go through. Thomas is glad he had the experience ”of being able to see myself doing that so I could pull away from it.”

When Thomas uses self-disclosure with clients today, it is in the interest of “exacting shared experience,” rather than telling clients his life story. Experiences he will share with clients include: “Struggling with fear, struggling with anxiety, or struggling with denial, or ‘A-ha!’ moments. That kind of stuff…methods of coping with craving. Methods of coping with obsession.” His goal for using self-disclosure in the therapeutic sense is to give clients “Something that they can grasp onto and possibly utilize for themselves.”

Thomas stated that the “majority of time” self-disclosure has been “beneficial” in working with clients: ”It provides them with a bit more comfort with the feeling of not being judged and with the opportunity to feel a little bit more open.” He said that he often asks himself about his intent for self-disclosure: “What am I trying to do here?” to weigh the potential
therapeutic benefits. Thomas added that there have been plenty of times when he chose to not self-disclose particularly in situations where he was not comfortable with the relationship developing with the client. He stated,

I needed to keep those boundaries real clear. And I felt that any kind of an additional, personal self-disclosure was gonna be misinterpreted by that person, so I had to be real careful about that.

As stated, over the course of his career, Thomas has reduced the amount of information he discloses to clients. Early in his career, he told clients his life story because, as he stated, his "ego" was deeply invested in his recovery and he was proud of the accomplishment. Currently, Thomas is forthright about his recovery with clients, but only shares bits and pieces of his life with certain clients as a way to "exact shared experience." In other words, Thomas reveals to clients how he managed tumultuous feelings in recovery such as anxiety and drug cravings. For Thomas, the goal of self-disclosure is to provide clients with information that may be useful to their recovery.

In conclusion, Thomas is a proponent of the selective use of self-disclosure in counseling. He directly informs clients that he is in recovery because he believes that it supports the therapeutic relationship. In addition, Thomas believes that self-disclosing his recovery to people in general is a necessary political act that raises awareness about the disease by giving it a human face.

Countertransference

Thomas described the experience of countertransference with a young male client who reminded him of his brother, an addict. Thomas stated that his brother, “Taught me how to shoot up when I was 14 years old, I think, and I had this mixed sense of idolization and hatred for this guy.” When working with the young man, Thomas said he felt “Rage, absolute rage…wanting
to smack the kid,” and thus was unable to work with him. He stated, “I mean, he just reminded me so much of my brother. I couldn’t do it. I just couldn’t work with him at all.” Thomas spoke to his supervisor about the client.

“Look, this guy, I got this stuff with my brother, and it’s unresolved,” and it brought up stuff that I had to begin to address again. I couldn’t work with the guy…I was beginning to blame, try and blame this kid, feelings of blame that I might have towards my brother or accusations, or all this stuff that I might be throwing at my brother, I wanted to throw at this kid.

In this instance, Thomas attempted to manage his own countertransference reaction by speaking with his supervisor about his own reaction, as well as distancing himself from this individual in the therapeutic milieu.

Thomas also described another experience involving a young male client who reminded him of himself at that age. He indicated that he had to be mindful of not over-identifying with this young male client: “I’m identifying with this kid so strongly that I don’t want to get to a point where I’m trying to develop a friendship with this kid.” As noted above, this client reminded Thomas of himself: “A lot of the qualities that I saw in myself when I was younger, you know, he had similar experiences when he was an adolescent.” Thomas stated that he wanted to reveal more information about his life to this client than would be prudent.

I found myself wanting to start using self-disclosure…I could have sat while this kid was talking to me going, “Yeah, me too. Yeah, I went through that. Yeah, I remember that.” I could’ve done that for an hour with this kid. It was fascinating.

Thomas decided in working with this “kid” to “hold back with the use of self-disclosure” and instead “pull the classic pose of just sitting back and nodding” his head to refrain from getting too close and developing a friendship with the client.
Spirituality

Thomas recognizes the importance of spirituality in recovery but also views it as “a double-edged sword” because clients are resistant to 12-step recovery.

I’ll try and introduce them to 12-step recovery just because I think that’s a pretty critical tool for someone to have at their disposal, and there’s no way to get around the fact that 12-step recovery is a spiritual path. It’s a spiritual expression. And inevitably, people have a lot of resistance to it because of that.

Thomas stated that he spends “a lot of energy trying to get people to look beyond that” by exploring the definition of spirituality with people and inquiring “what it means to them.” He often draws a “distinction between spirituality and organized religion,” and has the person come up with their own working definition of spirituality.

In essence, Thomas “simplifies matters” in spirituality by encouraging clients “To not get caught up in language…We’re just looking at something bigger than you.” In doing so, Thomas is asking clients to conceptualize, embrace, and surrender to an entity larger than themselves.

Again, it’s simplifying matters, like when I was talking earlier about removing the term “alcoholic” from the equation, you know, removing the term “God” from the equation. “Just look, let’s get that out of the equation, there’s something. What makes the tree grow? Who the hell knows? What makes the DNA go? All right, there’s something going on that’s bigger than you, just surrender to that.”

The role of spirituality in Thomas’s work has changed over time, mirroring his own personal spiritual development. Approximately 16 years ago Thomas experienced a “profound spiritual awakening,” that affected his work with clients: “I was coming from this place of non-judgment…and I really had this profound sense of interconnectedness and brotherhood with humanity, and really working at non-judgment, really working at suspending judgment.” In his current position, it is not as easy for him to suspend judgment of clients, and he finds himself getting disgusted a lot more quickly with some of his clients who have been “accused and found guilty of heinous, heinous crimes.”
I had a guy come into my office that repeatedly, ritualistically raped his daughters and had his wife partake in that and filmed it. And I’m trying to suspend judgment. And there’s a part of me that just wants to get up and choke this bastard.

In conclusion, feeling spiritually vital and compassionate for clients has lessened for Thomas over time because his current position puts him into contact with convicted felons. He struggles to be nonjudgmental and empathetic with clients on his caseload who have done great harm to others. Furthermore, Thomas said that he hasn’t had the time to devote to his own spiritual practice recently and thus it may be reflected in his work with clients.

Aside from Thomas's personal spiritual development and his reactions to clients, he values the role of spirituality in recovery, especially as it is expressed in 12-step recovery. He understands the 12-step program to be inherently a spiritual path that involves surrendering to a higher power. He has observed client resistant to any form or expression of spirituality contained in the 12-steps, and thus encourages them to differentiate between religion and spirituality, and develop their own understanding and meaning of spirituality.

Interview 8

David is a 66-year old European-American male who has been in recovery for 23 years. He holds a Ph.D. in counseling psychology and has 25 years of experience in the counseling field. He described his theoretical orientation as eclectic and cognitive-behavioral. David currently works in private practice as a psychologist and works with substance abuse clients on a regular basis.

Overall Meaning and Essence

David experiences the role of a recovering counselor as personally meaningful “in the sense of giving back” to others, which he said is “therapeutic in itself.” He stated, “When you’ve been through the experience itself, it adds another layer and dimension of meaning for you” in
For David, a client’s recovery process is “validating” to his own work in recovery. He explained how he feels validated using the following analogies:

For people that go through certain medical conditions, the amputees that help other amputees, or the sexually abused people that help other sexually abused people, there’s a sense of giving back in some ways that can feel particularly personally gratifying, I guess from that standpoint when it happens.

In “giving back” as a substance abuse counselor, David in essence reinforces and sustains his own recovery. Furthermore, David stated that there’s a spiritual aspect of giving back and extending himself “to someone who’s in need,” which is rewarding and deeply satisfying to him.

David feels that he “can bring a special contribution” to counseling substance abuse clients because of his own recovery. David described his recovery as “a rich reference” in guiding his work with clients because it provides him with “insight and sensitivity to aspects of the [recovery] process.” In working with clients, he draws on his personal experience at all stages of addiction and recovery: “Reflecting on my growing relationship with substances, the struggle that was encountered in it, the difficulty of ending that relationship…and the subsequent experiences of a sober lifestyle.” Thus, David, in referencing his own experiences, is able to recognize and understand a client’s “external behaviors” that are tied to the addiction and to “correlate a sense of the internal experience of what that could be” for the client. Understanding the “internal experience” of clients is the insight David draws on from his own recovery.
David’s own recovery professionally gives him a large degree of pragmatism and patience in working with clients. He stated that it facilitates his ability “To establish boundaries of what I can do and what I can’t do, and accept the limits of what my facilitation is gonna be.” In other words, his own recovery provides David with a realistic appraisal of “where the client is at” and how the therapeutic process will unfold, recognizing his own limitations as a counselor.

When David encounters resistance in clients, he doesn’t find himself getting angry but instead empathizes with the clients, “feeling sad” because “It is hard for them to recognize the destructiveness” of their behavior. He understands that for the clients “There’s a need for more encounters with painful events before they reach that place” where the recovery process begins. David’s professional pragmatism helps him to accept that some clients will not sustain recovery, and he indicated that this at times causes him to feel saddened. For example, he had two clients who recently died due to relapse. With regard to these clients he stated,

> It was the recognition of that being a potential outcome for those clients and feeling saddened that it had evolved that way, but recognizing that it’s also one of the liabilities of the process.

David’s recovery not only provides him with greater patience and pragmatism in working with clients, but also provides him with a “sense of connection” with what he terms “the common familiar struggle” of addiction and recovery. For example, with clients in recovery he stated that he connects with and feels "their sense of energy and hope and the real productivity of recovery.” He believes that without his own personal experience of addiction and recovery he might not feel “as rich a sense of empathy for what the people are encountering at that point.”

David’s orientation to counseling involves a “stages-of-change model” and he is able from his own recovery experience to know whether a client is “ready to make a change” and
embrace the recovery process wholeheartedly. David sees himself as “facilitating” recovery rather than producing it.

David also discussed the intersection of his own recovery experience with his formal education.

I'll have to say that the book learning and the education from that standpoint have been extremely useful and really helps a great deal. But my own personal experience woven in my mind at least in terms of how we conceptualize it and understand what’s going on with the client, I guess is the interaction I’m talking about.

That is, for David his personal recovery experience enriches and offers a new dimension to his work with substance abuse clients, which combined with his formal education, allows him to relate to clients, and at the same time have a deep understanding of their experience and their process of seeking recovery.

In conclusion, David relishes the role of recovering counselor, using his recovery to benefit others. For David, the meaning of being a recovering counselor is that his recovery is deeply significant to his work with clients, both personally and clinically. His recovery is a "rich reference" that he draws upon for insight, empathy, and pragmatic guidance in counseling. It is his recovery that connects him to the internal world of his clients, and helps him formulate interventions depending on what stage the client is at in their recovery.

**Self-disclosure**

David described his use of self-disclosure with clients as “really pretty low” in frequency, stating that he is guided by the rule that, “The only basis for self-disclosure is something that may be of benefit to the client. It’s not an opportunity for me to have a forum or a platform for me to talk about my own life.” When he does self-disclose, he is mindful of whether there would be therapeutic value for clients in his self-disclosure. He stated, “I want to keep the focus on them and their process.”
David is “selective” and “limited” in his use of self-disclosure, using it with clients for a numbers of reasons. David self-discloses with clients to either “Cement the relationship or emphasize the validity of some of the concepts that we’re talking about.” For example, he thinks that self-disclosure is especially helpful with clients who have an attitude of “I don’t want to talk to anybody who doesn’t understand.” For these clients, David believes that self-disclosure is therapeutically beneficial in forging a connection with the client and the client feeling supported in the therapeutic relationship: “It provides a sense of insight and empathy and a connection sometimes, you know, that I know wouldn’t be available to me at least if I hadn’t gone through the experience myself.”

David also uses self-disclosure to help clients understand recovery concepts and to instill hope in the recovery process. He communicates to clients regarding recovery, “It gets easier. That it’s more comfortable. That you don’t have nagging cravings and wishes and those kinds of things.” In revealing his own recovery status, he is helping clients understand that in their own recovery there will be changes: “A real shift in how you see yourself…it’s a change in identity that becomes comfortable, that you’re not an alcoholic whose trying not to drink, you become a person who just doesn’t drink.” His own life illustrates this point, and he thinks that this helps clients believe that “Life can be richer without it.” In this sense, self-disclosure instills hope in clients, especially those who according to David are at “A particular juncture where it is really tough for them or it feels like there’s a dead end to it or there’s no hope.”

In self-disclosing, David does not “go into tremendous detail with it” in his efforts to build relationships, illustrate recovery concepts, and instill hope. David noted that since his focus is on the client and their process, if therapy is going well and the client is making changes, then he doesn’t see the need for them to know his recovery history. Although David’s use of
self-disclosure is low, he thinks that some clients suspect that he’s in recovery. Clients have said to him after there was a self-disclosure “Well, I sorta guessed that” even though David had not revealed that information prior. David likely communicates his recovery status to clients indirectly through his insight into addiction and his ability to empathize with client’s struggles and resistance.

When asked if he self-disclosed more often early in his career, David said, “That’s a good question. I mean, my hunch would be I might have disclosed more before than I do now.” David felt that earlier in his career he may have said too much about his life to the client. He reiterated during this conversation that he is very “sensitive” to the issue of self-disclosure, especially because he has clients that have “been to other practitioners where it seemed they abused that.” Out of this awareness of counselors “misusing” self-disclosure, David is “extremely selective” in his use of self-disclosure, gauging at a particular moment in therapy, “What’s the point that you’re going to make here that may be of benefit to them?”

David told the story of a female client whose divorce and custody battle experiences in some ways paralleled his own.

She’s one of the few people where I disclosed more about my own experience as a way of buttressing her hope…When I divorced with a young child, my acts at the time were brought up as part of the court issue that I was an alcoholic and should be deprived the custody with my child.

David strongly empathized with this client, summing up the emotional cost of the situation: "And that’s really difficult. There’s a real sense of helplessness with it. There’s a real sense of victimization with it that can take place." David offered encouragement to the client, reframing recovery for her in a positive light.

It feels like you’re getting hit over the head for being an alcoholic, but there is an enormous difference between being an active alcoholic and recovering one, and your
sobriety is really the tool that will be best used, even in the court system, to be able to retain custody of your children and provide a strength, not a vulnerability.

Through his use of self-disclosure, coupled with words of hope and encouragement, his client was able to attend the court hearings and ultimately "feel more empowered" in her sobriety.

In short, David uses self-disclosure infrequently with clients, selectively gauging whether clients would benefit from knowing more information about his recovery. Like other recovering counselors in the study, David thinks he self-disclosed more often and with greater detail earlier in his career. Currently, when he self-discloses with clients the intent is to "cement" the therapeutic relationship and to give clients hope in recovery. His life serves as an example for his clients that one can overcome addiction and live a rich, productive life in recovery.

*Countertransference*

David believes that there are both positive and negative aspects of the countertransference experience. He stated that the positive experience comes from “A sense of resonating with and seemingly connecting with an experience that the client is going through that corresponds maybe with some of the experiences that I’ve had.” When David experiences positive countertransference, his recovery past is brought into the present by a client’s story, and he feels an emotional connection with the client. When asked for an example, David referenced the same story described above when he self-disclosed to a female client going through a divorce and custody battle.

David described the negative side of countertransference as the times when he feels sadness in "seeing people stuck." For David, there is a pang of sadness when people are "resistant" because he sees this behavior as simply "A reaction and [clients] not being ready and you know, just any number of other things." He usually doesn't interpret clients’ resistance in a personal way: "So I don’t get angry with it, you know, and rarely do I find myself reacting to it
from that standpoint." David indicated that in order to manage negative countertransference reactions he seeks peer supervision in his office. David told the story of working with a client who had a highly advanced addiction and subsequent health problems, and the client eventually passed away.

I struggled, and I’ll have to say, and actually consulted with my colleagues here on the staff because there was a part of me that wanted to acknowledge his passing. And at the same time, I wasn’t a family member; confidentiality was still a real consideration.

In the end, David sent a sympathy card and reflected on the client’s passing individually, and continued to carry with him a deep sense of sadness that his client was unable to overcome his own addiction.

**Spirituality**

David incorporates spirituality into counseling with substance abuse clients because it is, according to him, “the thing that is most damaged or adversely affected when people are in the throes of their addiction.” He stated that his clients will “Usually either talk about a sense of separation from spirituality or alienation from their religious upbringing or from themselves. A sense of really being at war with themselves.” David expects that most clients will develop a spiritual belief system and practice at some point in recovery, and thus he encourages them to expand their activities in that direction: “In terms of getting alone, having private time and space and quiet place and meditation.”

For his clients attending 12-step fellowship, “it is routine” for David to recommend to them that they explore their spirituality while in attendance. David noted that the spiritual component of the 12-step program is “probably the first and most frequent resistance” clients express with regard to attending meetings. He encourages clients who are resistant to 12-step
meetings to focus more on the shared experience with other people and less on the spiritual aspects of the program.

Look, there are some pieces to it that some people can react to, but there’s, if you can place less emphasis on that, and the other things to be derived from it, because here’s a collection of people who understand the experience, right?

In discussing spirituality with clients, David approaches the subject in a very “broad and non-evangelical way,” recognizing that spirituality is unique to the individual and for some “It may be yoga and, you know, Buddhism.” David personally views spirituality as the experience of a person feeling connected to “A meaningful reality outside of themselves…A sense that one can derive energy from some sense of proportion and stability and meaning.” For David, spirituality is a broad “umbrella term,” describing the expansion of one’s world through the belief that there is something “outside of you.” In terms of recovery, David does not view spirituality as essential to maintaining sobriety because “People are able to do that and be miserable sometimes.” What is essential about spirituality according to David is that it gives a person “A full human experience…in terms of a level and depth and meaningfulness and a sense of fullness,” which he believes may sustain recovery.

If David is working with a client who is “Very religiously oriented and it’s Christian and it seems to be a dominant piece or part of their life” he is not inclined to challenge or change their beliefs “as a therapeutic objective.” If the client’s questions about addiction and recovery revolve around their religion, and it dominates their discussions, then David considers referring the client to a Christian counselor or to a pastor.

As David discussed, he believes that spirituality is integral to “recovery work and drug and alcohol work” especially “because of the 12-step movement being as dominant as it is.” He does not question the “validity” of the spiritual approach in recovery but is concerned that
spirituality “Gets so narrowly defined that is has to be imposed on people in a format that doesn’t feel comfortable to them, that feels like it’s not a fit for them.”

In conclusion, David believes that clients can feel uncomfortable with and alienated from recovery resources such as AA/NA meetings, when spirituality is rigidly defined and imposed. Thus, he encourages his clients to pursue their own understanding and practice of spirituality. If it doesn’t fit within the AA/NA paradigm, he suggests to clients that they focus on other positive aspects of attending meetings, such as building supportive relationships with others in recovery. For David, spirituality is deeply personal and is something that people must discover in their recovery in order to be "whole" and "fully human."

Interview 9

Kevin is a 61-year old European-American male who has been in recovery for 24 years. Kevin entered recovery is his mid 30s. Kevin holds a master's degree in chemical dependency and has 12 years of counseling experience. His primary theoretical orientation is cognitive-behavioral therapy. He currently works as a substance abuse counselor at an inpatient substance abuse treatment facility.

Overall Meaning and Essence

During his mid 30s, Kevin entered an emergency detoxification unit for two days, and was encouraged from there to enter a long-term, inpatient recovery program. Unfortunately, his insurance did not cover the expense of an inpatient facility, and he left the detoxification unit with a referral to AA. At this time, he said he had little information about addiction and recovery, and had not been scheduled for continuing care. Instead, he said he was basically "Winging it, just not drinking, not using and so forth." He became involved in AA and struggled with what he termed "moderate psych issues, a lot of depression," which expressed itself in
"irritation, and a lot of home problems." The "essence" of his experience during the beginning of his recovery was captured in his statement: "This is terrible to go through."

Kevin identifies with substance abuse clients, stating that in his fifth year of recovery he became a substance abuse counselor, "That's when I began to see how similar my life was to many other people." During his recovery, Kevin may have felt somewhat isolated in the AA community. His family background was quite different than many of the people he encountered in AA.

I had a good social background. I was raised with two parents, and raised in the Catholic religion, so there were some values…Most of the people that I was dealing with in the rooms [AA], did not have them.

It wasn't until he began working as a substance abuse counselor that he encountered people with a similar family background and social class standing, that he began to feel a basic connection with other addicts.

As a counselor, Kevin said that he "identifies" with "lots of different kinds" of substance use. His primary drug of choice was alcohol, along with amphetamines, and later in his addiction, Xanax. He draws on these experiences in his work with clients, using his recovery as a reference to guide his work. For example, when working with clients, Kevin compares his own experience with addiction to theirs in order to generate solutions for the client.

What I was doing most of the time was gathering [client] data at the first outpatient session, then comparing it to mine [his experience], seeing what changes I had made, then kind of seeing if they would fit in with this person’s lifestyle.

Kevin would then give his clients options, referencing his personal experience of addiction and recovery: "So you know this worked best for me and here's the other options you can use."

In helping clients problem solve, Kevin was cautioned by supervisors and other substance abuse counselors about using his own experience with clients. Thus, although Kevin draws on
his own recovery experience in his work with clients, he does not speak directly from his own experience in generating solutions for clients: “I never presented it as mine, just here’s a way that people have gone through it [recovery].” Kevin is mindful of his recovery when working with clients, but also intentionally keeps his recovery at times private and hidden from clients. As he said, "I didn't feel a great need to identify with patients as a recovering person.”

