THESIS

GRIEF REACTIONS TO DRUG LOSS: A GROUNDED THEORY APPROACH

Submitted by

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In partial fulfillment of the requirements

For the Degree of Master of Science

Colorado State University

Fort Collins, Colorado

Summer 2013

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ABSTRACT

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Grief responses have generally been associated with death-related losses. However, there is growing research that suggests that individuals create attachments with non-human objects such as alcohol or other drugs. Few studies have addressed feelings of loss associated with drugs. In this study, we interviewed 10 individuals who were at early stages of recovering from substance misuse. While we primarily used a grounded theory approach to analyze the data, we also used attachment theory, theory of continuing bonds, and Worden's tasks of grief as guiding frameworks for our analysis. We found that participants' relationship with drugs tended to fluctuate over time and that their grief experiences varied depending on what stage of the relationship they were in with their drug of choice. All participants in this study reported having a relationship with the drug and experiencing physical, emotional, cognitive, and relational reactions to separating from the drug that were similar to grief experienced from a death-related loss. At the same time, all participants reported that their grief experiences with drug loss were "different" than their grief experiences with death-related loss. Clinical implications of the results of this study are included in the discussion.

ACKNOWLEDGEMENTS

I first want to thank my wife and children for their loving support while I completed this project, especially in the last few weeks. I could not have done all of this without it. I also want to thank Jenn Matheson, my advisor, for her patience and expertise in this area. She was so encouraging to me throughout this entire process. She spent many hours editing, teaching, and advising me as I struggled to get it all put together in a clear and coherent manner. I want to also thank the ten individuals who graciously volunteered to participate in this study, and to share their expertise in this area. I want to thank Linda Jeffers and all other supporting staff at North Range Behavioral Health who helped me in conducting this research at their facility, as well as Anjelica Daneshfar, who took an amazing amount of time transcribing the data. I also want to thank Lisa Miller and Jen Aberle, my committee members, for their enthusiasm about this subject and their willingness to support me through this process. I want to thank Debbie Fidler for being willing to make final edits to this project, even as I pushed it to the last minute. Lastly, I want to thank all of my colleagues who have been so encouraging to me throughout my entire grad school experience. Their support has been tremendous.

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Chapter 1: Introduction

William Worden (2009), considered by many to be a leading expert in the field of grief and loss counseling, has emphasized the profound impact that grief has on a person's emotional, physical, cognitive, and spiritual health. According to Worden, grief is defined as the feelings, behaviors, and cognitions that occur in response to a loss, whether that loss is material, personal, or symbolic (Harvey, 1996). Although most of Worden's work has centered on death-related losses (i.e., death of a spouse, sibling, or child), there has been substantial evidence demonstrating the existence of grief in response to non-death related losses. Studies looking at grief in non-death related loss include, but are not limited to, job loss (Harris & Isenor, 2011), organizational change (Bell & Taylor, 2010), infertility (Harris, 2011), relationship breakups (Boelen & van den Hout, 2010), migration (Sawicki, 2011), and drug loss (McGovern, 1986; McGovern & Peterson, 1986; Streifel, & Servaty-Seib, 2009). While there has been research done on both the yearnings associated with death-related loss (Worden, 2009) and the yearnings associated with drug withdrawal (Nees, 2012; Thorberg et al., 2011), very little research has been done to measure the similarities or differences between these grief reactions. The purpose of this study is to better understand the grief process of those giving up drug use and to better understand the similarities and differences between death and drug-related grief.

Significance of Study

According to the National Institute on Drug Abuse (2000), relapse rates for those in drug treatment range from 40 to 60%. Recidivism rates for those charged with drug-related problems are approximately 50 to 65% (United States Department of Justice, 2002). These rates imply that millions of lives are negatively affected both financially (National Institute on Drug Abuse, 2000) and relationally from substance misuse. According to Matheson and Haralson

(unpublished manuscript), treating grief early on in the process of ending one's drug use may have significant benefits for those in recovery. Because treatment for drugs and alcohol have not changed significantly in the past 10 years (National Institute on Drug Abuse, 2000), Matheson and Haralson assert that studying grief as it relates to drug loss may be the "missing link" for decreasing relapse and recidivism rates and increasing positive long-term outcomes. By learning more about the losses associated with the loss of drugs in one's life, we will be able to better help friends, families, and health professionals who work with those struggling with drug recovery-related losses.

Research Questions

In order to begin to understand the phenomenon of drug loss, I focused on the following research questions:

1. What emotional, physical, cognitive, and relational reactions occur in response to losing one's drug of choice?
2. To what extent do participants feel they have a relationship with their drug of choice?
3. In what ways have participants' relationship with drugs changed throughout their lives?
4. What thoughts and beliefs do participants have on the idea that they have experienced grief in the process of quitting drug use?
5. In what ways is drug-related loss similar or different to death-related loss?

Chapter 2: Literature Review

This study combines the field of grief and loss with the field of alcohol and other drug (AOD) misuse and treatment. I start by reviewing the literature on the history of AOD misuse as a mental health disorder followed by an explanation of current models and cycles of addiction. I continue by examining current treatment strategies for those struggling with AOD misuse. I then review the models of and treatments for grief and loss. Finally, I synthesize the research by examining the ways in which grief and loss interventions have been applied to drug treatment in the recent past.