A major theme in Kevin’s experience of being a recovering counselor is to maintain a certain amount of distance from his own recovery history. As stated above, Kevin said that he doesn't "feel a great need to identify with patients as a recovering person” because his recovery is only one aspect of himself. Kevin believes that addiction and recovery are not integral to a person’s identity or personality.

I don’t think you maintain the identity as an addict, but I think again it’s part of the personality, that’s a permanent piece in there. So, I can refer to it and it's far enough away now that it’s not, I don’t know, it’s not an entity unto itself.

Kevin reflected on the early years of substance abuse counseling and identified for himself an “ego piece,” when he prided himself on being in recovery and “wanted to become known as the recovering person.” Now, he perceives that his “ego has switched to, I want to be known as a good therapist.” He stated that he is conflicted about whether being in recovery and being a good counselor are compatible: “And I’m not sure the two of them go together. In fact, I’m positive that they don’t.” For Kevin, being a "good therapist" is his primary goal, and being in recovery may undermine his professional identity as a substance abuse counselor. Thus, Kevin seems to have expressed a certain degree of ambivalence about being a recovering counselor, as he sees this as perhaps inconsistent with being a good therapist. This same theme is apparent in Kevin's interview when he discusses AA, which is made up of people in recovery.
There appears to be a clear dichotomy in Kevin's mind between recovering counselors in the AA tradition, and those counselors with education and professional training.

Kevin distances himself from recovery, in part, because of what he has witnessed among members of Alcoholics Anonymous. He said that there is a tendency for AA members to be dogmatic in helping people in recovery, using the illustration of their own experience as the only “way” or path through recovery. For example, people in AA have said to him, “This is what you’ve gotta do. This is the way I did it. This works. I don’t think anything else does” work in recovery. Kevin said that these particular members were so focused on their belief that “this is the only way” that they didn’t give him “choices” in how to navigate his own recovery.

Kevin rejects this singular approach to recovery. He said that his natural response to being told “you have to do this and this is the only way” is to rebel. His work with clients has been shaped by these experiences and as a result he does not “make himself an authority” with clients. Instead, he gives clients choices and options in their recovery.

I try to make myself someone who is aware of a multitude of different avenues that they (clients) can take, things that can be done. But I still go back to that “you ain’t gonna tell me what to do” kind of attitude.

Kevin believes that giving clients choices and options is more effective in helping clients sustain recovery because, as he stated, “Most of the people I speak to and have spoken to over the last 20 years or so had that same rejection of authority kinda thing as I.”

As a counselor, Kevin made himself into someone "Who is aware of a multitude of different avenues that clients can take" through education and training. During his early years as a substance abuse counselor, Kevin went back to school to major in psychology, and was working in the field and gaining information about addiction and counseling at the same time. He stated that without the formal education that he was “Working kinda without a net, and I
didn’t realize the potential harm that could be done.” For Kevin, pursuing formal education opened up “All the pieces and methods and avenues available” for clients to stay sober, and as a recovering counselor he is able to “Temper the information with experience and then apply it with that experience as the moderator.” Kevin's education provided him with a scientific basis for understanding addiction as well as therapeutic principles and practices in the process of recovery. He has been able to take his education and mold that information with his recovery experience to provide clients with various treatment options and solutions.

Kevin believes that his primary role as a substance abuse counselor is to foster hope in the client, in the therapeutic process, and in recovery. He strongly believes that a person can change: “No matter where a person is in the addiction and/or in their life, you can recover, and it can by very good.” For Kevin, addiction is not entrenched and intractable, but instead is a disease that can be overcome through recovery. However, he tempers his optimism and hope for a client’s recovery by stating how difficult the process of recovery is: “I don’t think most people realize the depth of devotion you have to put to recovery.” In his opinion, the initial recovery period last up to “4 to 5 years” and should involve some form of continuing care.

Kevin’s task as a counselor is to help clients believe that “they can become ok” in overcoming their addiction. He stated that clients often “don’t believe it” and thus his task is to “reorient” them to the possibility of change by helping them to think in terms of problem solving. Hypothetically, he might say to a client, “If you do that, don’t you think this will work?” Kevin takes a pragmatic approach with clients in fostering hope in recovery by helping them generate ideas and solutions for remaining abstinent from drugs and alcohol.

Kevin believes that his primary role as a substance abuse counselor is connected to karma in the universe and “Giving back to some extent, getting into the purity of that.” Kevin recalled
his own “near death experiences in the addiction” and how the addiction negatively affected his overall mental health. He stated that he “had a lot of suicidal thoughts in the addiction” and "wrote poems in the beginning about the darkness and the wall and crashing and being bloody.” Thus, Kevin can readily identify with clients, especially those who tell him, “I feel like not actively killing myself but just wishing I were dead kinda thing.” Kevin says that “you can’t fake empathy” and that he is able to harness from his own addiction experiences empathy for clients who are clearly suffering. Thus, for Kevin, part of the experience of being a recovering counselor involves connecting with and empathizing with the painful experiences of clients in the throes of their addiction.

Clearly, Kevin's experience in recovery is beneficial to his work with clients. His recovery provided him with the motivation to become a counselor, and has enabled him to effectively help his clients. His recovery provides him with the raw materials to empathize, to foster hope, and effectively help clients generate solutions in recovery. Although Kevin draws on his recovery to help clients, he also sees his recovery as incompatible with being a "good" therapist, and thus downplays the significance of his recovery in working with clients.

**Self-disclosure**

Kevin was advised by supervisors early in his career to not self-disclose with clients. As a result, he is "cautious" in his use of self-disclosure, which is a "caveat he gives new counselors because it’s difficult to know where the boundary is and how far you can bend it and so on and so forth.” The boundary between what to disclosure and how much to disclose is ambiguous for Kevin, thus he generally refrains from revealing personal information to the client. Furthermore, Kevin believes that self-disclosure can take the focus off of the client: “Again, I think it comes down to, I’m not the one in treatment, I have to kinda keep that foremost.”
In discussing self-disclosure, Kevin said that he does not want to rely on his own personal recovery in working with clients: "I'm not going to bring my piece into it. I'm gonna use what I learned, interactive techniques that I was taught and so forth." Instead, Kevin relies on his education and training to facilitate counseling clients. Kevin's statements about self-disclosure reflect a recurring theme in his interview; what Kevin terms the "incompatibility" between being in recovery and being a counselor. His intent is to keep each aspect of himself separate in his work with clients.

Kevin said that often clients suspect that he is in recovery, however, because of his facial features: “With the broken veins and the red nose and all that stuff, people pretty much knew that there was something there. I got asked a lot." Kevin's facial features, indicative of alcoholism, bring forth questions from clients. Kevin's internal reaction to such questions was to wonder, "Well, why would you ask that?” Kevin indicated that questions from clients would make him feel uncomfortable and defensive: "You immediately kind put up another barrier" between you and the client. Early in his career, Kevin felt "awkward" when asked such questions because "It was kind of uncomfortable to say - I couldn't say no" to the client. Kevin also felt uncomfortable in these situations because he was trained to “not to use it (self-disclosure) at all” and he did not want “to project himself onto” the client. His general response to clients when they ask him if he's in recovery is, “I am, but I don’t want to speak about me. Let’s focus on you.” If a client presses for more information about Kevin’s recovery history, he would answer by stating:

I want to tell you the ways it can be done. If I get specific about me, we really get off track, we really go into something totally different. I don’t need to do it and it probably isn’t a benefit to you and our time is limited. So let’s stick with what’s going on with you.

Rather than directly self-disclosing his recovery history with clients, Kevin subtly communicates having a deep understanding of substance abuse by providing clients with basic
information about recovery. He said of his work with clients, "I'm not going to go in and tell you war stories about what went on in my addiction, but I can cue you enough that you know what I'm talking about.” In other words, Kevin does not need to directly self-disclose to a client because he communicates a deeply personal understanding of addiction and treatment to a client. Hypothetically, Kevin might say to a client:

“You know, the process you're going through is difficult, I appreciate that, and again, here's a way to go through it that hurts, doesn't hurt, hurts a little bit, hurts a lot, whatever, and I can appreciate you don’t wanna do it or you can’t do it right now.” And I give them that permission to have feelings.

Kevin is empathizing with the client’s experience without entering into a discussion of his own substance use. He is self-disclosing indirectly through an acknowledgement of the difficulty and hope of recovery.

Kevin makes a distinction in his use of self-disclosure depending on the context, stating that he “avoids it” in inpatient work, but has used it in outpatient work. He stated that 10 years ago:

I did it a little more because I had patients that I might have been seeing for two or three years (in outpatient). Many of them had met me at AA or NA functions or meetings...and it was discovered a lot more.

Once a client was aware of his recovery status, he said he was able “To open up a little more.” However, today in his inpatient work, he said with regard to self-disclosure that he "Avoids it as a personal thing. I give them information about it, but not identify it as something that was mine." Kevin's statement reveals his fundamental perspective on self disclosure. He generally avoids self-disclosure preferring to disguise his personal knowledge of recovery in subtle, indirect terms, thus still communicating to clients that he understands and empathizes with their recovery process. Also, it appears that Kevin avoids self-disclosure for professional
reasons, specifically to maintain his preferred identity as a "good counselor" rather than a recovering counselor.

_Countertransference_

Kevin stated that when countertransference arises that he doesn’t “usually recognize it immediately.” What happens he said is that: "It throws me off-center for a while, and when I’m starting to feel that off-center feeling, that’s when I need that kind of supervision.” He described an employment experience working with adolescent substance users to illustrate an experience of countertransference. At the time, he had a 14-year old son who was using drugs. His job entailed visiting schools and investigating complaints of chemical abuse by teenagers. About four months into the job, he noticed that he was feeling negativity towards the adolescents, especially cases involving heavy denial, which he stated “would just irritate me to no end.” He consulted with his supervisor and was given “direction regarding countertransference.” Ultimately, Kevin realized that he was not working “effectively” with his clients and concluded that he couldn’t “continue to do this” because he couldn’t understand why he had “such negative feelings towards these kids.” Thus, he asked to be removed from the school assignment, and be reassigned to a new setting and caseload.

Kevin’s reported example was not in the context of psychotherapy, but the experience is meaningful in better understanding how he responds to and manages countertransference in general. Kevin stated that he seeks supervision when he is feeling “off-center,” which seems to be a sign for him that he may be experiencing a countertransference reaction. In the case noted above, he asked to be reassigned because he perceived himself to be ineffective, and this request was granted. It seems that Kevin prefers to address his countertransference reaction in the context of supervision in order to decide how to proceed or work through such a reaction.
**Spirituality**

Kevin takes an eclectic approach to spirituality in his work with clients that stems from his own spiritual searching during recovery.

When I got into recovery, I had to believe there was a God no matter what they were gonna call God. It still was a God…That got me into Eastern philosophies, Ram Dass, and all that. So I just went through the whole gamut.

In the process of seeking spiritual knowledge, he came to the understanding that he can draw upon various traditions to support his recovery.

I can take a little bit of this and a little bit of that. And again, it kinda all flies back to the basis where you go to an AA meeting and they say everything’s there, take what you want, and leave the rest kinda thing.

In specifically working with clients, Kevin is aware that some clients may have resistance to religious concepts and thus he generally avoids overly religious language: “I even do, what’s his name, Darth Vader. There’s the force and then there’s the dark side.” He said that in most cases he can avoid the connotation of religion with clients and still communicate his point: "They still get the idea that something’s pulling in a positive direction and there is a negative.”

Kevin learns about a client’s own spiritual belief system and references it during counseling.

And I think for me, I feel like I am extremely well versed in religion. So I can, like basic Christianity, I can use that as a basis. If they are looking into Eastern philosophy, I can use that as a basis.

Kevin is very careful to not attack or dislodge a person’s belief system and instead works with clients to clarify their beliefs, but may at times challenge what he perceives to be naïve faith. For example, when he hears somebody say, “I’ll let God take care of it” he will question the client: “Well, how is God gonna do that? Are we gonna have the flash of light and a miracle occurs?” He attempts to bring a client into awareness by stating, “Let’s encourage what you
have now and put some kind of rationale in there on top of it.” Additionally, for clients who have not developed a spiritual belief system, he encourages exploration.

Do an adult study of whatever religion you think is the right one. If it doesn’t pan out for you, try another one. You’ll probably come to a conclusion somewhere that some of this and some of that is where it stands.

In conclusion, it seems that Kevin encourages clients to explore the various expressions of spirituality that are available, and to borrow from them the pieces that are of value to them. Kevin's recovery history and his personal approach to spirituality mirrors what he asks of clients, to be spiritual seekers in recovery.

Interview 10

Jennifer is a 41-year old European-American female who has been in recovery for 20 years. Jennifer holds a master’s degree in social work and has five years of professional counseling experience. Her theoretical orientation is reality therapy coupled with the use of psychodrama. She currently works as a substance abuse counselor at an inpatient substance abuse treatment center.

Overall Meaning and Essence

Jennifer described her recovery as "difficult and hard and uncomfortable and insecure" because she didn't feel fully accepted by the AA community. Members often asked her, "How could she be an alcoholic at 18 years old?" Thus, Jennifer questioned whether or not she had an addiction, thinking "Oh, my god, maybe I'm not. Maybe I really don't belong here." It was difficult for Jennifer to find AA members who were willing, as she said, "To give me a chance to figure it out and support me in the process." She believes that one of the most important pieces to recovery is for a person to find "A place where they belong and where they fit in." The experience of people being resistant to her presence at meetings left her feeling "stuck for a long
time," however, she was able to eventually find people who "were just incredibly supportive and had open arms."

Having been an addict, Jennifer is “Highly motivated to want to connect with and help people with addiction to recover.” She believes that her own recovery provides a shared experience with a client that establishes “immediate contact” with them. She stated, “It builds trust. It builds rapport a little bit faster.” Clients are thus more comfortable taking “Risks and sharing information they otherwise wouldn’t, believing that a recovering person can help them more than someone who’s not a recovering person, regardless of their education.”

Jennifer believes that the shared experience of addiction with clients gives her “an edge” as a counselor not only in building rapport, but also because she has personal knowledge of and experience with addiction.

I have a little more information about the lengths and the levels that individuals who are in addiction go to for manipulation, avenues that they go through or lengths that they go to in order to replace their addictive behaviors with substances and to different behaviors such as eating, sex, relationships, and all those kinds of things.

In working with substance abuse clients, Jennifer believes that she takes more “risks” in terms of “confrontation and challenging and pushing them beyond their defenses.” She stated that her non-recovering counterparts “may not be as willing to push the envelope” as she does with clients, although she qualifies that she is mindful of “where a client is and what they can tolerate.” Although Jennifer stated that she confronts and challenges clients probably more than non-recovering counselors, she also stated that she has a “higher tolerance for addicts and alcoholics who like to get over on the system and be manipulative” than do non-recovering counselors. In this sense, she sees herself as less challenging about client behavior than someone who’s not in recovery: “I might have higher thresholds for letting that slide by than some of my counterparts, which also doesn’t necessarily serve the client well.”
Jennifer’s tolerance for a client’s manipulative behavior stems from having "A sense of empathy and compassion for where people are and the kinds of experiences that they talk about.” She suspects that the depth of compassion and empathy she feels “happens a little bit more strongly” for herself than somebody who’s not recovering. She added that “Without doing a whole lot of personal work, those same energies can be very disruptive to the therapeutic relationship.” Jennifer emphasized the importance of self-awareness as a recovering counselor: “I am very self-aware about what goes on in my own life,” ensuring that her own issues do not become salient in therapy. Jennifer believes that learning about one's own history and developing insight is critical in doing effective counseling with clients. She honestly said, "By no stretch of the imagination, do I believe that I’ve resolved all of my issues in life and I’m ready to move on with this healed place.” Instead she sees the path of self-understanding as one that a person discovers over time in their “willingness to continue to learn about themselves and better themselves.”

Jennifer sees herself as an advocate for people who are chemically dependent whom she describes as “incredibly brilliant, very creative, and incredibly resilient” people who can be “wonderful resources in several avenues of our society.” She emphasized how difficult it has been over the years for the substance abuse and recovery community to get their addiction recognized as a “genuine, full-fledged, disease process.” She noted that when she became a substance abuse counselor 18 years ago that "It wasn’t a professionalized industry and we were still going through those struggles.” She thinks that providing counselors with education and “some skill sets” as well as “getting beyond just the 12-step philosophy” has been really important in improving the substance abuse field.

Jennifer noted that effective substance abuse counseling often involves “taking risks” and
helping clients to express what they are thinking but may not be able to actually communicate.

Some things that they think but may not say, that are pretty basic to recovering people in that moment of “a-ha”, whether that’s coming to recognize their addiction, coming to recognize some other behavior as an underpinning of their addictive behaviors, or experiences underpinning their behaviors.

In the process of giving voice to client thoughts, Jennifer uses “a lot of humor” because: "There are things that chemically dependent people find really humorous in retrospect, whereas the normal human being without the experiences might find odd." The "things" Jennifer referred to "…involve illegal activity. Or the lengths that we go to hide, mask the addictions, and what we do to make ourselves socially acceptable as recovering people or addicted people.”

In her therapeutic approach, Jennifer said that she has been “taking some risks” in the use of new therapeutic techniques such as psychodrama and experimental group therapy styles. Her goal in the use of these techniques is for “People to move from their staunch belief systems and childhood-rooted belief systems into, at least, having the willingness to look at where the beliefs came from.” She referenced her own experience in articulating this goal by stating that part of her process of getting and staying sober involved “Understanding why I value what I value and why I believe what I believe.” Her sobriety thus prompts her “To ask questions of clients about where they come up with their set value systems and what makes something acceptable versus unacceptable.” Challenging a client’s belief systems and values in that regard, and letting them have ownership of their beliefs, Jennifer works with clients by “Creating an environment where they can ask questions about what they are [values and beliefs], and whether or not they fit for them” on the road to recovery.

To conclude, Jennifer believes that being a recovering counselor gives her "an edge" over non-recovering counselors with clients. According to Jennifer, clients see her as a credible therapist who because of her recovery is better equipped to help them. The "edge" Jennifer has
with clients is her personal recovery history, which gives her the courage to take risks with clients, challenging them when appropriate. However, Jennifer also sees herself as someone who can be too soft and understanding with clients, because she recognizes "where they are at" in recovery and empathizes with their manipulation, resistance, and other difficulties. Jennifer revealed an interesting contradiction in her empathetic responses toward clients. Her empathy can be both helpful or harmful to clients depending on the context and their specific needs in the moment. Thus, Jennifer stressed the importance for recovering counselors to work on themselves and their own unresolved issues, and to remain mindful of how their recovery issues potentially can hinder the therapeutic relationship.

Self-disclosure

Early in her career, Jennifer relied more on her recovery and less on her education and training in working with clients. Jennifer used “a lot of self-disclosure” because as she said, “It won me that immediate relationship, and it expedited the rapport building.” Jennifer was not fully aware, however, of “why she was doing it [self-disclosure] at the time.” With supervision and guidance, she learned that self-disclosure “eliminated having to put a lot of thought into what strategies and what interventions to use.” In other words, disclosure was an “easy” way to connect with clients early in Jennifer’s career. She believes that her use of self-disclosure interfered with her own development as a counselor in learning “To structure and formalize the therapeutic alliance with a client without doing that [self-disclosure] and with using the skills that I went to school to learn.”

Over time, Jennifer became more conscious of her motivation for using self-disclosure, often asking herself a series of questions in the process of counseling.

Was my motivation to connect with the client and normalize an experience of their own to help them not be so isolated or judgmental about self? Was I self-disclosing because
their discussion was triggering something within myself, that I had some kind of hunger that I didn’t want to let them know, that that’s a common problem and I’m stuck there, too?

Jennifer stated that this self-inquiry has been a "process" in learning to be "more selective about" her use of self-disclosure.

Jennifer believes that self-disclosure “can work against” her as clients, especially older clients, question whether or not she can “genuinely help them.” Jennifer entered recovery when she was in high school. When clients ask her if she's in recovery, she says, "Yes, I am," which often leads to additional questions about her age, her length of recovery, and experiences in the substance abuse field. Jennifer said that when older clients, those over 40, knew about her recovery history they doubted that she could genuinely help them because she "wasn't in addiction when she was married and had kids." Thus, as Jennifer stated, her use of self-disclosure with this client population can “work against her.”

Jennifer believes that her self-disclosure is “more helpful with younger people.” She often is given younger clients by supervisors because: "I can talk very honestly with them about how to stay sober in college, how to stay sober completing high school, how to stay sober and turn 21.” She stated that the outcome of her self-disclosure is much more positive with younger clients because she is able to use her recovery experience to help them, especially with regard to school, peer groups, and going to AA meetings. For example, she talks to clients about how she "worked through" recovery. Specifically, she says to younger clients that she knows how difficult it is to be abstinent in college, especially because of the "feelings that come up when people are totally rejecting of you because you can't drink." She said of these clients: "They need someone to help them figure out how to walk that path and some preparedness for that."
Thus, she references her own personal experience of addiction and recovery with clients to help them find "that path."

In conclusion, Jennifer, like other recovering counselors in the study, indicated that she over-relied on self-disclosure to build rapport with clients early in her career. She has reduced the use of self-disclosure with clients through the process of supervision and self-inquiry, specifically interrogating her motivation for self-disclosure and deciphering what she is trying to accomplish therapeutically.

Countertransference

Jennifer experiences emotional discomfort with clients who she “genuinely believes are alcoholic through to their core” and who “place themselves in positions that are risky.” To illustrate her experience of countertransference, Jennifer tells the story of a female client who was the same age as Jennifer’s mother when Jennifer’s mother died of alcoholism. The client discussed with Jennifer her desire to have a drink on her 23rd wedding anniversary. Jennifer experienced “a very strong reaction” to the client’s intent to drink on her anniversary. Jennifer believes her reaction was “fear-based” as she contemplated the outcome of “What would happen if she would drink on her anniversary?”

The client ultimately wanted Jennifer’s permission to drink. Jennifer felt “very challenged” to find a way to tell the client that she “believed it was really detrimental for her (to drink)” but that she “respected her right to make the choice.” Jennifer informed the client that she would support her regardless of her decision and that they would talk about her anniversary when the client returned. Jennifer acknowledged that this was not a “natural position” for her to take because “It flies in the face of being a recovering person.” Although she overtly supported
her client’s choice, her internal dialogue was that of “a recovering person.” She thought to herself, “You’re crazy, this is insane. You’re making a bad choice.”

Jennifer illustrated another experience of countertransference that occurred with two female clients in the dual diagnosis unit who were “just completely non-compliant, and completely manipulative.” Jennifer was a new mother at the time. Both clients were also mothers of young children, and had a history of poor parenting. They had wanted to leave treatment for some time. Jennifer cried in front of these two female clients: “I was so exhausted one day and I was so tired that I just started to cry. And I don’t usually cry with clients.” She said to the clients:

You know, you’re gonna hurt somebody. It’s going to be your kids. It’s going to be your parents. It’s going to be you. But somebody that you love is absolutely going to be devastated by you leaving, because neither one of you will stay sober.

Jennifer said that she was not in the “habit” of telling clients that they would use substances if they left treatment. She believes that the female clients stayed in treatment “a while out of guilt” but they eventually “ended up leaving at different times for different reasons.” She spoke to her supervisor about the incident and regrets that she never had the opportunity to explain to these clients why she was so emotional that day.

In both of the examples noted above, Jennifer’s unresolved issues were being touched by the client’s issues and circumstances. In the first case, the loss of her mother to alcoholism seems to have increased Jennifer’s internal reaction to her client contemplating drinking for her wedding anniversary. In the second, Jennifer’s feelings associated with the responsibilities of motherhood were brought to the surface for her. Jennifer stated that when countertransference arises she “Does a lot of self-talk in terms of what question do I want to ask next and why do I want to know that information? How is this helpful information?” She also seeks the guidance
of “wonderful supervisors who have been willing to listen to issues that have surfaced” for her.

Jennifer strongly believes that supervision helps in managing countertransference especially when supervisors “Share with me, ask questions that maybe supervisors in traditional jobs wouldn’t ask, while at the same time, not becoming my therapist” and have the willingness to encourage her to get professional help if the issues are interfering with her work as a substance abuse counselor.

_Spirituality_

Jennifer’s use of spirituality in counseling has evolved into her work and was not something that she “brought in initially, early on.” She now feels personally and ethically bound to discuss spirituality with clients.

If I don’t communicate that on some level with them, about having some relationship with their own spiritual system, then I will have done them a disservice…I’ve come to a place where I trust that there are faith, hope, sort of divine guidance has a lot to do with keeping addicts alive and have a lot to do with keeping addicts from killing other people.

Jennifer believes that a client’s faith or their spiritual beliefs play a significant role in recovery: “And sometimes there are moments I suspect, in every recovering person’s life, where it’s just them and their spiritual beliefs that stand in between them and their next drink or drug use for whatever reason.” Hope and spiritual connection are personally and professionally meaningful for Jennifer and thus she believes “To try and recover without it is incredibly difficult.”

If clients are resistant to the idea that there is a greater entity, Jennifer puts the notion of God or a higher power in “concrete” terms for them. She asks them to consider the faith that they put into their drug providers.
I remind them that they honestly have absolutely no idea what they’re using, particularly with illicit drugs and they are embedding complete trust in their dealer or the people who are providing them substances. And that’s a profound thing. That’s their life.

Jennifer informs her clients that if they are willing to put their faith in people to support their addiction, then she hopes they can, “Have a similar place to draw that hope and to place that trust, to help them save their lives.” She has found that few clients challenge or contradict her example of illustrating faith in something outside of oneself: “There’s not a whole lot to say when you’re shooting IV drugs and you’re not the one who made them and you don’t know where they came from.”

In conclusion, Jennifer seems to have gradually incorporated discussion of spirituality into her work with clients. Not only does she report encouraging clients to examine their own spiritual belief systems, but she also indicated that she challenges them in concrete ways to examine where they place their faith in life and how this may affect potential consequences for them. At this point in time, Jennifer sees it as imperative that discussion of spirituality be part of the counseling process, and that she assist her clients in the development of their own spirituality to prevent relapse or other negative consequences.

**Construct Analyses**

The following sections are the result of comparing and contrasting meaning units between research participants within each construct, which resulted in the emergence of thematic patterns or “structural descriptions.” The structural descriptions have been grouped together by construct and the participants’ voices have been blended with thick description to present the participants’ lived experiences in relation to each construct. Collectively, the structural descriptions of each construct make up the “construct analyses” for this study.
Overall Meaning and Essence

“Giving Back” Through Helping Addicts to Recover

Being a recovering substance abuse counselor involves having “a very personal” experience with addiction and recovery. All participants in the study spoke of the significance of their own recovery, and the various ways it intersected with their work as counselors. First, being a recovering substance abuse counselor involved drawing upon one's personal experience of addiction and recovery to help those suffering from an addiction.

I believed as a counselor that I could take part of my experiences plus the way I interact with people and that I could turn that into something that would be beneficial to a bunch of people. And so it was really coming from a very personal perspective. (Jack)

My real intrinsic value and the real essence of why I do this is to help people…My goal is to help as many people as possible…and to help people make change and you know, live fuller, happier lives. So that is definitely the essence of it. (Charles)

Eight recovering counselors in the study articulated in various ways a strong desire to help others through the process of recovery. As Charles stated above, helping other people is “the real essence” of his work. The process of helping people is “very personal” for recovering counselors who use their recovery to benefit others. As they help others through recovery, many counselors find the experience personally rewarding and even healing.

Addiction is really profound suffering on a lot of levels…At the end of the day, as with a lot of people that go into this field, I was trying to extract some kind of positive meaning from the wreckage of my past. (Thomas)

When you’ve been through the experience itself, it provides another layer and dimension of meaning to you. So there’s really a sense of contribution…that has a spiritual aspect to it. And there’s a sense of being able to make a contribution that’s meaningful in a sense of giving back, which is therapeutic in itself. (David)

For recovering counselors like David and Thomas, their work with clients is an endeavor ripe with spiritual meaning and personal significance. Thomas and David specifically spoke of the “therapeutic” and healing experience of being a substance abuse counselor. By helping
others, Thomas “exacted positive meaning” from what he termed “the wreckage of my past.” In other words, if one can contribute to the betterment of others, then one can heal from past suffering. As counselors make a “contribution” to people and their communities, the return for them is acceptance of the past and a sense of making peace with it.

Instances of what David termed “giving back” elevate recovering counselor’s work to the realm of the spiritual through healing and generativity. Correspondingly, recovering counselors drew upon spiritual concepts and ideas, such as "karma" and those found in the 12-step philosophy to explain their efforts to "give back" to the broader community.

I do think it depends to some extent on the idea that there is some karma in the universe and you do have to give back to some extent, get into the purity of that and so on and so forth. But, I don’t see any real problem with giving back and getting paid for it. (Kevin)

The meaning of it was really substantial to me in the sense that it meant I was pursing a vocational calling that had a lot of spiritual meaning with AA…I think it was in essence a religious experience for me and it was not unlike being kind of a passionate member of the church or faith of some kind. (Lance)

The twelve steps are essentially extending yourself to someone who’s in need. In a therapeutic enterprise, I think it’s healing…it’s gratification, I guess you can say, but it’s at a level of feeling like it’s meaningful. You know, it’s not just an exercise, but there’s importance to it that you feel is personally relevant to you. (David)

For Lance above, his recovery in AA was “a religious experience” as he drew upon the spiritual tenets and principles of the program. In embracing the AA tenets of “extending yourself to someone in need” and using one’s own recovery to help others, many of the participants discovered their professional calling as recovering counselors. Through the 12-step recovery, Thomas, like many other recovering counselors embraced the tenet of using his own experience to benefit others:

And in the twelve steps they talk about a phenomenon I call the twelve promises, and one of which says, “We will reach a place in our recovery where we will no longer regret the past nor wish to shut the door on it, and we will see how our experiences can benefit
others.” So I had this “Eureka!” moment, like yeah, this is it. I want to go in and I want to help people. (Thomas)

As noted above, recovering counselors were very committed and highly motivated in helping people through recovery. Counselors brought to their therapeutic relationships an optimistic outlook on their client’s ability to recover because they themselves had weathered their own recovery.

Because of a personal insight with it and connection to it…I guess, is a sense of the energy and the hope and the real productivity of recovery, the transition that is terrific to see. (David)

David feels the “hope and energy” that is manifest in a person’s recovery, feeling enlivened by his contribution to that recovery. Often, an abiding hope and deep faith in recovery kept them in the addictions field long after others may have left or “burned out.”

And I think, maybe the important thing about it, that has kept me in the field is that people with addictive disorders can actually recover, then go on, and have really great lives. So, I think one of the reasons that I’ve stayed in the field over all those years is that you actually get positive feedback and actually see people go on…is very positive reinforcement. (Jack)

Seeing his clients go on to “have really great lives” strengthens Jack’s commitment to his work and clients. Counselors used their hope and faith in recovery therapeutically, encouraging their clients to envision the possibility of recovery.

Yes, and I think to me that’s what Alcoholic’s Anonymous does. I mean, that’s what the whole focus is, that there is hope that you don’t have to be this way anymore. And I carry that with me into my counseling…And to me, that’s what my job is, to instill hope. (Linda)

I just know that it can be done and I think that kind of basic belief, that no matter where a person is in the addiction and/or in their life, you can recover, and it can be very good…At the beginning of recovery, most people don’t believe they can become ok. They just don’t believe it. (Kevin)

Both Kevin and Linda base their work with clients on the premise of hope and the belief that clients can recover, in that their own personal experiences of recovery served as the primary
example of that accomplishment to clients. A personal experience of recovery weaves together the spiritual themes of healing, hope, and faith, which are often found in 12-step programs, with a concerted effort to make people’s lives better. For recovering counselors, their careers were launched after overcoming addiction, and thus their recovery plays a central role in their efforts to help substance abuse clients.

*Empathy, Understanding, and Identification: “I Know Where They [Clients] are Coming From”*

As stated, the meaning and experience of being a recovering counselor involves drawing upon one’s own knowledge of addiction and recovery to help others. A second way recovering counselors’ personal experience of recovery intersected with their work and helping clients is that it gave them a greater understanding for where their clients were “coming from.”

Primarily, the way my personal recovery influences my work is that I have a lot more understanding of the trails and tribulations that people go through. (Linda)

I know where they are coming from…When I see a person totally perplexed. They want to change and they just have no clue where to start. (Charles)

Nine out of ten recovering counselors indicated that their recovery provided them with “insight and sensitivity” into the recovery process. Counselors felt that they had a deep understanding of the internal world of addicts, recognizing thoughts and feelings that they themselves had experienced in their recovery. One counselor in particular, David, eloquently captured this theme illustrating how personal experience of recovery provides a more in-depth understanding of his clients. David said that his recovery was “a rich reference” in guiding his work with clients because he easily recognized the internal struggle and difficulty people faced in overcoming an addiction.

The personal experiences I have can be a rich reference in terms of guiding the work that I do. I think of it as a major contribution to insight and sensitivity to aspects of the process in its various stages… So my personal experience and reflecting on the development of my use of substances, the struggle that was encountered in it, the
difficulty in terms of coming to the place of ending that relationship. The process of the
development of all the subsequent experiences of a sober lifestyle really allows me in
some ways to recognize not only the external behaviors, but also correlate a sense of the
internal experience of what that could be. (David)

David intimately understands the complexity of the recovery process, especially the
typical thoughts and feelings associated with each stage of recovery. He reflects on his
experiences at each stage of recovery, and is able to draw on those experiences in working with
clients. He intimately knows “where they are at” at each point in the recovery process. His
recovery history allows him to recognize the typical behaviors of addicts, and to understand what
they are experiencing internally. David is aware of his own biography as clients move through
their own stages of recovery. Thomas expressed a similar awareness in the following
statements:

I remember distinctly struggling with so many of the issues that plague the addict in
early recovery, middle recovery, or in late recovery, you know, the different stages of
recovery. And I can remember some of the madness that I went through, and some of the
thought processes, the denials, the rationalizations, the justifications, the substitutions, all
of the games that addicts play. I went through them and I remember them vividly. And I
can see it in others. (Thomas)

Thomas vividly remembers his internal experience of recovery, especially “the madness”
and denial, and recognizes those same struggles within his clients. Recovering counselors such
as Thomas are able “to see a little clearer” into an addict’s internal world, which is part of the
essence of being a recovering counselor. Recovering counselors believed that their recovery
allowed them to see below the surface of things; the “lies,” “games,” and “denial” perpetuated in
addiction.

So, my addiction has, in my mind, benefited my ability to work with others with
addiction. Simply because, you know, I hope I have the ability to see a little clearer,
some of those thought processes and some of the lies and the games that we tell ourselves
in order to maintain that delusion. (Thomas)
Just a real appreciation for that confusion and that it's not the lack of willingness that it would appear to be. And it's not the lack of motivation that it would appear to be…And unless you have been that confused it is really hard to know what that is like with every part of you to want to change something and have no idea where to start. (Charles)

Charles’s recovery allows him to more accurately interpret a client’s behavior, in particular a client’s confusion. According to Charles, understanding the truth behind that confusion rather than what it simply “appears to be” (e.g., lack of motivation), requires a first hand experience with that same type of confusion. Additionally, when a counselor “sees clearly” into the lives of their clients, they are less likely to be deceived or manipulated by their clients.

I also suspect being in recovery gives me just a little more information about the lengths and the levels that individuals who are in addiction go to for manipulation, avenues that they go through or lengths that they go to, to replace their addictive behaviors with substances and to different behaviors such as eating, sex, relationships, and all those kinds of things. (Jennifer)

We’re doing a treatment meeting with a guy and he was saying how long he had been clean…And I said, "Look at your fingers man, you know, you got fresh blisters on your fingers from holding a crack pipe." Some of the people didn't notice that because they didn't have that intimate knowledge…If you hadn't been there you wouldn't know what to look for. (Charles)

Having intimate knowledge of substance abuse, Charles like many other counselors recognized the signs of substance use even when a client denied that use. Charles’s non-recovering colleagues believed that the client above was “clean” because they didn’t possess experiential knowledge of drug use. If a substance abuse client is aware that a counselor possesses “intimate knowledge” of substance use, he or she may be a little bit more open and honest with recovering counselors because their deception will likely be recognized and challenged.

And what happens is that immediately it disarms a lot of the defense mechanisms a client would use ‘cause they go, “I know I can't use that one. This guy is going to see right through that.” It is just the fact that they know that I know. Automatically they drop a whole set of defenses that they would have been able to utilize with a non-recovering person. (Charles)
As Charles stated, being a recovering counselor “disarms” the defense mechanisms that a client would use with non-recovering people. A client knows that the recovering counselor will “see through” any falsehoods. Although counselors believed that clients were more likely to be non-defensive and open with them, they also identified instances when clients were resistant to the therapeutic process. In such cases, counselors’ experiential understanding of addiction and recovery gave them patience and greater empathy for a client's unwillingness to engage in the therapeutic process. Counselors seemed to communicate that a personal experience with addiction cultivates empathy toward clients in general, and specifically toward those who are resistant to treatment.

Being able to connect and have a sense of empathy and compassion for where people are and the kinds of experiences that they talk about, I suspect, happens a little bit more strongly for me than maybe somebody who’s not recovering. (Jennifer)

Jennifer believes that as a result of her own recovery she experiences greater empathy and compassion for clients than a non-recovering counselor. Recovering counselors were specifically empathetic with clients who were “stuck” or resistant in their recovery. Recovering counselors stated that they understand client resistance; they understand the “internal conflicts” that arise in recovery and are patient with clients when those conflicts are expressed. Paula understands the resistance stating plainly that, “I’ve been there and I’ve done that.” She continued:

I know the type of guilt and shame, the internal conflicts, that addicts/alcoholics generally experience, as well the denial and all those defense mechanisms…I think that has helped me develop more understanding and patience with assisting addicts/alcoholics because I’ve been there and I’ve done that, and I have some understanding of it. (Paula)

Probably without the personal experience of going through it and how that can feel and that kind of thing, I might not feel as rich a sense of empathy, I guess, for what the people are encountering at that point. (David)
David believes his “rich sense of empathy” for clients is the result of his own struggle with addiction and recovery. He knows how it feels to be that person in recovery.

In terms of resistance, I don’t find myself getting angry. It’s more of a sense of recognition that the person is not in that place yet, where it’s hard to them to recognize how destructive it is and there’s almost a sense that there’s a need for more encounters with painful events before they reach that place, and a sense of sadness with that sometimes. (David)

David’s empathy toward resistant clients is clear from his statements. He can empathize with the person who is not ready to change their life, recognizing that more suffering is ahead. Feeling empathy toward substance abuse clients is part of the experience of being a recovery counselor. This empathy is connected to understanding another person’s experience as one’s own. Recovering counselors are able to more quickly make this leap from themselves to the internal world of their clients and back because of their recovery. Thus, having a personal experience with recovery gave counselors the means to quickly and readily identify with substance abuse clients.

Recovering counselors strongly identified with their clients, recognizing the “similarities” and “parallels” between their lives and that of a client. Counselors often viewed their clients as people just like themselves who, as Kevin said, “were working through stuff.”

That’s when I began to see how similar my life was to many other people…In treatment, I once again ran into sorta middle or upper-middle income people who were working through stuff…I was able to identify with a lot of different kinds of use. (Kevin)

My own addiction process ended up after all these years of experience just simply paralleling most of the clients that I have worked with…You start to notice something is wrong and not working right in your life and then suddenly you discover what’s going on…there’s a lot of denial that goes on. (Jack)

Through identifying with clients, recovering counselors mostly hold positive views of their clients. Counselors saw their own lives revealed in that of their clients, and thus felt a sense
on kinship and camaraderie with them. For Thomas, people in addiction or recovery were easy to relate to because they could laugh and find humor in their addiction experiences.

I still love addicts. They’re crazy. Their denial is just off the wall. Their stories are beautiful. Their humor, I mean, I feel comfortable with them. Clearly, because I lived that life, you know, and there’s a camaraderie there, that I can’t go into a church group and share some of my experiences and have people be able to identify or find humor in that. (Thomas)

I have very strong roots in advocacy for the chemically dependent. I think the chemically dependent are incredibly brilliant, very creative, and incredibly resilient, and can be wonderful resources in several avenues of our society. (Jennifer)

Counselors like Jennifer held their clients in high esteem, seeing them as smart, creative, and resilient. Jennifer viewed people in recovery as valuable to their communities because of their talents, and thus saw herself as their advocate. Through identification with clients, some counselors held an egalitarian ethic in their work with them. Relationships with clients were built on equal terms, without clear roles or hierarchies.

I don’t view myself as being particularly different than my clients…I believe that counseling is a face-to-face, as-close-to-equals-as-possible experience. I don’t want to be placing myself way above the client, with the client populations that I work with. (Jack)

Likewise, Kevin does not see himself as an “authority” on recovery. He sees himself as someone to “help” in the process of recovery. Distancing himself from the role of expert, Kevin identifies with his clients and their basic need for help in recovery:

So I don’t try and make myself an authority, I try to make myself someone who is aware of a multitude of different avenues that they can take, things that can be done. (Kevin)

Recovering counselors expressed that they feel particularly equipped to understand where a client is and to "meet them where they are." Additionally, they expressed that this ability may help them to accept some of the limits that might exist with certain clients because of a lack of readiness for change, which recovering counselors are able to recognize through reflection on their own process of change.
Well I mean, personally I feel like it's facilitated my ability to establish the boundaries of what I can do and what I can’t do, and accept the limits of what my facilitation is gonna be. So my personal experience, in some ways particularly informs me of that. Is that person ready to make a change? Do they see that there’s a problem? If they are ready to make a change, really, how well formulated is it? (David)

Well, my experiences through my own recovery enable me to more effectively meet the patient where they’re at…When I look at an individual and see him struggling, it is sometimes very helpful for me to relate it back to something that happened in my recovery, to say, “Yeah, you know, I had an anger problem early on and I couldn’t see it…” Having gone through the experience myself, it’s easier for me to identify, most of the time, sometimes I’m so far off base it’s unbelievable, but most of the time, it’s easier for me to identify where that particular person is in receiving whatever it is that he or she’s supposed to be receiving at that particular point in time. (Jim)

*Personal Experience is the “Selling Point” with Clients*

All but two of the participants in this study indicated that their personal experience of addiction enhances not only their understanding of, but also their therapeutic alliance with, substance abuse clients. According to Jack, a recovering counselor's personal experience with addiction "sells" clients on the counselor and on the success of recovery. A recovering counselor can use their personal experience "positively" with the client, establishing their credibility as a person who can help the client.

I have seen a lot of counselors, we’ve had a fair number of interns come through here, we’ve had people come and go and, to me, there still seems to be a value in having some kind of a personal experience with addiction and working in the addiction field. Maybe it’s only the selling point, that it’s one more experience that you can use positively with the client. (Jack)

I have observed over time, I guess, that being in recovery and connecting with clients when that’s shared with them, for them establishes an immediate contact. It’s much easier for them, for whatever reason, to believe that a recovering person can help them more than someone who’s not a recovering person, regardless of their education. (Jennifer)

Jennifer’s personal recovery experience gave her "immediate contact" with clients who trusted her because of her own recovery history. Eight recovering counselors said that their personal experience with addiction and recovery made it easier for them to "connect" with
substance abuse clients and earn their trust. Counselors believed that trust is built in the therapeutic relationship when the client knows that a counselor's understanding of addiction and recovery is based on more than education and training.

Forming a relationship that is based on more than knowledge, I don’t know, is it an advantage for counselors or is it an advantage for a client, but whatever it is, it opens up the possibility of forming a therapeutic relationship on other than just knowledge. (Jack)

But I do believe that there is something about the experience…it would be the same thing as providing services with post-traumatic stress disorder from a combat situation. There’s going to be a connection between someone that has experienced combat, talking with somebody, dealing with that, than someone who hasn’t. (Thomas)

Experience rather than knowledge, according to Jack, is the "selling point with clients.'

Thomas agreed with Jack and explained the recovering counselor-client bond using the analogy of combat veterans and their shared experience of PTSD, and Jim indicated that through a sharing of personal experience the recovering counselor may help the addict through the process. Shared experience between a counselor and a client forms an immediate bond. Recovering counselors and their clients are able to “connect” on more than the formal therapeutic relationship. The connection between the two is deeper and more powerful, according to Charles, because of a recovering counselor’s past addiction.

When I can connect with somebody on that, you know, and hold their hands through the 10 or 15 days of ongoing withdrawal symptoms…You know, when I can connect with them, it is really powerful you know and that comes from personal experience. You know I don't know that I could connect with them on that same level without the personal experience. (Charles)

Recovering counselors also discussed that they were able to establish rapport with clients more quickly than non-recovering counselors. Counselors like Jennifer believed that having a shared experience of addiction earned her the trust of clients and made it more likely that clients would "open up" in counseling, sharing intimate details about their lives.
It builds trust. It builds rapport a little bit faster. My observation is that they’re willing to take risks and share information they otherwise wouldn’t. (Jennifer)

Jennifer’s observation as a recovering counselor is that clients may not be as willing to “take risks” with non-recovering counselors. The recovering counselors in this study expressed that feelings of shame may prevent substance abuse clients from revealing painful or difficult issues to their non-recovering counselor. According to Paula, a remedy for shame involves the client knowing that a counselor is in recovery.

But I think that addicted folks have just been so wounded in their lives and have so much shame and hopelessness at times…I don’t think being a recovering counselor is really necessary to have that open heart, but they seem to feel more at ease in self-disclosing some really difficult issues…they assume that you’ve done the same things even though you haven’t. (Paula)

Addicts know pain and shame and humiliation on a first name basis. And they’re gonna feel more comfortable with someone that has experienced that in their mind…They’re gonna know that they’re less likely to be judged….They have such a profound sense of shame internally that discussing the frailties, discussing the cracks in their armor- it’s gonna be too painful to share with someone that hasn’t been there. (Thomas)

Substance abuse clients may assume that a recovering counselor has had experiences similar to their own and thus feel more comfortable “opening up” to them. Counselors like Paula and Thomas believe that substance abuse clients feel accepted and understood by recovering counselors and that frees clients to “open up” without fear of judgment or condemnation. As David said, it is going to be “too painful” for substance abuse clients to share their weaknesses “with someone that hasn’t been there.”

Ambivalence of a Recovering Counselor: “I Could Have Been More and Better”

Another major theme derived from the interviews is that recovering counselors feel some degree of ambivalence about being recovering people within their profession. Recovering counselors expressed this ambivalence in different ways depending on whether they were referring specifically to themselves or their work as counselors, and there are three “subthemes”
within this section that reflect those differences. Overall, seven counselors indicated some type of ambivalence about either becoming a substance abuse counselor, the importance of their recovery status, or the possibility of being labeled a "typical" recovering counselor, suggesting that they are uncomfortable with some of the common stereotypes about recovering counselors. Some of their statements regarding the first subtheme, getting into, or being in, the substance abuse field, are as follows:

So, I kind of fell into substance abuse counseling. It wasn’t something that I really wanted to do. (Paula)

When I first started the process of doing counseling, I always said I don't want to work; I never want to work in a treatment center. Never. Never. Never. Never. Never want to do substance abuse. (Linda)

Well I have to confess to a certain element of self-doubt; I think in my career as a recovering counselor, that it is a consolation prize, that I could have been more and better. (Lance)

Furthermore, as noted above, several of the participants seemed to minimize the importance of their recovery status in their work with clients, which is the second subtheme in this section. Interestingly, these same individuals later contradicted themselves in discussing some of the ways in which their recovery status enhances their work.

I’ve worked with some wonderful, wonderfully gifted people who are not recovering from any type of addiction who work with addicts and alcoholics and I don’t really see any difference in the work that we do in trying to help them because most people are recovering from something and/or trying to learn how to live with something that they don’t have a lot of control over. So, I really don’t see that much difference. I’ve seen some very detached, harsh, cruel, recovering substance abuse counselors in the 20 years that I’ve been in the field. (Linda)

Well it would be like if I was recovering, if I was a doctor, if I were recovering from any type of medical disease and working with people. I don’t really attach that much importance to my own recovery history to what I’m doing. (Paula)

Two additional counselors in the study mentioned the same “doctor” analogy, which may suggest that this is a fairly common way of thinking in the addictions field. Nevertheless, it is
striking that these counselors minimized the importance of the impact of their recovery status on their work with clients, but later went on to express how they feel their personal history enhances their clinical work, suggesting perhaps some level of conflicted feelings about their identities as recovering counselors.

Another way in which ambivalence about being a recovering counselor manifested in the interviews involved participants distancing themselves from the common stereotypes associated with recovering counselors, which was the third subtheme to emerge within the theme of ambivalence.

Instead of getting a job at a treatment place and going through certification, I went to college. So I already knew from the get go that I did not want to be stuck in the, "I'm a recovering counselor mode. I'm a clinically educated, trained professional who happens to be in recovery." When I give any response that doesn't sound like the traditional recovering counselor respond, people go "Aren't you the one in recovery?"  (Charles)

At one point I probably wanted to become known as the recovering person, kind of thing. And I think the ego has switched to, "I want to be known as a good therapist" now. And I’m not sure the two of them go together. In fact, I’m positive that they don’t.  (Kevin)

And when I work with people, I say "I am the exact opposite of any counselor you have ever worked with, you know, especially in recovery.” Because I think as much as I might have stereotypes about clients, I think clients have stereotypes about recovering counselors. They already know what they are going to hear from those folks, so they can go ahead and shut off their ears…One of the things I have to do is break through that initial barrier where they have had me stereotyped as a recovering counselor.  (Charles)

The finding that recovering counselors seem to experience ambivalence related to their own recovery status, entering the substance abuse field, or being associated with the common stereotypes regarding recovering counselors is interesting, and raises questions about what may be contributing to such ambivalence. These three subthemes emerged separately but seem potentially related as consequences of the professionalization of the substance abuse field, and the self-perceived de-valuation of recovering counselors (an issue to be further discussed in the following chapter). The three subthemes were not individually substantial to the point of
constituting separate themes in their own right, and thus have been grouped into one thematic category in this section.

In conclusion, this study identified the themes embedded within the overall meaning and essence of being a recovering substance abuse counselor as: (a) “Giving Back” Through Helping Addicts to Recover, (b) Empathy, Understanding, and Identification: “I Know Where They [Clients] are Coming From, (c) Personal Experience is the “Selling Point” with Clients, and (d) Ambivalence of a Recovering Counselor: “I Could Have Been More and Better” (See Table 2). While the individual responses to the "overall meaning" interview question varied greatly and contained complex individual material, these thematic categories clearly emerged through the phenomenological reductions of the interview data.

Self-Disclosure

Reduction of Frequency and Refinement of Intent: From “Big, Long War Stories” to “Therapeutic Strategy”

Seven participants discussed their tendency early in their career to tell clients too much about themselves. One counselor termed this phenomenon, telling “big, long war stories” about addiction. For example, Thomas said when he first started working with clients that “I would catch myself telling them my life story.” The rich and compelling life of an addict made for lengthy, story telling among counselors. Two counselors in particular saw themselves as natural storytellers, who could tell stories “without any problem for days and days and days.”

I’m a story teller and I’ve got some stories to tell. And early on I made a mistake of talking about my adolescence and it would turn into these big, long war stories. They [clients] wanted to hear, “What did you do?” They wanted to hear how exciting it was…(Linda)

Other than being good storytellers, there were a number of reasons that recovering counselors revealed more about themselves to clients early in their career. One reason for less
restrained self-disclosure was connected to the climate of the substance abuse field when
counselors entered the profession. A number of recovering counselors said that unlimited self-
disclosure was a common practice in the substance abuse field 20 or more years ago. Jack said
that it was common to tell "A chunk of your life story at a focus for a group and then to see what
kind of discussions it would prompt.” In other words, it was normative in the substance abuse
field for counselors to not only reveal their recovery to clients, but also to tell stories about their
lives as a method of intervention.

Another reason counselors gave for self-disclosing too much early in their career was
because of a lack of education, training, and adequate supervision. Paula said that she “didn’t
know how to do anything else” therapeutically but to self-disclose her recovery because “That
was the only thing we had was our recovery history.” Paula didn’t have any other tools, training,
or knowledge of therapeutic techniques early in her career, relying on self-disclosure as “the
 technique.” Another counselor, Jennifer, also discussed her reliance on her personal recovery in
working with clients, stating that self-disclosing was simply “easy” because it “won me that
immediate relationship” with clients, rather than putting thought into building the therapeutic
alliance through more formal and therapeutic means. It was only through supervision that
Jennifer became aware of why she used a lot of self-disclosure in her early work.

Early in their career many of the recovering counselors themselves were fairly new in
their recovery. Thus, for one counselor, Thomas, his early career was “ego-driven,” as recovery
was at the forefront of his identity. He said that recovery was a “badge of honor” he wore and
thus talked “too much” about his own addiction and recovery. Thomas views this dynamic as
common among those new in recovery.
Only three recovering counselors reported no change in their use of self-disclosure over time. When both Jim and Kevin entered the substance field as counselors they were told by educators and supervisors to avoid self-disclosure, as it was literally considered “a sin” in certain treatment settings. Thus, Jim and Kevin did not engage in telling “big long war stories” like the other recovering counselors early in their careers. The third recovering counselor for whom self-disclosure rates did not change over time is Lance. He said that his use of self-disclosure changed “contextually rather than chronologically” based on the expectations and policies of the treatment facility where he was employed.

Among recovering counselors who self-disclosed more often in their early career, all have reduced their self-disclosure with clients becoming more purposeful and selective in revealing information about themselves to clients, and thus using self-disclosure as a therapeutic strategy rather than an automatic practice in counseling. As Linda said, her use of self-disclosure is more “treatment focused” today than it was early in her career, and thus her use of self-disclosure has declined. Similarly, Paula has reduced self-disclosing to clients: “I am very choosy about the times I self-disclose. I want to use it as a therapeutic strategy.”

Many of these counselors, over the course of their careers, pursued formal education at colleges and universities, and adopted a professionalized outlook on self-disclosure, either using it judiciously with clients or not at all. In deciding whether to self disclose, recovering counselors are much more likely today to interrogate their motivation and purpose for self-disclosure with clients, asking themselves: “What am I trying to do here?” (Thomas) or “What is this going to do for impact?” (Paula). In asking themselves such questions, clients are foremost in the minds of recovering counselors. For example, Jack pondered, “Is it going to be helpful to the client?” The majority of recovering counselors expressed the same sentiment as Jack on self-
disclosure, considering the client’s needs, characteristics, and the potential benefit of self-disclosure. Because self-disclosure is client- and treatment-focused for the majority of recovering counselors today, their use of self-disclosure has declined over time and is used “sparingly.”

In addition, recovering counselors differentiated between levels of self-disclosure from sound bites to war stories, and various personal revelations in-between. As stated above, recovering counselors who told “long war stories” about their addiction and recovery early in their career became more judicious in their use of self-disclosure over time. Most have reduced their self-disclosure to brief “sound bites” and “saying just enough” so the client knew they were in recovery without getting into “war stories.”

So I’m not going to go in and tell you war stories about what went on with my addiction, but I can cue you enough so that you know what I’m talking about. (Kevin)

If I was self-disclosing, it might be a minute sound bite and that would generally be it…Reminding them that I’ve been there. It’s the common thread of experience that is so important that is being pulled out of the substance abuse field. (Jack)

Through brief self-disclosure, Jack reminds clients that “he’s been there.” He bemoans how shared recovery between a client and counselor, what he terms the “common thread of experience” is downplayed in the substance abuse field. Another counselor, Charles, perceives the initial self-disclosure of recovery with clients as “establishing a baseline” of credibility.

I will tell a client when I first start working with them…I will just reveal that I am in recovery. Period. And to me I am just kind of establishing a baseline so that they in the back of their head go, “Ok, when this guy tells me something he is not just telling me it from a textbook.” (Charles)

Charles wants his clients to be aware that his knowledge of addiction and recovery comes from more than a textbook, it comes from personal experience. Other counselors, including
Charles, communicate their knowledge of recovery more subtly through their understanding and empathy.

It’s the use of empathy, that at least they get a sense that I know where they are coming from. And I don’t have to self-disclose for them to know that I know where they are coming. (Charles)

Charles coined the term “indirect self-disclosure” to capture a way of communicating that he understands a client’s experience without directly linking it to that of the counselor.

This was a preferred form of self-disclosure by counselors concerned about the clients learning too much about their lives.

I give them information that they could go look it up in the library…It is very generalized. Again, it is more indirect self-disclosure. You know, basically I communicate the knowledge [of addiction] and I say, “Well you are probably feeling like this…” (Charles)

In indirectly self-disclosing, Charles does not reveal specific information about his life, but draws upon common knowledge of addiction.

Some counselors were hesitant or cautious about using self-disclosure with clients. For these counselors, self-disclosure was seen as a “last resort” when they realized that nothing so far was working with a client.

I use disclosure as just my last kind of tool in the toolbox. (Paula)

To me, in order to have the hope, they gotta have options. And if they start saying, "Well, I can’t do it because of this, and I can’t do that because of this, and they start narrowing their treatment options," so that is primarily why I self disclose. (Linda)

When counselors believe that a client is close to relapse and that the therapeutic situation requires another approach, they may self-disclose more information about their lives than simply a “sound bite.”

And then if they are continuing to struggle with being overwhelmed…But only when I have done all the other stuff and it’s kinda a last resort deal, and again when I see that it’s close to a relapse. (Charles)
I said to this client, “I was actually an abuser.” And for some reason this seemed to make a difference to this person and they ended up saying, “Why did you tell me that?” And I said, “Because this is one of the issues that you’re trying to figure out how to deal with.” (Jack)

In revealing more than his recovery status, Jack attempted to normalize the client’s experience; reducing the client’s shame.

“Building Clinical Capital,” Problem Solving, and Instilling Hope

Recovering counselors indicated several reasons for self-disclosing their recovery with clients. Prominent among the reasons given for self-disclosure included the development of client trust in the therapist, helping client’s navigate recovery, and instilling hope in clients. More than half of recovering counselors said self-disclosure facilitated the counselor-client relationship, earning them trust with the client.

As stated earlier, recovering counselors believe that self-disclosing their recovery with clients establishes immediate rapport with a client, enhancing their credibility with a client, and quickly earns their trust. Lance spoke specifically about earning trust or "clinical capital" through self-disclosure, stating that, "Clients had this sort of instantaneous trust for you” if they knew you were in recovery. Jack echoed Lance’s words, stating that self-disclosure “Reminds clients that I’ve been there,” and according to Jack that information is sufficient for the client “to trust you.”

Client trust in recovering counselors likely stems from the shared experience of addiction, or what Lance terms the “common thread of experience.” The “common thread of experience” shared by the counselor and client weaves together the counselor’s past with the immediacy of the client’s addiction to build a therapeutic relationship. Recovering counselors in this study believe that clients are more likely to trust them because they know about addiction
“first hand.” Lance said that clients' trust in recovering counselors comes from “having been through what you’re trying to help them get through.” Thus, for David, self-disclosure of one's personal history “cements the relationship,” and can be especially helpful with a client who has the attitude of, “I don’t want to work with someone who doesn’t understand.”

Recovering counselors also self-disclosed with clients to help them navigate their recovery. In helping clients through recovery, six recovering counselors reveal information about their lives to illustrate to clients basic recovery principles, how to “work” recovery, and solve problems in their daily lives. For example, if a client is “struggling” in their recovery, counselors might reveal to that client how they coped with and solved a specific problem in their own recovery. Thomas termed this use of self-disclosure as “exacting shared experience.” Through sharing his own struggles “with fear, anxiety, and denial” during recovery and thus giving clients “something they can grasp and utilize for themselves,” Lance is also normalizing the challenges of recovery and all of the emotional turmoil that may arise. In a similar vein, Jim attempts to normalize client struggles: “What the process was like for me and here’s my stuck points…Maybe you’re having some of the same kind of problems.”

Lance, like Thomas and Jim, uses his own life story to help clients navigate their recovery. Lance explains to clients how he used basic recovery skills “to manage events and conflicts and experiences” during recovery. For Lance, he takes a narrative approach to counseling, “storytelling” from his own life as a way to provide clients with direct “evidence” of a person solving problems in recovery. In a similar vein, Jennifer reveals to clients “how she worked through things” in recovery, helping clients “figure out how to walk that path.” It is by sharing their personal experiences, especially the obstacles along the path to recovery, that recovering counselors helped their clients find their way on that recovery path.
A third pertinent reason for self-disclosure among recovering counselors was to instill hope in clients, especially when clients were “struggling” in the recovery process. Four counselors indicated they used self-disclosure as a way of fostering hope in clients. Linda said that her self-disclosures were often prompted by a client giving up hope in their recovery and “narrowing their options in treatment.” Linda believed that client’s hope in the recovery process is based on their perception of whether treatment can work for them. And thus, she reveals to the client something positive about her own recovery process, communicating to clients that “It can work for you because it worked for me.” Similarly, David used self-disclosure with clients who felt they had reached a “dead end.”

If they’re at a particular juncture where it’s really tough for them or it feels like there’s a dead end to it or there’s no hope that kind of thing. And that’s probably the kind of thing that would prompt me to self-disclose. (David)

Generally, in giving a client hope for a successful recovery, counselors told clients a brief story about them or gave them an antidote for recovery. The same was true when counselors helped clients to solve problems in their lives; they shared personal information analogous to their client’s life. In both cases, self-disclosure included details or stories about the counselor’s life. When counselors used self-disclosure to facilitate a relationship with a client, they revealed to the client that they were in recovery and little or nothing more.

The Pitfalls of Self-disclosure: “It Can Work Against Me”

Recovering counselors also discussed the pitfalls of self-disclosing with clients. Interestingly, all three female counselors in this study identified problems that they had encountered with self-disclosure. As stated earlier, a primary drawback of self-disclosure, at least early in a counselor’s career, is revealing too much about their lives.
And I do not talk about my recovery. I don’t tell them I’m in recovery. I just don’t talk about it for multiple reasons. One of the reasons is if we talks about what I’ve done, then that’s what we are going to focus on. (Linda)

Revealing information about recovery will, according to Linda, shift the focus off the client and their recovery process back to the counselor. In addition, counselors believed that self-disclosure could “work against them” with clients. For example, clients may not identify or feel connected to the counselor simply because he or she is in recovery, especially if they have had negative experiences with AA or negative feelings toward a family member in AA.

So it’s not like it’s universally accepted. So it’s possible you can tell someone, “I’m in recovery, I’ve been sober this amount of time”…just could really turn them off because of their transference. (Lance)

I wasn’t in addiction when I was married and had kids, so clients would say “You don’t understand.” So sometimes that information can work against me. And it has and those have been difficult relationships. (Jennifer)

Lance thinks that announcing one’s recovery can bring up negative transference in clients, “turning them off” to the therapist. For Jennifer, her clients were unable to identify with her recovery because they felt that she was unequipped to understand their unique struggles in recovery. Jennifer believes that self-disclosing “worked against her,” undermining her credibility with some clients and making it difficult for her to build trusting relationships with them.

For female counselors working with certain clients, self-disclosure may not build or strengthen the therapeutic relationship as one would expect. Paula, like Jennifer, had her credibility called into question by clients because of using self-disclosure.

They [male clients] knew I was recovering and they used that to discount everything I said, basically with the attitude that well, "You’re just like us, what do you know? You don’t know anything." (Paula)
Paula’s quote raises an interesting question that the data in this study is unable to answer. Is self-disclosure counterproductive for female recovering counselors working with male clients? From Paula’s perspective, the answer to this question is “yes.” Male clients called into question her ability to help them and made negative assumptions about her as a result of her recovery.

And I don’t think it’s safe especially for women to self-disclose in a group in a building where there is no protection because certain clients [male] get the wrong idea about recovering women counselors…They just assume that any female is easy game. (Paula)

Paula has observed that male clients hold certain stereotypes about recovering women, such as these women are sexually available and “easy.” Other counselors have identified a parallel with Paula’s story. Clients may have preconceived ideas about recovering therapists, whether they are female or male, that renders self-disclosure therapeutically ineffective.

The really resistant and defiant client will associate recovering counselors with AA and NA or whatever. “[They would say] So you’re a preacher rather than a therapist.” If they’ve got a preconceived notion, self-disclosure isn’t really in my particular best interest. (Jim)

Counselors identified other problems they associated with self-disclosure such as a client using the information to undermine, verbally attack, or manipulate the therapist.

My self-disclosure ended up somehow being manipulated by clients to meet their needs. They would remind me of something I said and it would catch me off guard. So it got to be uncomfortable. (Paula)

But when you see pathological manipulative features, it would be used as ammunition later, so I just don’t. (Charles)

Paula has experienced the negative repercussions of self-disclosure as clients used information about her life as “a tactic for manipulation.” Similarly, Charles is aware that self-disclosure can be used as “ammunition” especially by clients with personality disorders. Charles’s choice of the word “ammunition” suggests that self-disclosure can be damaging to
counselors and their relationships with clients, opening the door for non-productive exchanges between the two.

Self-disclosing with clients can also cause difficulties in counselor’s relationships with other co-workers, especially with non-recovering counselors. Specifically, for some participants relational tension arose between recovering and non-recovering counselors over the use of self-disclosure with clients. For example, Jim recalled incidences with recovering counselors who expressed frustration and anger toward him over his self-disclosure of recovery with mutual clients.

So whenever I would self-disclose for whatever reason…It was not uncommon for non-recovering counselors to come to me afterwards and say, “Thanks for sabotaging my therapeutic alliance with that particular group or person.” (Jim)

Jim’s non-recovering colleagues felt that their credibility with clients was undermined by clients knowing about Jim’s recovery. Such reactions from colleagues are why Jim said in his interview that he viewed his recovery as a “plus when working with clients” and a “minus” with other non-recovering professionals. The “minus” according to Jim is that non-recovering counselors may view his recovery as an “unfair advantage” with clients in establishing their credibility, building rapport, and facilitating change.

Before concluding this section, it is important to point out that among recovering counselors there was not a consensus on the appropriateness of self-disclosure with clients, nor in the amount of information to divulge to clients. Two counselors in particular, Paula and Linda who had self-disclosed early in their careers, were adamantly opposed to it today. Linda views her recovery as “irrelevant” to her work and does not openly share her recovery with clients in principle. Other counselors like Jim and Kevin are very “cautious” in their self-disclosure, either because they question the motives of a client’s inquiry about their recovery, or because of
concern about the professional ramifications with colleagues over its use. Still, other counselors held no reservations about self-disclosure and were very open with people about their recovery.

I’m pretty open with my recovery, almost as a political statement…I also believe that in order for addiction to be recognized as a much more commonplace and treatable ailment, there has to be more people that take the risk to acknowledge that "I’m a recovering addict" and to put a face to the disease. (Thomas)

In conclusion, self-disclosure is a tool that the majority of recovering counselors used “sparingly,” either to establish rapport with clients, help them problem solve, or give them hope for recovery. The content and amount of information that recovering counselors revealed to clients depended on their intent and what they wanted to see happen with clients. Generally, simply informing clients in a few words that they were in recovery was sufficient to earn a client’s trust. Self-disclosure with the intent to problem-solve or instill hope usually required more lengthy and detailed revelations. For some counselors, very personal and specific self-disclosures were to be avoided and used only as a “last resort” when the client was close to relapse. Although most recovering counselors self-disclosed at the very minimum their recovery status to clients, they were aware of the problems that could surface as a result of their self-disclosure. Thus, for the majority of recovering counselors, they used self-disclosure “judiciously” as a therapeutic strategy, thinking of how it could benefit the client. The resulting themes for self-disclosure were: (a) Reduction of Frequency and Refinement of Intent: From “Big, Long War Stories” to “Therapeutic Strategy,” (b) “Building Clinical Capital,” Problem Solving, and Instilling Hope, and (c) The Pitfalls of Self-disclosure: “It Can Work Against Me.” (See Table 3).

Countertransference

The construct of countertransference was the most difficult construct to analyze due to the highly variable responses of recovering counselors. Some of the variability in
countertransference responses was to be expected because of the uniqueness of each counselor’s past, in particular their family life. Differing perspectives and diverse stories among counselors on this construct were likely the result of how counselors defined or understood the construct. Although the researcher provided recovering counselors with a definition of the construct prior to and during the interviews, there was still confusion about countertransference. For example, some recovering counselors would identify an emotional reaction or an empathetic response as an example of countertransference. In short, recovering counselors had the most difficulty answering questions about countertransference than with any other construct due to their uncertainty over what counseling experiences actually constituted examples of countertransference.

What is notable about the construct of countertransference is that it presented the fewest patterns in the data compared to other constructs. One pattern that was found included counselors experiencing countertransference with clients who were similar in presentation, history, or personality to that of family members or to themselves. Another pattern that arose from the data concerned emotional and behavioral manifestations of countertransference for recovering counselors. The final pattern to emerge was that recovering counselors discussed the various ways that they managed countertransference from simply acknowledging and identifying what was happening to them in the therapeutic relationship to seeking more formal supervision.

*Clients Who Remind Counselors of Family Members or Themselves: “Just Like My Brother and Sister”*

As stated, not all counselors correctly identified actual countertransference issues in their work because of a lack of clarity around the term. For example, Kevin told the story of working
in a substance abuse prevention/intervention program in a school setting with adolescents. He recalled how frustrated he was with some of the teenagers to the point that he disliked them.

I had a 14 year old son that was doing drugs…I couldn’t understand why I had such negative feelings towards those kids. Now it seems like, “Gee that’s obvious.” (Kevin)

Kevin’s experience is akin to countertransference but his example does not fit the actual definition for countertransference because his feelings arose outside of a psychotherapeutic relationship. He was not counseling the adolescents he worked with, and thus his reactions would not be formally considered as countertransference.

Five recovering counselors said that they experienced countertransference with clients who reminded them of immediate family members such as parents and siblings. Clients who physically resembled and/or behaved like a family member could provoke strong negative reactions such as anger in recovering counselors.

And it was coming out and I would snap at them. And I was just not therapeutic at all…And after about six months all of a sudden it hit me that these guys were just like my brother and sister. Exactly. I mean the total disregard for anybody else, total focus on themselves. (Linda)

I had a bizarre, still do, relationship with my brother. This was the guy that taught me to shoot up when I was 14 years old. I have this mixed sense of idolization and hatred for this guy. And I remember working with this kid who reminded me so much of my brother. I just couldn’t work with him at all. (Thomas)

Thomas said that he felt “absolute rage” toward his client who reminded him of his brother, and wanted “to get up and smack him” while he was talking. His anger toward this client was so intense that he concluded in consultation with his supervisor that he could not effectively work with this client. Various emotions other than anger arose for recovering counselors experiencing countertransference. For example, Jennifer felt tremendous fear and anxiety when working with a client who reminded her of her mother who died of alcoholism.
I had a client in my private work who is in the process of trying to decide whether she is an alcoholic. She is my mother’s age. My mother died of alcoholism…I start to get really uncomfortable when people that I genuinely believe are alcoholic through to their core place themselves in risky positions. (Jennifer)

This particular client had decided to drink on her anniversary and Jennifer felt very “uncomfortable,” fearing for the health and well being of the client. According to Jennifer, emotions such as fear may arise for her if clients make “risky” decisions similar to that of her alcoholic mother.

Four recovering counselors spoke about countertransference with clients who reminded them of themselves or their experiences, especially when they were in the throes of addiction. Two counselors, Charles and Lance, had strong reactions to clients who shared their drug of choice. For example, before his recovery Charles overused prescription medication to manage anxiety. He experiences anxiety with clients who have a similar addiction history, especially when they are “stuck” or resistant in treatment.

The ones that tend to be treating or their primary purpose for substance abuse is to reduce anxiety. It is almost like I am more motivated to get them to the other side of that because I know what is on the other side of it. So it is more of an anxiety for them you know. (Charles)

Some counselors experienced countertransference with clients whose story brought up for them painful memories from the past. For example, Jack “reacted strongly” to clients who had a history of abuse of girlfriends, wives, or children.

I still find that I have the ability with certain things that happen with clients to react in a negative manner…A fair number of people under the influence that have children abuse them…During my addictive process, the first seven years of my son’s life, there was emotional abuse…I do react strongly to that. (Jack)

When working with “abusers,” Jack’s guilt and sadness over what he terms the “emotional abuse” of his son arose. Jack clearly stated that he has little tolerance for people with
a past history of being abusive, and will refuse to work with the client unless the issue is resolved immediately and there is no more abuse perpetuated.

*Manifestations of Countertransference: “Anxiety, Anger, Confrontation, and Rescuing Clients”*

During the course of the interviews, patterns emerged associated with manifestations of countertransference for counselors that were both emotional and behavioral in nature. Specifically, counselors discussed emotional reactions to clients that were rooted in their own unresolved issues, either with substance use, family members, or oneself, and these emotional reactions ranged from experiences of anxiety to sadness to rage. Additionally, behavioral manifestations were reported that ranged from confrontations of the client to asking that the client be reassigned to another counselor.

Charles was the first participant to discuss having an emotional manifestation of countertransference when working with clients, specifically when those clients are struggling with making progress or coming to an insight. Charles indicated that he experienced anxiety when clients are not progressing in treatment or if they are on the verge of reaching a new insight about their addiction but are having trouble arriving at that insight. Two other recovering counselors reported experiencing anxiety when working with clients and having their own unresolved issues touched upon in the counseling process. Jack stated that, “A portion of my clients will go on and die.” He seems to have communicated that this creates an internal experience of anxiety for him, and because of this he will “want to overwork” in an attempt to reduce his own experience of anxiety for his clients. Jennifer, like Jack and Charles, experiences anxiety in relation to clients. For Jennifer, her issues growing up with an alcoholic mother surface when clients dependent on alcohol are naïve or in denial about their ability to manage
their drinking in social situations. With these clients, Jennifer reacts in what she terms a “fear based” manner.

I start to get really uncomfortable when people that I genuinely believe are alcoholic to their core place themselves in positions that are risky…In the third session she (client) started talking about wanting to have a drink on her 23rd wedding anniversary…There was a very strong reaction, I think it was fear that what would happen if she drank on her anniversary. (Jennifer)

Another emotional manifestation of countertransference among recovering counselors was anger or rage. Five recovering counselors reported feeling some degree of anger toward clients when sessions brought up something personally painful or offensive to them. In Paula’s case, angry feelings were the result of judging a client’s life and choices, as a client’s values clashed with her values. Paula, an animal activist, had a client who fought chickens as a hobby. Paula strongly disapproved of the client’s behavior and thus disliked her client from the beginning of treatment, as her judgment and anger were difficult to contain in sessions.

I’m sure she could see my judgment was coming out because I’ve always kind of seen myself as an animal activist. I hate dog fighting. I hate chicken fighting. I hate bull fighting. I hate anything like that. I hate it. (Paula)

In Paula’s case, “hating” animal fighting in general was an issue that she could not get past in working with this specific client. Counselors harbored anger toward clients for a number of other reasons that were rooted in their own issues and experiences. For example, Linda responded in anger toward clients who were similar in personality and attributes to her siblings for whom she still held painful feelings of loss and resentment. There were times for counselors when their anger boiled over into rage toward clients. Jim spoke of a client who was similar in appearance, mannerisms, and behavior to a client who had committed suicide. This particular client was indirectly communicating a wish to end his life during a group session, in which Jim responded with uncontrolled fury.
In group he said something or did something and I went off. I got into his face. I was to the point that I was literally screaming at him. This went on for a good five to ten minutes, which was clearly it’s my stuff coming up to where I gave him a verbal lashing that was just as shaming and as un-therapeutic as it could be. (Jim)

Jim was unaware at the time of giving the client a “verbal lashing” that his rage was connected to his unresolved feelings about a client who had committed suicide. Only later during supervision and reviewing the videotape of the session did he realize the connection between his issues and his behavior with the client. Unlike Jim, Thomas realized immediately the source of his anger, but nonetheless felt rage toward a client who reminded him of his brother.

A kid came into rehab and reminded me so much of my brother. [Interviewer: What kind of feelings did he bring back for you?] Rage. Absolute rage. It was so interesting. And yeah, I remember listing to this kid talk and he had similar mannerisms and I just wanted to get up and smack him. (Thomas)

Another emotion that arose from countertransference among recovering counselors was sadness. Specifically two counselors, Jennifer and David, experienced deep sadness in relation to their clients whose lives in some way touched upon their personal struggles and issues.

In the negative side of things, it’s probably these days the sadness of seeing people stuck you know, not so much the resistance I do really interpret as just being sorta like a reaction and not being ready...When I see people, even including the deaths that have occurred that just could not quite make it. (David)

And I had these two women in the dual diagnosis unit. They were just completely noncompliant, completely manipulative. Both had had some really long track records in their parenting skills that were very harmful to their kids. They both wanted to leave treatment and I was so exhausted one day that I just started to cry. (Jennifer)

Jennifer’s expression of sadness through tears arose during a time of transition to motherhood and the corresponding fear and confusion she experienced in relation to this new role. These female clients seemed to heighten her fears about motherhood, and thus she “broke down” when these clients threatened to leave treatment.
As stated, recovering counselors expressed countertransference both emotionally and behaviorally. Behavioral manifestations of countertransference among this group of recovering counselors involved rescuing clients, confronting and arguing with clients, and asking supervisors to reassign a client to a different counselor. Two counselors attempted to “rescue clients” when their own anxiety was heightened in a session. “Rescuing clients” entailed rushing the therapeutic process by pushing clients “too hard” or giving clients answers and solutions rather than allowing them the space for self-discovery.

I could put in 100 hours a week and with some people that would not make a bit of difference…So I think there’s a real tendency as a recovering counselor to want to overwork, to want to do too much, push too hard…And mostly they’re pretty good about reminding me that that they will work at their own pace. (Jack)

I get kind of anxious or impatient with the person because I see, countertransference-wise, I see. I know empathetically where they are at and that they are on the verge and the negative problem is that I rescue because I’ve helped them over the hump. (Charles)

Jennifer is another counselor who experiences anxiety in relation to clients, but does not resort to “rescuing them” like Jack and Charles. Jennifer more successfully manages her anxiety in the therapeutic space, even at times when her thoughts are filled with worry about a client, she gives her clients the space to struggle and make mistakes.

A second behavioral manifestation of countertransference among recovering counselors was confronting or arguing with clients. Three counselors reported confronting or arguing with clients. Linda felt herself getting mad at a certain type of client, and would argue with them about their choices and behavior.

I was getting mad. And it was coming out and I would snap at them…I was getting into power struggles with them. I was confrontational you know, I was arguing. And part of it was that I didn’t know any better. (Linda)

The third behavioral manifestation of countertransference was avoidance as indicated by three recovering counselors who had asked supervisors to reassign a case.
And I started having negativity toward the whole process then reviewed that with the supervisor...I had a 14-year old son who was using drugs at the time. [He said to his supervisor] “I can’t continue to do this.” I wasn’t effective at all and essentially asked to be taken off. (Kevin)

I had to talk to my supervisor and say, “Look, this guy, I got this stuff with my brother and it’s unresolved” and it brought up stuff that I had to begin to address again… I couldn’t do it. I just couldn’t work with him at all. (Thomas)

In each case, Thomas and Kevin could not come to terms with countertransference, choosing in part to avoid strong feelings that arose in relation to clients. In Kevin’s case, he believed that he could not be effective with a group of clients because of his anger, and chose to be reassigned rather than address and work through his anger. Thomas felt so much rage toward a client that even in addressing his feelings toward his brother he felt he could not continue counseling this client. Avoidance in each case may have also been out of concern for the client’s well being and the potential for the therapeutic process to be compromised.

**Managing Countertransference: “Awareness, Supervision, and Self-talk”**

Seven recovering counselors said that they usually sought supervision or consultation with colleagues when countertransference arose with clients.

I went to a recovering therapist. I went to somebody that I knew that I admired and was a mentor for me. As soon as I self-disclosed you know it normalized it to hear him say, “It’s normal, it happens to us all.” (Jim)

I had to talk to my supervisor and say, “Look, I got stuff with my brother and it’s unresolved” and it brought up stuff that I had to begin to address again. I couldn’t work with the guy. (Thomas)

I don’t usually recognize it immediately; I just know it throws me off center for awhile. And when I’m starting to feel that off-center feeling, that’s when I need that kind of supervision. (Kevin)

In some cases, once recovering counselors recognized the origin of their feelings, and what in the client provoked their reactions, they were better able to manage their feelings.
Once I recognized it, it wasn’t an issue anymore. I still don’t like narcissists, but I’m surrounded by them all the time. (Linda)

Other strategies recovering counselors used to manage countertransference included

“self-talk” where they would have an internal dialogue about their feelings while counseling a client.

It really is self-talk just sitting there and going ok, wait for it. I just really have to repeat to myself to be patient…And if I can’t resist the urge [to rescue] then I will redirect myself instead of shooting straight to the answer and rescuing, I will come to the concept from a different angle. (Charles)

I don’t get as frustrated as I used to because now I’ve got enough experience, enough training…So when somebody is getting under my skin a little bit, I have to stop and say, “Oh there’s something going on with that person.” (Linda)

That starts to surface and I start to think about that very clearly in the session…I do a lot of self-talk in terms of “What question do I want to ask next and why do I want to know that information?” (Jennifer)

Linda’s self-talk involves realizing she is emotionally reacting to a client from her own issues.

For Jennifer, after she realizes that countertransference is happening with a client, in the next session she carefully monitors her reactions and therapeutic strategies with the client.

In conclusion, the construct of countertransference was least understood by the participants in this study and thus produced the least in the way of themes or patterns. Given the various definitions and ideas about countertransference in the counseling field, however, this degree of variability and confusion about the moderate definition were to be expected.

Additionally, the countertransference reactions that participants did describe were often unique to their own personal histories or personalities, such as Paula's reaction to a chicken-fighting female client, and as a result the accumulation of patterned responses was limited. Nevertheless, there were three resulting themes that emerged associated with countertransference as follows:

(a) **Clients Who Remind Counselors of Family Members or Themselves:** “Just Like My Brother
“and Sister.” (b) Manifestations of Countertransference: “Anxiety, Anger, Confrontation, and Rescuing Clients,” and (c) Managing Countertransference: “Awareness, Supervision, and Self-talk” (See Table 4).

Spirituality

Openness and Complexity of Spirituality: “A Belief in Something”

All recovering counselors discussed the concept of spirituality in a broad sense, and the absence of references to specific religions or religious institutions was notable. Some counselors said that spirituality was indescribable while others saw it as an exploration of a person’s beliefs, values, and relationship to the larger world. Often the language counselors used with regard to spirituality was vague because of their emphasis on a client’s subjective understanding of it. Recovering counselors were generally open-minded about and accepting of various spiritual beliefs and practices, recognizing the value in self/spiritual discovery.

I can sit and listen to fundamentalist Christians talk and I can listen to pagans. I had one guy who was a Celtic shamanist, and it allows me to be supportive of all of it. And I can say, “that’s great,” and mean it. Because I really think sincerity, they can pick up on that…It allows me to support whatever their religious beliefs are. (Linda)

As a consequence of being broad-minded about spirituality, some counselors were reticent or unable to define spirituality because of its complexity and very personal nature.

That it’s really difficult to talk about because it covers such a wide swath that is so personally defined. (David)

Spirituality to me is just, I can’t define it, I don’t know of any two learned people in the world that, if they write the same definition down, will come up with the same exact answer. (Jim)

So spirituality has been a complex issue for me in my recovery…it has been very difficult for me to keep it simple. So I don’t. I keep it complex…So I guess my spirituality is kind of hooked up to an almost intellectual complexity and I know a lot of people discourage that, but that’s just who I am and how I do things. (Lance)

Lance stated he was unable to keep spirituality in “simple” terms because of his deep
contemplation of it’s meaning. Additionally, other counselors viewed spirituality generally in nonreligious, vague terms that involved beliefs and values.

I define spirituality as in, even if it’s nothing more than their belief system in the therapeutic approach…that in itself is a type of spirituality…Some sort of belief system, you know, that enables them to go ahead and engage in that stuff by the clinician. So I see it, my little premise is, you can’t define it. (Jim)

I would define spirituality just so you know where I’m coming from, is not a religious, necessarily, experience. It is just a belief in something that is greater than you, whatever it is. (Jack)

And that’s what kind of spirituality is to me. Once again, it’s that, finding what your basis is, how do you decide right and wrong…It is a kind of quest to be able to explain why you are and kinda why you usually do what you do. (Kevin)

Note that Jack’s definition of spirituality leaves the idea of “a belief in something” undefined. Similarly, Jim above does not specify the contents of a spiritual “belief system,” suggesting that a person’s faith in therapy is akin to a type of spirituality, with faith as the defining feature. Kevin also does not address the specifics of spirituality, associating it with the nebulous qualities of values, self-understanding, and motivation.

The complexity of spirituality for recovering counselors was evident in their personal history, their search for a spiritual path, and the evolution of their approach to spirituality in their work as counselors. The majority of counselors indicated in the interviews that their recovery process involved a search for life’s meaning and a spiritual reality. Although not all counselors indicated their particular religious or spiritual leanings, the ones who did indicated that they had explored in their recovery many Western and Eastern religious and spiritual traditions.

When I got into recovery…I was told that AA and NA were not religious, although they certainly followed most Christian doctrines and etcetera pretty closely. Started to fight those by reviewing the history of Wilson and Dr. Bob…found out that they had gone through religious processes but really rejected most organized religion and then came to a different understanding of spirituality. That got me into, kinda, Eastern philosophies, Ram Dass, and all that. So I just went through the whole gamut. (Kevin)
I went through a pretty profound spiritual awakening, probably about 16 years ago, and I was really stoned on spirituality. I mean, I was reading everything. I was reading Christian mysticism, Hinduism, Buddhism, a lot of esoteric text, the Upanishads. I mean, you can see that whole bookshelf, it’s almost all of it, is religious text, I mean, I just -- You know, and I gravitate more towards Buddhism more than anything. (Thomas)

Thomas said he was “stoned on spirituality” during recovery, “reading everything” about religion and spirituality. The six counselors who identified a spiritual framework for their lives either tended to “gravitate” like Thomas towards Eastern traditions, earth-based religious practices, or a more broadly defined Humanistic-Existential philosophy.

I’m an existential kind of guy. I mean, that’s kinda obvious. But having said all of that, I’ve never lived in a bubble, and some of my greatest awareness has come through my struggles. (Jim)

I am a non-Christian, non-Jew, non-Muslim, which in the dictionary says I’m a pagan. More earth religions but no religion really. My favorite place to pray is out in a tree. And I developed this spirituality in AA… and they would say it’s a God of your understanding. So that opened, it freed me to choose. (Linda)

Spirituality is difficult for me to talk about. I just took a class on spirituality and counseling at Lenoir-Rhyne, which was a real Christian-based course, and I’m kind of a mixture of Christianity and Buddhism. (Paula)

For counselors like Paula and Linda, there is the sense that their spirituality is amorphous and perhaps open to change. As Paula said, “I’m kind of a mixture” of two traditions. This seemed to be true for all the counselors who identified a spiritual leaning; that their spiritual beliefs were open to revision through self-reflection, self-study, and experience. In other words, counselors loosely held their beliefs to be true for them, but only for them.

The purpose for examining recovering counselors own spiritual history and beliefs was to provide a context for understanding the role of spirituality in their work with clients. To briefly summarize the above findings, all recovering counselors in the study were non-religious individuals who reflected upon spiritual traditions, concepts, and ideas in their own lives and
recovery. For most, spirituality was a complex matter because it involved a process of exploration and self-discovery that is unique to the individual.

Addiction Needs a Spiritual Solution: Transcending a “Me-centered World”

All recovering counselors in the study spoke of the importance of addressing spirituality with substance abuse clients, encouraging clients to reflect on spiritual ideas and themes in their recovery.

The quick answer is, yes, spirituality plays a role. And I certainly recognize its importance in a practical sense as well as a theoretical sense. (David)

But yeah, I mean, so I recognize the importance of spirituality in recovery. When I’m working with an individual I try to get them to explore it. So yeah, I mean, I fully understand that it’s a critical component of recovery and I try to get people to utilize it as best I can. (Thomas)

There are moments I suspect, in every recovering person’s life, where it’s just them and their spiritual beliefs that stand in between them and their next drink or drug use...And if I don’t communicate that on some level with them, about having some relationship with their own spiritual system, then I will have done them a disservice. (Jennifer)

Recovering counselors like Jennifer, above, believe that spirituality plays an important role in sustaining recovery because of the nature of addiction. Recovering counselors conceptualize addiction in both individual and spiritual terms that involves isolation and a disconnection from self, core values, other people, and ultimately spirit; all problems that require a spiritual solution. For example, the counselor below sees the addict as a person mired in self-centeredness who needs to expand their sense of self to include the broader world.

With the personality traits typically attributed with addiction -- selfishness, self-centeredness, you know ego-type stuff. I do use some spiritual concepts with that, about how through substance abuse, they’ve developed a me-centered world as opposed to a anything-but-me-centered world. You know, then you kind of end up being forced to use spirituality in that sense. (Charles)

Charles’ notion of addicts living in a “me-centered world” was echoed by other counselors who spoke specifically about addicts living a life of social and spiritual isolation.
But being able to get to the point to say that “I need your help,” because truly, one of the most significant components of addiction to me is the isolation. (Jack)

It’s a challenge to work with someone who doesn’t have any sense of spirituality, any sense of spirit within them, because they are so isolated sometimes within themselves that they’re just not connected to other people, animals, the world…There’s an absence of spirit, of some type of human spirit within them. (Paula)

According to Paula, an “absence of spirit” within a client leaves them isolated, and it may be difficult for them to reach recovery. The idea that substance abuse clients are lacking in “spirit” was identified by other recovering counselors as well, such as Lance and Jack who believe that addicts have lost connection to their inner “core” and the basic moral and religious values they had prior to abusing substances.

That it may be about spiritual need or lack or want, but it’s a human problem, and that these are all human beings suffering…That they’re usually humans that have lost contact with the core, and aren’t about to get it back without someone caring about them, since you’re going to move them in that direction. (Lance)

Most people have so violated whatever the basic beliefs that they started out life with, that there is a moral bankruptcy, certainly, a really strong moral ambiguity. And spirituality offers people a way of beginning to rebuild that and change it and own up to who they are. (Jack)

And it’s the thing that is damaged or adversely affected when people are in the throes of their addiction. They usually will either talk about a sense of separation from spirituality or a separation from, an alienation from, their religious upbringing…and from themselves, a sense of really being at war with themselves. So, I recognize its importance. (David)

David claims that a separation from spirituality leads to inner turmoil and the experience of “being at war” with the self. He stated that because one’s spirituality is “damaged” in addiction, then the path out of addiction into recovery involves repairing a damaged spirit and a loss of connection to self, values, etc. As Jack said, spirituality gives clients a way to “rebuild” their lives. In conclusion, recovering counselors articulated a need for clients to embrace spirituality in their recovery. To these counselors, spirituality sustains recovery as clients
develop a world view and set of values that lessen their isolation and connects them to
“something outside of themselves.”

“Individualized” or “Client-driven” Approach to Spirituality

In discussing spirituality with clients, all recovering counselors took an “individualized”
or “client-driven” approach. Some counselors such as Charles were circumspect about bringing
up the topic of spirituality, considering the needs of the client and whether he or she would
benefit from an exploration of spirituality.

When it seems to be a client, that their presentation, their comments, whenever they
suggest that they have a lack of connection, or a lack of hopefulness, a lack of a
spiritual connection…from whatever else that it would be beneficial…So I do use it, but I
use it very client specific, very individualized. (Charles)

Other counselors communicated a desire for spirituality to be “client-driven” in the sense
that it is self-initiated, arising from a client’s religious background and interest in exploring
spiritual beliefs and practices.

I think spirituality, and a belief in something, often leads people back around because of,
perhaps, earlier training, to some kind of a religious experience. I don’t push that, I don’t
emphasize that, that’s completely client driven in that sense. So if somebody says, “Do
you believe in God ?” I may say, “Yes, but my personal beliefs are my personal beliefs.”
(Charles)

I’m not oriented, even in terms of my own emphasis on spirituality, to try and persuade
someone along any one particular line. And I certainly don’t operate like Christian
counselors…They want to sorta sell to the person and have them adopt. I certainly don’t
come from that kind of orientation. (David)

Counselors such as David and Charles are cognizant of keeping their own framework for
spirituality separate from their work, thus giving clients the freedom to develop their own
beliefs. Counselors encouraged their clients to explore their spiritual beliefs, develop working
definitions and practices of spirituality that support their recovery.

And so, I guess my encouragement would be, do an adult study of whatever religion you
think is the “right one.” If it doesn’t pan out for you, try another one. You’ll probably
come to a conclusion somewhere that some of this and some of that is where it stands. (Kevin)

Some of the first things that I’ll do is try and explore the definition of spirituality with people. What does it mean to them? And try to draw a distinction between spirituality and organized religion and have the person come up with a working definition for them of what is spirituality, what is their relationship with the world around them, what is their place in the world in the larger scheme of things, in the big picture. (Thomas)

And I encourage them to expand their activities and directions that may encourage it, even in terms of getting alone, having private time, private space, quiet places and meditation. And if they want to discuss it, then I’ll do that, but, as you can hear, in a very broad and non-evangelical way, so I’ll do that and I recognize its importance. (David)

Counselors like David encourage client exploration of spirituality in a “very broad and non-evangelical way,” asking clients to draw distinctions between religion and spirituality. Although counselors did not direct their clients toward specific religious beliefs or practices, they often asked clients to consider in spiritual terms “the larger picture.” Consideration of the “larger picture,” counselors hoped, would shift client awareness to a greater reality outside of themselves. As noted above, the problems counselors see as inherent in addiction – self-centeredness, isolation, disconnection – are difficult to change without a powerful antidote.

I believe that people need to be able to kinda tap into that power, because by themselves, I think addictions are more powerful than most people, which is one of the reasons we have so damn many addictions counselors running around… (Jack)

Jack believes that clients must tap into a higher power because of the tenacity of addiction. In other words, people need something “greater” than themselves to overcome their addiction. A majority of counselors spoke of this “greater reality” that they hoped clients would embrace and rely upon in their recovery. Counselors encouraged clients’ self-exploration and “self-study” of spirituality in asking clients to reflect upon the “larger picture.”

Do you make the sunrise? Do you make the sunset? No. OK, well then what does? There’s some power greater than you. There’s something bigger than you. It’s
simplifying matters you know, removing the term God from the equation. What makes
the tree grow? Who the hell knows? All right, there’s something going on that’s bigger
than you, just surrender to that. (Thomas)

I will try to figure out some kind of a way to get them to look at the things that you’ve
been doing have not helped. Can you see that there might be other directions that you
could go and get that help?...And suggesting there might be a power greater than them,
whatever it is, that might be positive, and what have they got to lose by trying that?
(Jack)

At the same time, I recognize the importance of attending to those activities and those
efforts to develop a sense of connection to forces outside of yourself. That is usually, in
whatever forms that comes, and it can come in a variety of forms, that is part of the
development and growth that takes place with healthy recovery. (David)

According to David, “healthy recovery” involves a client forging a spiritual life and
connecting “to forces outside” of themselves. Counselors saw spirituality as integral to recovery
as it mitigated client isolation and disconnection. For example, Charles thought that a client’s
acknowledgement of a “greater reality” in recovery gave them the ability “to seek and adhere to
solutions and answers outside of their own head.” Another counselor believed it gave clients
“meaning and stability” in life, and “energy” and “strength” to draw upon during recovery.

There’s a real sense of being connected to a meaningful reality outside of yourself, a
sense that you can derive some energy from, some sense of proportion and stability and
meaning…you’re asking those, even posing them to yourself suggests a connection to
something bigger than you, to considerations beyond you in some way. (David)

Something to give them strength…There has to absolutely be something outside of them
that has given them the resilience. And when I say outside of them, I don’t mean parents
or systems or those kinds of things, but something certainly instilled or available to them
to draw from as a resource for strength. (Jennifer)

“Necessity” of Spirituality to Recovery: “It May Not Be Essential to Abstaining”

As stated, all counselors in the study believed that spirituality was an integral component
of the recovery process. During the interviews, counselors were asked whether spirituality was
absolutely necessary and essential to the recovery process, and to consider whether recovery
could occur without the spiritual component. Only two counselors suggested that recovery was possible without an active spiritual life.

I don’t think it’s absolutely necessary, I really don’t. I think, again, it goes back to everybody does what everybody has to do in order to make it work. And for me, if I hadn’t had had this spiritual piece, I would’ve been in trouble. (Linda)

Linda points out that each individual has a different approach to making recovery work, but concedes that for herself the “spiritual piece” in recovery was essential. Linda emphasizes the uniqueness of the recovery process while another counselor, Jack focused on the universal criteria for basic recovery, which is abstinence.

Yeah, although I would like to answer that I think everybody should develop a sense of spirituality, I don’t think it’s necessary for people to be in recovery. I think that the only thing that is necessary for people to develop a recovery process for themselves is abstinence. (Jack)

Another counselor agreed with Jack that spirituality is not “essential” for abstinence but that it is “essential” for being human. To the extent that spirituality facilitates human development and having a purposeful and meaningful existence, then without it as Charles said “growth” is “limited.”

It may not be essential to abstaining, because people are able to do that and be miserable sometimes. But my sense is, it may be, I guess my sense is, it’s essential to a full human experience, I guess, I don’t know how else to say it, in terms of a level and depth and meaningfulness, a sense of fullness. (David)

I don’t believe that their recovery, that it’s required. I do believe that their growth potential is limited. (Charles)

Client Resistance to Spirituality: A “Touchy Subject”

Eight recovering counselors spoke of client resistance to spirituality and their efforts to counter that resistance. Counselors were particularly sensitive to client resistance to discussions of God, religion, spirituality, and the 12-step program. Thus, counselors tread delicately and
cautiously into conversations with clients about spirituality, especially in referencing God or religion.

Just trying to find assessment tools for spirituality or talking about spirituality to clients without scaring them or without insulting them is something I’m working on now, because, with the 12 steps, of course it’s all about spirit, connecting spirit, and faith and hope and meditation and prayer and believing in something you can’t see. (Paula)

I don’t make it as any kind of a condition because many of the people that I’m dealing with, spirituality equates with religion, which is a bad word, and if you start talking God stuff and whatever, they’re just gone out the door. (Jack)

Counselors experienced client resistance to spirituality primarily when encouraging them to adopt 12-step recovery principles and to attend meetings. Most of the recovering counselors in the study became sober through 12-step programs and thus utilize many of the principles of the program in their own work. As Thomas expressed below, introducing 12-step recovery tools to clients can be a “touchy subject” because of its inherent spirituality and references to God and/or a higher power.

Well I tell you, that’s a very touchy subject…if I’m working with somebody, inevitably, I’ll try and introduce them to 12-step recovery just because I think that’s a pretty critical tool for someone to have at their disposal. And there’s no way to get around the fact that 12-step recovery is a spiritual path…And inevitably, people have a lot of resistance to it because of that, because the word God is used…(Thomas)

And that’s the, probably, the most first and frequent resistance to going into 12-step meetings. “I’ve heard it’s like a religion and you’ve gotta do, you know, you know, whatever because they use power, as you understand them, a higher power, and they have the Lord’s Prayer.” For those people that are sensitive to that, it kicks that up with them. (David)

Counselors used various strategies to manage client’s resistance to the spiritual concepts and themes of the 12-step program. Some counselors avoid an explicit reference to God and/or religion.

There’s the force and then there’s the dark side. And that way, a lot of times, I can stay away from the connotation of religion, but they can still get the idea that something’s pulling in a positive direction and there is a negative. (Kevin)
Other counselors, such as the one below, chose to “disguise” 12-step concepts to make them more palatable to clients.

Somebody who appears to benefit from 12-step concepts, I still disguise it…It’d never be mentioned as part of the group. Only if at the end of that group, everybody grasped it, and I’m not seeing gobs of resistance to the overall concept…The next week when they come back, I will say remember what we were talking about last week, well this relates to the 12-step concept of the first step or the second step approach.” I kind of disguise it real well. (Charles)

It is only after clients “grasp” certain concepts that Charles links them to their source, the 12-step program. By keeping the sources of ideas and concepts for sobriety hidden, Charles is able to quell and diffuse resistance that may arise. Other counselors anticipate client resistance to 12-step concepts, and thus encourage them to not “get caught up” in the spiritual/religious language used.

Don’t get caught up in the language. Realize that there’s a big door here. We’re just looking at something bigger than you. We’re just looking at a larger picture. Call it whatever the hell you want and try to find a definition that works for someone. And a lot of people are very, very resistant to that. And it’s, boy, it’s a difficult process. (Thomas)

Thomas experiences client’s resistance to a “higher power” as identified in 12-step recovery as a “difficult process” to work through. Thus, he asks them to look beyond the concept to the larger picture, as a tool for sustaining recovery. Other counselors manage client difficulty with spirituality by reframing 12-step recovery programs as opportunities to connect with similar people in recovery.

I try and get them to recognize is that either their group, AA, their sponsor -- there are examples of people who are doing things every day that they haven’t been able to do. And while that may not be a real strong spiritual connection, it’s certainly a person connection. And if they can’t get past the abstract nature of spiritual beliefs and they need something concretized, then they need to start looking at people who they can look up to, respect…(Jennifer)

Look, there are some pieces to it that some people can react to, but there’s, if you can place less emphasis on that, and the other things to be derived from it, because here’s a
collection of people who understand the experience, right?...I had some that were so adamant in terms of not wanting to go in a religious group, and, you know, that doesn’t rule out spirituality to me…it’s still important for a sense of connection. (David)

Both David and Jennifer deemphasize the spiritual and religious aspects of 12-step programs, encouraging clients to think about the concrete reality of attending meetings with like-minded people. Jennifer also addresses client resistance to spirituality by asking clients to consider the faith that they put in their “dealers.”

And when people are totally resistant, what I remind them of is that they honestly have absolutely no idea what they’re using...They are embedding complete trust in their dealer...And if they have the willingness to do that for their addiction, I hope that they can have a similar place to draw that hope and to place that trust, to help them save their lives. And that kind of concrete example usually draws very little reaction or very little contradiction from them. (Jennifer)

Jennifer’s concrete exercise with clients illustrating faith is met with little resistance by those clients. Jennifer asks her clients to take the faith they’ve been putting in their dealers and to find another source for their faith in order to begin sobriety.

In conclusion, an examination of the participants’ lived experiences regarding spirituality relative to their work as recovering substance abuse counselors elicited the themes of: (a) Openness and Complexity of Spirituality: “A Belief in Something,” (b) Addiction Needs a Spiritual Solution: Transcending a “Me-centered World,” (c) “Individualized” or “Client-driven” Approach to Spirituality, (d) Necessity of Spirituality to Recovery: “It May Not Be Essential to Abstaining,” and (e) Client Resistance to Spirituality: A “Touchy Subject” (See Table 5). While the variations in participants' responses were complex, these themes clearly emerged as the data was horizontalized and phenomenologically reduced. The resulting textual description has sought to represent the lived experiences of the participants of this study through extensive use of the participants' voices, as well as thick description of their lived experience.
Chapter 5: Discussion

Introduction

The discussion of this study will begin with a reflection on the study's findings, including an examination of the implications for theory and research. This section will be followed by an explication of the limitations of this research study. Next, future avenues or potential other areas of inquiry related to this study will be discussed. Finally, implications for training and practice will be explored, followed by a few concluding remarks.

The Recovering Substance Abuse Counselor

The purpose of this study was to better understand the lived experience of recovering substance abuse counselors in connection with the constructs under investigation. Specifically, I sought to better understand the overall meaning and essence of being a recovering counselor, as well as how one’s recovery status informs one’s work with substance abuse clients. Furthermore, it was my goal to better understand how recovering counselors experience the constructs of self-disclosure, countertransference, and spirituality in one's work with substance abuse clients. In reflecting on the study's findings, I feel that the goals of the study were, for the most part realized, and that the lived experiences in relation to these constructs emerged through the interview and data analysis processes, and through the presentation of the results.

Bracketing Revisited

Upon returning to the bracketing of the co-analyst’s and my own preconceived notions, ideas, and expectations concerning what might come out of this study, it is striking that many of our preconceived notions were independently reported in the interview material. For example, we both expected that recovering counselors would report utilizing self-disclosure to build a strong therapeutic alliance or rapport with clients, but that they also use self-disclosure
judiciously, which is an expectation that was confirmed in the results. Another expectation that we shared, which was confirmed in the results, was that recovering counselors would see spirituality as an important component in the treatment and recovery processes, and therefore in their work with clients. These expectations were based largely on the existing literature, personal experience in the substance abuse field (in the principal investigator's case), and from influence through conversations with others about the substance abuse field, which preceded this study.

Nevertheless, there were some surprising results that emerged through the data analysis that lend richness to the study results that would not be present in the absence of such unexpected material. Specifically, the pattern of ambivalence that emerged in the overall meaning and essence of being a recovering counselor was both unexpected and quite interesting, and raises further research questions and directions that may be explored in future efforts. In conclusion, it was through bracketing and setting aside our own preconceived notions, ideas, and expectations that the co-analyst and I were able to approach and analyze the interview data in this study from an unbiased position, and because of this, unexpected patterns were allowed to emerge through the data analysis. In the following sections, the study findings will be discussed within each construct and will be framed within the context of existing research findings.

**Overall Meaning and Essence**

This study represents the first attempt to investigate the overall meaning and experience of being a recovering substance abuse counselor. It is no surprise, however, that the first theme that emerged from the overall meaning question was a desire on the part of recovering counselors to help other addicts overcome addiction. This theme goes straight to the heart of the wounded healer archetype and speaks to the essence of what it means for an individual to
transcend a problem and then go on to help others with the same problem. For many of the participants, the desire to help others with a problem they once faced was the driving force in entering the substance abuse counseling field. Indeed, the substance abuse counseling field was originally developed within the wounded healer framework as one recovering addict helping another, a process that has continued to date (White, 2000).

As stated by a majority of the study participants, it appears that their previous history of addiction enables them to develop a higher level of empathic attunement, understanding, and identification with clients, which was the second theme to emerge from the overall meaning question. This theme is related to what Hayes (2002) refers to as positive manifestations of countertransference that may occur for therapists who have experienced a "wound" so similar to their client that it resonates within the "soul" of the therapist and their inner-subjective experience. This thematic pattern of responses is also similar to those found in the qualitative studies conducted by Cain (2000) and Grapp (1992) in their investigations of "wounded healers," as embodied in psychotherapists who either had been self-identified as "wounded" at one point in their lives, or who had been hospitalized for psychiatric reasons in their past.

In both of these previous studies, the participants overwhelmingly supported the idea that their own history of being wounded, or personal experience, helped them to empathize more closely with their clients, and that this in turn enhanced their clinical work with these clients through a more trusting therapeutic relationship. That is, the participants in Cain and Grapp's studies reported that not only did their previous wounds or personal experience enable them to be more empathic with clients, but that this empathic attunement enabled them to develop a stronger therapeutic alliance with clients, thus enhancing their clinical efficacy. Likewise, the recovering counselors in this study reported that their personal experience with addiction enabled them to
build a stronger therapeutic alliance with their clients, thus enhancing their clinical efficacy. The importance of personal experience in connection with building the therapeutic alliance was the third theme to emerge in the overall meaning portion within this study and, as noted above, this pattern was previously found by Cain (2000) and Grapp (1992) in their investigations of wounded healers.

It may be the case, however, that the enhancement of empathic attunement and development of the therapeutic alliance reported in this study was increased by the relative experience of the participants and their level of "distance" or degree of "healing" from their addiction. Previous research on countertransference has demonstrated that therapists' unresolved conflicts can negatively affect the process of psychotherapy (Gelso & Hayes, 2007). For example, Hayes, Yeh, and Eisenberg (2007) surveyed bereavement counselors who had experienced a loss, as well as surveyed their clients, and found that the level to which therapists missed their loved ones was inversely correlated with client perceptions of therapist empathy. That is, the more therapists missed their loved ones the less empathic they appeared to their clients. Similar findings are present in the countertransference literature, which lends support to Jung's (1963) notion that a therapist must first transcend their own wounds to help others with the same problem. Jung (1963) referred to the wounded healer archetype when he stated "Only the wounded physician heals" (p. 134). Jung went on to discuss wounded healers in stating that:

The patient's treatment begins with the doctor, so to speak. Only if the doctor knows how to cope with himself and his own problems will he be able to teach the patient to do the same. (p.132)

The final theme to emerge in the overall meaning of the participants' experience as recovering substance abuse counselors in this study was that of ambivalence, or the existence of mixed feelings in being a recovering counselor. This finding was both striking and surprising,
and does not appear in previous research findings. Ambivalence in this study took a number of forms, and was expressed in ambivalence in becoming a recovering counselor, ambivalence about being associated with stereotypes commonly associated with recovering counselors, ambivalence about one's level of professional training, education, or career accomplishments, and ambivalence about the importance of one's recovery status in working with clients. It is difficult to speculate as to why the experience of being a recovering counselor might invoke feelings of ambivalence. Perhaps this is a reflection of the professionalization of the field with the increase of non-recovering master's level substance abuse counselors, which may in turn cause recovering counselors to feel somewhat de-valued. It may also be that this is simply a reflection of the larger overall human condition being expressed in these particular participants as recovering counselors, part of which inevitably involves some degree of self-doubt. Regardless, the experience of ambivalence clearly emerged in this study as an important piece of being a recovering counselor.

_Self-disclosure_

Over the years the use of self-disclosure with clients has become more commonly accepted within the counseling field in general, and seems to be positively viewed by clients when used judiciously (Knox & Hill, 2003). Self-disclosure, however, has likely always been a part of the substance abuse counseling field, which was developed within the wounded healer framework, and thus self-disclosure was probably assumed in many settings as part of the helping process (White, 2000). The sole previous attempt to investigate the use of self-disclosure among recovering substance abuse counselors was conducted by Sweeney (1996). Sweeney's findings were generally that recovering counselors self-disclose more early in their careers and become more judicious as time goes on. She also found that recovering counselors...
tend to self-disclose to reduce clients' fear, to connect with the client, and to normalize the 
recovery process. Finally, the participants in Sweeney's study also voiced concerns about 
potential negative effects of self-disclosure, particularly indiscriminate disclosure, which may 
take the focus off the client.

The results of Sweeney's (1996) investigation were echoed in this study. The vast 
majority of the participants in this study indicated that they have reduced the frequency of their 
self-disclosure and that they have refined their intent in choosing to self-disclose. Furthermore, 
participants in this study indicated that they tend to self-disclose in order to build client trust, to 
problem solve, and to build hope. These reasons for using self-disclosure correspond with the 
overall literature on the perceived therapeutic benefits of using self-disclosure in psychotherapy, 
and are supported by research findings on the effects of self-disclosure. Simone, McCarthy, and 
Skay (1998) surveyed psychotherapists concerning their rationales for self-disclosing to clients 
and found that their reasons included the promotion of universality, to give encouragement, 
modeling, rapport-building, and to explore alternatives for clients. Additionally, Edwards and 
Murdock (1994) surveyed psychologists to investigate therapist variables that affect frequency, 
content, and reasons for therapist self-disclosure and found that, among other reasons, they often 
disclose to increase similarity between clients and themselves, or promote a sense of 
universality. These reasons correspond with those given by the participants in this study and are 
generally supported by research that examines the effects of such disclosures.

Self-disclosure to clients has been shown to be potentially beneficial in the 
psychotherapeutic process. Barrett and Berman (2001) conducted an experimental study of 
therapist self-disclosure in a university counseling center and found that increased therapist self-
disclosure correlated with a reduction in client symptoms in addition to clients liking their
therapist more. Other studies indicate that clients prefer that therapists disclose information about themselves early in the psychotherapeutic process and that they disclose numerous types of information, including information about their feelings and personal relationships (Hendrick, 1988; Nyman & Daugherty, 2001). Furthermore, Myers and Hayes (2006) conducted an analogue study with undergraduate students and found that when working alliance is high, potential clients see therapist disclosure as deepening the counseling process and results in perceiving the therapist as more expert. These research findings lend credibility to the notion that recovering counselors in this study may be self-disclosing in ways that help to build rapport and a strong working alliance with clients, and that such disclosure may in some ways help with clients’ problem resolution through a deepening of the counseling process.

Finally, participants in this study pointed out the potential pitfalls in self-disclosing to clients, such as "telling long war stories" and taking the focus off the client, an insight shared by those interviewed by Sweeney (1996). These reasons correspond with the overall literature on therapist self-disclosure and reported reasons for not disclosing. For example, Simone, McCarthy, and Skay (1998) found that counselors chose to not self-disclose primarily due to boundary issues among other reasons. Boundary issues seemed especially salient for female recovering counselors in this study due to experiences of inappropriate treatment by male clients who learned of their recovery status.

The similarities in Sweeney's (1996) study and this study are striking and lend increased credibility to one another. Based on the aggregate findings, it seems reasonable to state that a fair number of recovering substance abuse counselors entering the field use self-disclosure more frequently early in their careers and become more judicious over time. It is unclear if this pattern holds true for counselors outside of the substance abuse field due to a paucity of research
investigating frequency of self-disclosure as counselors become more experienced. In addition, it appears that recovering counselors in both Sweeney's study and this study tend to disclose to normalize the recovery process, connect and build trust with clients, and to help clients practically solve problems, which are all reasons cited in the general self-disclosure literature. Lastly, there seems to be a degree of skepticism associated with self-disclosure in that it may at times be overused or used for the wrong reasons, perhaps a mistake made more often by those new in recovery and new in the substance abuse field. As noted above, these reasons are also addressed in the general self-disclosure literature, mostly framed as concerns associated with boundary issues (Simone, McCarthy and Skay, 1998).

Countertransference

As previously discussed, the construct of countertransference proved to be challenging to explore in this study. As there are various definitions of countertransference in the field, the research participants seemed to have various understandings of the definition being used in this study and often gave examples of countertransference that were not consistent with the moderate definition. These types of examples included experiences that occurred outside of psychotherapy or reactions that were not seemingly rooted in the counselors' unresolved issues. Nonetheless, there were three thematic patterns that emerged associated with countertransference. The first theme involved the origins of countertransference, and specifically participants being reminded of self or a family member. The second theme to emerge was that of corresponding emotional and behavioral manifestations, such as anger and confrontation or anxiety and "rescuing" clients. Finally, the third theme involved management strategies such as awareness, seeking supervision, and self-talk.
The origins of countertransference reactions noted by the recovering counselors in this study are similar to some of those evident in the existing countertransference literature. Williams, Judge, Hill, and Hoffman (1997) found that countertransference reactions tended to occur in response to client content that was similar to the counselor’s own unresolved issues, and this pattern was echoed in this study. Notable examples are Charles’s attempts to manage his own anxiety in session and Paula’s reactions towards her chicken-fighting client. In addition, Hayes et al. (1998) found that countertransference reactions may be rooted in family issues (among others) and triggered by perceptions of client progress or client similarity to the therapist (among others), all of which were reported among recovering counselors in this study. Thomas’s feelings of “rage” towards the client who reminded him of his brother and Charles’s experience of anxiety when working with Xanax addicted clients come to mind as notable examples.

The emotional and behavioral manifestations of countertransference reported by recovering counselors in this study are also reflective of the overall countertransference literature. The primary emotional manifestation of countertransference that has been studied through analogue research is state anxiety, an emotion that has served as a fairly reliable indicator of the presence of countertransference (Rosenberger & Hayes, 2002). In this study, Charles, Jack, and Jennifer all reported experiencing state anxiety manifestations of countertransference and both Charles and Jack indicated that they tend to want to "rescue" clients to alleviate their experience of anxiety. Overly projecting oneself and providing the client with insights and answers, or "rescuing" the client, is a common behavioral manifestation of countertransference reported in the literature as an attempt to reduce state anxiety (Gelso & Hayes, 2007).
Furthermore, as research on countertransference has progressed and field studies have emerged, a more wide range of emotional countertransference manifestations have been brought to light, including anger, boredom, sadness, and even feelings of nurturance (Rosenberger & Hayes, 2002). While boredom and nurturance did not come up in this study, five recovering counselors reported feelings of anger and two recovering counselors reported feelings of sadness as emotional manifestations of countertransference. In instances of anger, recovering counselors mostly reported behavioral manifestations of confronting and arguing with clients, which is consistent with the overall countertransference literature (Gelso & Hayes, 2007).

In reflecting on the existing countertransference literature, Gelso and Hayes (2007) point out that there is evidence to support the notion that anxiety management and self-integration in the therapeutic process are effective strategies that may reduce the likelihood of negative countertransference reactions. Indeed, the recovering counselors in this study seemed to endorse the notion that reducing their own anxiety, either through self-talk or seeking supervision, helps with the occurrence and management of countertransference. Additionally, recovering counselors in this study also seemed to suggest that awareness of potential countertransference helps to mitigate potential negative effects or the further development of a negative reaction, a view shared by Gelso and Hayes. It may be, however, that self-awareness alone is not always enough to mitigate the occurrence of negative countertransference reactions. Robbins and Jolkovski (1987), as well as Latts and Gelso (1995), found that self-awareness in and of itself was not enough to offset the occurrence of negative countertransference reactions, and instead found that an interaction between awareness and self-integration may lead to a reduction in countertransference reactions.
Spirituality

The most widely shared beliefs expressed by recovering counselors in this study was that of the importance and complexity of spirituality in the treatment and recovery processes, and thus in their work with clients (at least ideally given enough time). All of the participants in this study defined spirituality in a broad sense and spoke to the indefinable nature of this construct. Thus, the first theme to emerge concerned the openness and complexity of spirituality for recovering counselors in their work with clients. For example, a number of the participants self-identified with a mixture of traditions, such as Paula with Christianity and Buddhism, while others were hesitant to identify with any particular tradition. All of the participants spoke of a “higher power” in non-institutional terms, and spoke of working with clients to develop an open understanding of this concept, thereby reducing client resistance to twelve-step recovery.

A second theme emerged in that all of the participants spoke to the importance of the cultivation of a sense of spirituality to overcome addiction, or that addiction needs a spiritual solution, which was endorsed by eight participants. Two participants, however, explicitly indicated that the development of spirituality is not absolutely necessary for recovery to take place in all cases. The emphasis on the importance of spirituality for recovering counselors in this study was consistent with Schaler’s (1996) findings that recovering counselors (and those who attend AA) tended to have a higher degree of spiritual thinking than do their non-recovering counterparts. Schaler’s investigation in conjunction with this study together lends support to the idea that recovering counselors value the importance of spirituality in the recovery and substance abuse treatment processes, and that exploration of a client’s sense of spirituality should be part of the counseling process.
Lastly, the majority of participants indicated that because of the inherent complexity of the construct, and given the broad understanding of spirituality, that working with clients around issues of spirituality needs to be individualized for each client. That is, because of the highly subjective and individualized nature of the construct, exploration of spirituality should be an individualized process that allows for flexibility and creativity within the counseling process.

Study Limitations

The primary limitations of this study are those that are commonly associated with qualitative research in general, and phenomenological research more specifically. These limitations are centered on the issues of generalizability and subjectivity. It is undoubtedly the case that qualitative research, and specifically phenomenological research, does not seek to gather information through the use of “objective” positivist measures that quantify, dichotomize, or otherwise numerically classify information. Instead, phenomenological inquiry seeks to gather highly descriptive and detailed interview material that speaks to the internal experience of the research participants, and that seeks to communicate their experiences from their perspectives in the form of the textual descriptions. A result of phenomenological research being conducted within a constructivist paradigm is that the information gleaned is by definition not generalizable. That is, while the findings of this research study speak to the experiences of these particular participants, it cannot be claimed that the findings are representative of other recovering substance abuse counselors.

It is also true that the participants in this particular study were largely older recovering counselors with considerable experience in the field, and therefore their reported experiences may be quite different from a younger group of research participants. It is difficult to speculate, but younger counselors with less experience may have had different views on the
constructs under investigation. Additionally, the participants in this study were primarily male, with seven male participants and three female participants. It may also be the case that a group of research participants with more female members would have different experiences to report. This may have been especially true in the case of self-disclosure, since two female participants reported discomfort with self-disclosure due to mistreatment by male clients who became aware of their recovery status. Another issue with this study was the lack of racial/ethnic diversity within the research participants. All of the participants of this study were European-American, and it may be that the results are affected in some ways by this lack of ethnic/racial diversity among participants. Although the scope of this research project was not to represent all recovering substance abuse counselors, only these particular participants, the lack of diversity along the lines of age, level of experience, gender, and race/ethnicity may been seen as a limitation.

Some aspects of the data analysis procedures in this study, namely the choice of specific meaning units, as well as the construction of thematic clusters and textual descriptions, were somewhat subjective in nature and required a degree of judgment, discussion, and compromise on the part of the principal investigator and co-analyst. While it is impossible to know if different analysts or procedures would have produced different results, it is clearly a subjective process that is the result of co-creation between the participants and researchers. That is, the study results emerged primarily from the expressed experiences of the participants, but also in part through an intersection of these expressed experiences with those of the principal investigator and co-analyst. Therefore, one potential limitation of this study is a certain degree of subjectivity within the data analysis process, which results in a particular “angle” on the
expressed experiences of the research participants, and is an inherent part of phenomenological research.

Future Research

Research into the lived experiences of recovering substance abuse counselors is in its early phase of development. To date, there have been no research studies that examine the overall experience of recovering substance abuse counselors prior to this study. Instead, as noted above, the literature on the recovery status of substance abuse counselors has primarily been in comparison with non-recovering counselors in terms of efficacy, treatment approach, and personality characteristics (Culbreth, 2000). While these are important areas of inquiry and provide valuable information about how recovering counselors differ from their non-recovering counterparts, they tell us little about the actual experience of being a recovering counselor. Concerning overall meaning and essence, continued research efforts should specifically continue to investigate the experience of ambivalence on the part of recovering counselors, as the emergence of this theme was an unexpected and striking result of this study. Furthermore, while this study has yielded a large amount of data concerning the lived experiences of recovering substance abuse counselors regarding the self-perceived overall meaning and essence of their experience, as well as their experiences of using self-disclosure, experiences of countertransference, and spirituality in counseling, research in all of these areas are in early stages of development and should be continued.

This study is the second to date to investigate recovering counselors’ use of self-disclosure. As noted above, Sweeney (1996) investigated recovering counselors’ use of self-disclosure and found themes similar to the findings of this study. These findings together lend more evidence concerning recovering substance abuse counselors tendency to reduce their levels
of self-disclose over time, as well as their rationales for and concerns about the use of self-disclosure. Nevertheless, research efforts to better understand recovering counselors' uses of self-disclosure should continue, and future lines of inquiry may investigate the use of self-disclosure by younger recovering counselors with less recovery time, as well as how the use of self-disclosure is perceived by clients of recovering counselors. Finally, the findings of this study that female recovering counselors are less comfortable with self-disclosure, perhaps because of past experiences of being discounted, harassed, or ill-perceived by male clients, is an interesting finding that raises important questions for further inquiry into the effects of gender on recovering counselors’ use of self-disclosure.

The construct of countertransference is a particularly difficult construct to investigate, and the obstacles that I encountered in this study are a reflection of those difficulties. Nonetheless, research into the countertransference experienced by recovering counselors should continue, as well as origins of such reactions, manifestations, management strategies, and effects on the therapeutic relationship. Continued research efforts may seek to investigate the countertransference reactions of recovering counselors with particular clients by collecting data from both counselor and client immediately following counseling sessions or immediately following a course of treatment. Additionally, quantitative measures may be used to supplement qualitative data to further investigate the strength, duration, and frequency of such reactions, as well as the efficacy of management strategies.

The investigation of the use of spirituality by recovering substance abuse counselors in the substance abuse counseling process is in its early stages of development. While previous research has investigated levels of spiritual thinking among recovering (and non-recovering) counselors relative to recovery status and AA participation, and spiritual well-being among
substance abuse counselors relative to other counselor variables and client spiritual well-being, this study examined the use of spirituality in the counseling process by recovering counselors. These research efforts need to be buttressed with continued research in this area to more fully understand the uses, effects, and process by which recovering counselors use spirituality or spiritual concepts in the substance abuse counseling process. Furthermore, the recent development and refinement of a number of spirituality measures may be used to more effectively measure the use of spirituality in the counseling process by recovering counselors.

Implications for Training and Practice

The implications for training and practice of this study primarily center around increased awareness of the strengths and potential areas of difficulty for recovering individuals who are going on to work with clients struggling with substance abuse issues. Specifically, it appears through this study and other research efforts that it is important that training programs and recovering practitioners in the field remain keenly aware of the potential benefits and possible pitfalls of the use of self-disclosure of one's recovery history with clients. Based on the results of this study, it seems as though increased clinical experience leads to a more judicious use of self-disclosure, and there may be a need for training programs to more fully address this issue as recovering individuals transition to working in the field. Additionally, the experiences and manifestations of countertransference and management strategies reported by these recovering counselors lend further support to the notion that training programs and practitioners in the field may focus increased attention on self-awareness and self-integration in order to reduce the frequency of negative countertransference reactions. Finally, the results of this study suggest that the importance of spirituality in the treatment and recovery processes seems to be shared among the recovering counselor community and there may be a need to more fully integrate
spirituality into treatment protocols. There may also be a need for increased training on the exploration of spirituality for counselor trainees. Specifically, working with client resistance to spirituality and twelve-step recovery meetings may be indicated in the continued training of counselors practicing in the substance abuse field, as well as in the training of substance abuse counselors preparing to enter the field.

Perhaps the most important implication for training and practice to come out of this study involves the need for re-valuation of recovering counselors in the substance abuse field. In recent decades the substance abuse counseling field has undergone a profound transformation as the field has become more professionalized and in some ways restrictive. One unfortunate consequence of these changes is the seemingly apparent trend of the reduction of recovering individuals entering the substance abuse field. While there have not been systematic research efforts to document the reduction of recovering individuals entering the field, it only takes a brief look around many treatment facilities to notice the dramatic increase of non-recovering counselors from master's degree programs relative to the treatment centers of the 1970s and 80s which were dominated by recovering counselors. There have, of course, been important reasons for the substance abuse counseling field to become more professionalized and the need for increased levels of training for substance abuse counselors is clear. I wonder, however, if there is a stigmatization of recovering counselors in the field that has led to the feelings of ambivalence that I encountered in the recovering counselors in this study. In conclusion, I find it vital that we acknowledge the importance of personal experience with addiction and the insights that recovering counselors bring to therapy. Their unique contributions bear light on the necessity that we continue to recruit recovering individuals to work as counselors in the substance abuse field. Certainly there is room for recovering and non-recovering substance
abuse counselors to work side-by-side in a combined effort to help addicted individuals overcome substance dependence.

Concluding Remarks

My journey into the lived experiences of recovering substance abuse counselors began a few years ago with the conceptualization of this study. My personal connection to recovering counselors, however, goes back a few years further with my entrance into the substance abuse field as a practicum counselor at a small outpatient substance abuse facility. The journey has been long, fascinating, at times exhausting, growth-producing, humbling, and perhaps most of importantly, at some level healing. I feel honored that the recovering substance abuse counselors who participated in this study were willing to share their personal, meaningful, interesting, and at times painful experiences with me, and I experienced their sharing on a personal level that touched me deeply and in profound ways.

In reflecting on this study, I feel inspired by the stories of struggle, transcendence, and eventual sharing through the reaching out to other addicts by these recovering counselors. They remind me of the depths of human suffering, the ability for self-healing, the generous human spirit, and the striving in all of us to know a better place and a better life for ourselves and others. I see aspects of myself in these recovering counselors and aspects of them in myself, and I am reminded of the oneness that binds us all together. I am reminded that we all need each other and to lend a helping hand to those in need. I see that while we all experience wounds during the course of life that it is through introspection, self-examination, shared experience, and human connection that in time those wounds may be healed and we may go on to become a wounded healers. In this we come full circle as this study first aspired to understand the archetype of the wounded healer as embodied in the recovering substance abuse counselor. Somehow that sounds
too academic to capture what I learned through this study. It was not so much the insights that were gained or the patterns or themes that emerged, but the experience of coming to know and bear witness to the experiences of these recovering counselors that touched the depths of my being. In conclusion, I would like to give thanks for their generosity in sharing, the wisdom within their words, and their reminder to me of the value in charity and human connection.
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Appendix A: Recruitment Letter

November 13, 2007

Dear Substance Abuse Counselors:

I am writing to request your help with my dissertation research project on counselor recovery status and substance abuse counseling. The purpose of this study is to investigate recovering substance abuse counselors’ lived experiences of how one’s previous history of addiction affects current work with clients who are dealing with substance abuse issues. Therefore, I am seeking to conduct in-depth (2 hour) interviews with counselors and who are in recovery from an addiction and who are currently working with clients who are dealing with substance abuse issues within individual or group therapy in a professional setting. These interviews will focus on issues related to counselor self-disclosure of recovery status, experiences of countertransference (reactions based on the counselor’s unresolved issues), and spirituality in the recovery and treatment processes, as well as the overall experience of being a recovering substance abuse counselor. In order to participate in this research project you will be asked to be involved in one in-depth interview (2 hours) and be will be asked to review the interview transcription and analysis at a later date, a process that should take approximately one additional hour. Participants have the choice to decline answering any of the interview questions or to drop out of the study at any point in time. The confidentiality of research participants will be maintained at all times and the names of participants will be changed in the dissertation and any subsequent publications. As a token of my gratitude, I will be offering participants $25 for partial reimbursement for their time, or a prorated amount for individuals who drop out of the study early. Your participation as one of a small group of mental health professionals would be extremely helpful and greatly appreciated.

If you would like to participate in the current study, please contact Carson Ham at either cch140@psu.edu or (814) 404-6280. You must be at least 18 years of age to participate in the study. You may decline to answer any specific interview questions or withdraw your participation at any time. If you have any questions or concerns about the study, please feel free to call Carson Ham at (814) 404-6280. If you would like to receive a summary of the study’s findings, please email Carson Ham at cch140@psu.edu. I will gladly inform you of the results of the study as soon as they are available.

As fellow mental health professionals, I am grateful for your willingness to consider participating in this study. You participation will help us further the body of knowledge about counselor recovery status and substance abuse counseling. Please keep this letter for future reference.

Sincerely,
Carson C. Ham, M.A.
Appendix B: Participant Letter

February 6, 2008

Dear Dr./Ms./Mr.,

Thank you so much for choosing to participate in my dissertation research investigating recovering substance abuse counselors’ experiences of countertransference, uses of self-disclosure, and beliefs associated with spirituality in the recovery and treatment processes. I am very much looking forward to speaking with you about these issues in detail. Enclosed you will find a demographic form and an informed consent form to be completed prior to our interview. In addition, I have enclosed a copy of the interview questions and two definitions so that you will have the opportunity to think about and reflect on your experiences regarding these phenomena in preparation for the interview. I am honored that you have chosen to share this very personal and meaningful information with me for the purposes of my dissertation research. Please do not hesitate to contact me at cch140@psu.edu or (814) 404-6280 if you have any questions or concerns.

Sincerely,

Carson C. Ham, M.A.
Appendix C: Informed Consent Form

Informed Consent Form for Social Science Research
The Pennsylvania State University

Title of Project: The Wounded Healer: A Phenomenological Investigation of the Recovering Substance Abuse Counselor

Principal Investigator: Carson C. Ham, M.A.
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University Park, PA 16802
(814) 863-3799

Other Investigator(s): Kai Dawn Stauffer LeMasson, Ph.D.

1. **Purpose of the Study:** The purpose of this research is to investigate the lived experiences of recovering substance abuse counselors. Specifically, the current study will explore issues related to the use of self-disclosure of one’s personal history of addiction to clients, experiences of countertransference (reactions based on the counselor’s unresolved issues), and the role of spirituality in the treatment and recovery processes. Approximately 6-15 recovering substance abuse counselors will be interviewed in the current study.

2. **Procedures to be followed:** You will be asked to participate in one in-depth (2 hour) interview concerning your experiences of addiction and recovery, self-disclosure, countertransference, and spirituality. The interview will be recorded and transcribed. The researchers will be analyzing the interview text for patterns, similarities, and differences with other interview material from this research project. In addition, the principal investigator will send the interview transcription and analysis to you at a later time for verification of accuracy.

3. **Discomforts and Risks:** There are no risks in participating in this research beyond those experienced in everyday life. Some of the questions, however, are personal and might cause discomfort. Specifically, it may be uncomfortable to discuss previous experiences of addiction and recovery, as well as how one’s previous addiction affects work with current clients.

4. **Benefits:** The benefits to you may include the opportunity to learn more about yourself by participating in this study. It is possible that you may come to a better understanding of your own recovery from addiction and ways it might improve your counseling abilities with clients who are dealing with substance abuse issues.

The benefits to society may include the scientific community and future clients learning more about how substance abuse counselor recovery status affects substance abuse counseling.
5. **Duration/Time:** In order to participate in this research project, you will be asked to respond to interview questions for approximately 2 hours, although you may decline to answer any questions and may withdraw from participation at any time. In addition, you will be asked at a later date to check the interview transcription and analysis for verification, which will take approximately one additional hour.

6. **Statement of Confidentiality:** Your participation in this research is confidential. The data will be stored and secured at 800 W Beaver Ave, State College, PA 16801 in a locked office. Only the principal, advisor and co-investigator will have access to the tapes. They will be destroyed after they have been transcribed. The transcribed material will be stored in the same location and will be destroyed after a period of 7 years. Penn State’s Office for Research Protections, the Social Science Institutional Review Board and the Office for Human Research Protections in the Department of Health and Human Services may review records related to this research study. In the event of a publication or presentation resulting from the research, no personally identifiable information will be shared.

Your name will be changed in the publication of data in order to protect your identity. In addition, the location of their employment will not be published or otherwise made available.

7. **Right to Ask Questions:** Please contact Carson C. Ham at (814) 404-6280 with questions, complaints or concerns about this research. You can also call this number if you feel this study has harmed you. Questions about your rights as a research participant may be directed to Penn State University’s Office for Research Protections at (814) 865-1775.

8. **Payment for participation:** Participants will be offered $25 as compensation for their time. Payments will be prorated for participants who choose to withdraw from the research early, at a rate of $8.33/hour. Payments will be made following the interviews in the form of a mailed personal check.

9. **Voluntary Participation:** Your decision to be in this research is voluntary. You can stop at any time. You do not have to answer any questions you do not want to answer. Refusal to take part in or withdrawing from this study will involve no penalty or loss of benefits you would receive otherwise.

You must be 18 years of age or older to consent to take part in this research study.

If you agree to take part in this research study and the information outlined above, please sign your name and indicate the date below.

You will be given a copy of this consent form for your records.

________________________________________________________________________
Participant Signature Date

________________________________________________________________________
Person Obtaining Consent Date
Appendix D: Interview Questions

1. Tell me about the overall meaning and essence of your experience as a substance abuse counselor who is recovering from an addiction and working with clients on issues associated with substance abuse. How does your personal history of addiction inform your work with clients who are dealing with substance abuse issues?

2. Tell me about how your recovery status affects your provision of corrective experiences to clients in therapy.

3. Have you used self-disclosure of your personal history of addiction with clients who are struggling with substance abuse issues, and if you have, in what ways and why? How has this affected therapy with them? Are there times when you have chosen not to use self-disclosure or times when you regret using self-disclosure? Please describe these situations.

4. What types of countertransference reactions, both positive and negative, have come up in your work with clients who are working on substance abuse issues, and how have these been resolved and/or affected the therapeutic process? How were these reactions triggered and managed?

5. Does spirituality play a role in your work with clients who are working on substance abuse issues, and if so, how?

6. Is there anything else that we have not discussed up to this point that you feel is relevant to your overall experience as a recovering substance abuse counselor?

Definition

Countertransference - Therapist reactions or behaviors that are based on or rooted in the therapist’s unresolved issues. These reactions may affect the therapeutic process and relationship in positive or negative ways.
Appendix E: Demographic Questionnaire

Please answer the following questions fully and to the best of your ability. Your honesty is appreciated and valued. Thank you for your time and cooperation!

Section 1: Background

Name: __________________________  Age: __________

Gender: _________________  Ethnicity: ___________

Section 2: Education

Highest Degree: _______________  Field/Discipline: _______________

Section 3: Professional Experience

Years of counseling experience since highest degree: _______________

Theoretical orientation: ______________________________________________________________________

Section 4: Personal Experience

How long have you been in recovery from substance dependence? _______________

Please provide a brief autobiographical statement or description of your life events, interests, etc. up to this point in as much detail as you prefer. You may use the back of this page to complete this section if necessary. Please print clearly.
Table 1

Characteristics of Recovering Counselor Participants

<table>
<thead>
<tr>
<th>Name (fictitious)</th>
<th>Age</th>
<th>Years in Recovery</th>
<th>Degree</th>
<th>Years in Field*</th>
<th>Theoretical Orientation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Charles</td>
<td>36</td>
<td>19</td>
<td>BA</td>
<td>13</td>
<td>Motivational Interviewing &amp; 12-step</td>
</tr>
<tr>
<td>Jack</td>
<td>60</td>
<td>25+</td>
<td>MA, LPC</td>
<td>15</td>
<td>Did not indicate</td>
</tr>
<tr>
<td>Linda</td>
<td>52</td>
<td>22</td>
<td>MA, MSW</td>
<td>9</td>
<td>Solution-focused CBT, &amp; Strengths-based</td>
</tr>
<tr>
<td>Paula</td>
<td>55</td>
<td>27</td>
<td>BA</td>
<td>23</td>
<td>Solution-focused &amp; Narrative</td>
</tr>
<tr>
<td>Lance</td>
<td>54</td>
<td>28</td>
<td>BA</td>
<td>23</td>
<td>CBT</td>
</tr>
<tr>
<td>Jim</td>
<td>51</td>
<td>18</td>
<td>BA</td>
<td>16</td>
<td>Client-centered</td>
</tr>
<tr>
<td>Thomas</td>
<td>46</td>
<td>22</td>
<td>BS</td>
<td>12</td>
<td>Eclectic</td>
</tr>
<tr>
<td>David</td>
<td>66</td>
<td>23</td>
<td>PhD</td>
<td>25</td>
<td>CBT, Eclectic</td>
</tr>
<tr>
<td>Kevin</td>
<td>61</td>
<td>24</td>
<td>MS</td>
<td>12</td>
<td>CBT</td>
</tr>
<tr>
<td>Jennifer</td>
<td>41</td>
<td>20</td>
<td>MA, MSW</td>
<td>5</td>
<td>Reality therapy &amp; Psychodrama</td>
</tr>
</tbody>
</table>
Table 2

Overall Meaning and Essence of Being a Recovering Counselor

<table>
<thead>
<tr>
<th>Themes</th>
<th>Description of themes</th>
</tr>
</thead>
<tbody>
<tr>
<td>“Giving Back” Through Helping Addicts to Recover</td>
<td>Recovering counselors indicated a strong desire to help others through the process of recovery. As they help others through recovery, many counselors find the experience personally rewarding and even healing.</td>
</tr>
<tr>
<td>Empathy, Understanding, and Identification: “I Know Where They [Clients] are Coming From”</td>
<td>Counselors understood the internal world of addicts, recognizing thoughts and feelings that they themselves had experienced in their recovery. Thus, recovering counselors had a &quot;rich sense of empathy&quot; for their clients. In conjunction, recovering counselors strongly identified with their clients, recognizing the “similarities” and “parallels” between their lives and that of a client.</td>
</tr>
<tr>
<td>Personal Experience is the “Selling Point” with Clients</td>
<td>Having a personal experience with addiction recovery made it easier for counselors to &quot;connect&quot; with substance abuse clients and earn their trust. Counselors believed that trust is built in the therapeutic alliance when the client knows that his or her understanding of addiction and recovery is based on more than education and training.</td>
</tr>
<tr>
<td>Ambivalence of a Recovering Counselor: “I Could Have Been More and Better”</td>
<td>Counselors indicated some type of ambivalence about either becoming a substance abuse counselor, the importance of their recovery status, their level of education/training relative to non-recovering counselors, or the possibility of being labeled a &quot;typical&quot; recovering counselor, suggesting that they are uncomfortable with some of the common stereotypes about recovering counselors.</td>
</tr>
<tr>
<td>Themes</td>
<td>Description of themes</td>
</tr>
<tr>
<td>----------------------------------------------------------------------</td>
<td>------------------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Reduction of Frequency and Refinement of Intent: From “Big, Long War Stories” to “Therapeutic Strategy”</td>
<td>Recovering counselors self-disclosed more often early in their career. All have reduced their self-disclosure with clients becoming more purposeful and selective in revealing information about themselves to clients, and thus using self-disclosure as a therapeutic strategy rather than an automatic practice in counseling.</td>
</tr>
<tr>
<td>“Building Clinical Capital,” Problem Solving, and Instilling Hope</td>
<td>Recovering counselors used self-disclosure to facilitate the counselor-client relationship, earning them trust with the client. In addition, recovering counselors reveal information about their lives to illustrate to clients basic recovery principles, how to “work” recovery, and solve problems in their daily lives. Lastly, self-disclosure among recovering counselors is used to instill hope in clients, especially when clients are “struggling” in the recovery process.</td>
</tr>
<tr>
<td>The Pitfalls of Self-disclosure: “It Can Work Against Me.”</td>
<td>Pitfalls of self-disclosure include taking the focus off clients; undermining counselor credibility and the therapeutic relationship; eliciting recovering counselor stereotypes; using self-disclosed information against a counselor for manipulation; and tension with colleagues and the expressed resentment of non-recovering counselors.</td>
</tr>
</tbody>
</table>
Table 4

Countertransference Themes

<table>
<thead>
<tr>
<th>Themes</th>
<th>Description of themes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clients Who Remind Counselors of Family Members or Themselves:</td>
<td>Clients who physically resembled and/or behaved like a family member could provoke strong negative reactions such as anger in recovering counselors. In addition, counselors experienced countertransference with clients who reminded them of themselves or their experiences, especially when they were in the throes of addiction. Specific, instances of counter-transference involved a counselor's drug of choice or painful memories from the past.</td>
</tr>
<tr>
<td>“Just Like My Brother and Sister”</td>
<td></td>
</tr>
<tr>
<td>Manifestations of Counter-transference: “Anxiety, Anger, Confrontation, and Rescuing Clients”</td>
<td>Counselors discussed emotional reactions to clients that were rooted in their own unresolved issues, either with substance use, family members, or oneself, and these emotional reactions ranged from experiences of anxiety to sadness to rage. Additionally, behavioral manifestations were reported that ranged from confrontations of the client to asking that the client be</td>
</tr>
<tr>
<td>Managing Countertransference: “Awareness, Supervision, and Self-talk”</td>
<td>Counselors usually sought supervision or consultation with colleagues when countertransference arose with clients. Once recovering counselors recognized the origin of their feelings, and what in the client provoked their reactions, they were better able to manage their feelings. Other strategies recovering counselors used to manage countertransference included “self-talk” where they would have an internal dialogue about their feelings while counseling a client.</td>
</tr>
</tbody>
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Table 5

Spirituality Themes

<table>
<thead>
<tr>
<th>Themes</th>
<th>Description of themes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Openness and Complexity of Spirituality: “A Belief in Something”</td>
<td>Recovering counselors were generally open-minded about spirituality and accepting of various spiritual beliefs and practices, recognizing the value in self/spiritual discovery. Counselors viewed spirituality generally in nonreligious terms. For most, spirituality was a complex matter because it involved a process of exploration and self-discovery that is unique to the individual.</td>
</tr>
<tr>
<td>Addiction Needs a Spiritual Solution: Transcending a “Me-centered World”</td>
<td>Recovering counselors conceptualize addiction in both individual and spiritual terms that involve isolation and a disconnection from self, core values, other people, and ultimately spirit; all problems that require a spiritual solution.</td>
</tr>
<tr>
<td>“Individualized” or “Client-driven” Approach to Spirituality</td>
<td>Counselors communicated a desire for spirituality to be “client-driven” in the sense that it is self-initiated, arising from client’s religious background and interest in exploring spiritual beliefs and practices. Counselors encouraged their clients to explore their spiritual beliefs, develop working definitions and practices of spirituality that support their recovery.</td>
</tr>
<tr>
<td>Necessity of Spirituality to Recovery: “It May Not Be Essential to Abstaining”</td>
<td>Only two counselors suggested that recovery was possible without an active spiritual life. To the extent that spirituality facilitates human development and having a purpose and meaningful existence, then without it, counselors believed that growth and hope for recovery are limited.</td>
</tr>
<tr>
<td>Client Resistance to Spirituality: A “Touchy Subject”</td>
<td>Counselors treaded delicately and cautiously into conversations with clients about spirituality because of client resistance. Counselors experienced client resistance to spirituality primarily when encouraging them to adopt 12-step recovery principles and to attend meetings. Counselors managed client’s resistance by not referencing God or religion, disguising spiritual concepts, and reframing 12-step recovery programs as opportunities to connect with similar people in recovery.</td>
</tr>
</tbody>
</table>
Curriculum Vita
Carson C. Ham
Email: carsonham@gmail.com

Education:
• Ph.D. Counseling Psychology, 2009
  The Pennsylvania State University
• M.A. Community Counseling with an Emphasis in Addictions Counseling, 2004
  Appalachian State University
• Graduate Certificate in Addiction Counseling, 2004
  Appalachian State University
• B.S. Anthropology, 1998
  Appalachian State University

Recent Clinical Experience:
• The Pennsylvania State University, 2004 – 2009
  Counseling and Psychological Services Pre-doctoral Intern, 2008-2009
  Counseling and Psychological Services Associate Clinical Staff, 2007-2008
  Counseling and Psychological Services Graduate Assistant, 2006-2007
  Counseling and Psychological Services Practicum Counselor, 2005-2006

Publications:
expectancies of outcome: Implications for the counseling process? Manuscript in
progress.
Alternative and Complimentary Therapies, 10(3), 135-143.
Alternative and Complimentary Therapies, 10(4), 200-205.

Presentations:
expectancies of outcome: Implications for the counseling process. Paper
presented at the regional meeting of the North American Chapter of the Society
for Psychotherapy Research, New York, NY.
Poster presented at the Pennsylvania State University Graduate Poster Exhibition,
University Park, Pennsylvania.
therapists’ emotional intelligence. Paper presented at the North American Chapter
meeting of the Society for Psychotherapy Research, Burr Oak, OH.

Certifications:
  National Certified Counselor (NCC)
  Certificate Number: 90530
  Certification Date: July 7, 2004