Substance Misuse Literature

AOD misuse as a mental health disorder. AOD misuse has been viewed as a treatable disorder since the 1930's with the advent of Alcoholics Anonymous. Prior to that, AOD's were often misused, but not considered a diagnosable, treatable health disorder. The notion of addiction began to emerge after prohibition, but it was not until 1952 that terms such as alcohol abuse and dependence were included in the Diagnostic and Statistical Manual (DSM) (American Psychiatric Association [DSM-IV-TR], 2000). Today, AOD misuse is categorized through the DSM under two basic categories: abuse and dependence. The DSM describes substance abuse as having the following patterns: failure to fulfill major role obligations, substance use in physically hazardous situations, legal problems, and persistent social or interpersonal problems. The DSM describes substance dependence as having the following patterns: increased amounts of the substance; weakened effect with the same amount of substance use; characteristic withdrawal symptoms; substance use in order to relieve or avoid withdrawal symptoms; larger amounts of substance use over a longer period of time; unsuccessful efforts to cut down or control substance

use; a great deal of time is spent in activities to obtain the substance; use the substance or recover from its effect; important activities are given up or reduced because of substance use; and continued substance use despite having persistent physical or psychological problems that have been caused or exacerbated by the substance. AOD misuse, as defined in this study, is the use of alcohol or other drugs to the extent that one could be diagnosed with alcohol abuse or dependence according to the DSM.

With the emergence of DSM categorizations of AOD misuse came an increased number of treatment options for individuals suffering from AOD misuse. While not all treatment models are based on sound theory, scholars have endeavored to develop theories that can explain the process of addiction to better design treatments that address those underlying processes. The most commonly used models of addiction are the moral, sociocultural, psychological, disease, neurological, and biopsychosocial models (Fisher & Harrison, 2013). Most practitioners today agree, however, that there are multiple factors which impact one's decision to misuse, and there is no premier theory to which all experts adhere.

Models of addiction. Six of the most common models of addiction include moral, sociocultural, psychological, disease, biopsychosocial, and neurological models. The first explanation of drug addiction to emerge was the moral model (Fisher & Harrison, 2013). The moral model of AOD misuse posits that individuals have personal choice and that addiction is a consequence of that person's choice (Fisher & Harrison, 2013). The sociocultural model of addiction looks for external factors such as culture, religion, family, and peers that influence addiction (Fisher & Harrison, 2013). The psychological model of addiction posits that AOD use is secondary to other psychological conditions such as emotional problems that push individuals toward AOD use to relieve pain. (Fisher & Harrison, 2013). This model also suggests that some

individuals have addictive personalities and that pain relief derived from drug use can create bad habits of continual drug use. The disease model of addiction posits that addiction is a disease and that it is not secondary to other conditions (Kurtz, 2002). This model suggests that the disease is chronic and incurable, and that abstinence is the only justifiable goal to treatment. The medical model posits that addictions occur primarily from chemical reactions in the brain (Leshner, 1997). This is one of the reasons why practitioners believe addiction recovery rates are so low (Lewis, Dana, & Blevins, 2011). The biopsychosocial model of addiction explains addiction by combining the sociocultural, biological, and psychological, cognitive, environmental, and developmental perspective (Fisher & Harrison, 2013).

The cycle of addiction. These models may help us in understanding why some individuals fall into what I term the "cycle of addiction." Research McLellan and colleagues (2005) have conceptualized addiction as a chronic relapsing condition. In other words, many individuals who misuse substances find themselves caught between a cycle of recovery and relapse. A plethora of research has gone into understanding the phenomenon of "cravings," or the urge or desire to use a substance (Agrawal et al., 2013; Carter & Hall, 2013; Joos et al., 2013; Kavanagh et al., 2013; Witkiewitz et al., 2013). While the craving construct is a complex and ever changing process, researchers agree that cravings are "at the heart" of client relapse (Witkiewitz et al., 2013). Research on cravings have focused on three main explanations: biological, emotional, or cognitive factors. Biological models posit that addiction is a "brain disease" and that the etiology of addiction is born out of neurobiological processes (Witkiewitz et al., 2013). Emotional models of addiction posit that addiction occurs in response to the avoidance of negative affect such as stress. Cognitive models suggest that addictions are ingrained in cognitive processes such as the cravings associated with seeing a picture of someone

drinking alcohol (Thorberg et al., 2011). The DSM defines withdrawal as "a substance-specific syndrome due to the cessation of (or reduction in) substance use that has been heavy or prolonged" (DSM, 2000, p. 201). For example, alcohol withdrawal is described as having two or more of the following conditions: hyperactivity, hand tremors, insomnia, nausea or vomiting, hallucinations or illusions, psychomotor agitation, anxiety, and seizures. Because substance withdrawal can be painful, both emotionally and physically, the process of ending the abuse of one's drug of choice can be a long and labor-intensive process. This process may consist of many instances of relapse and recovery before ending the relationship is complete (Miller, 1994). Some organizations, such as Alcoholics Anonymous (AA), suggest that recovery is on-going process and that one's relationship with a substance can never be completely severed (Alcoholics Anonymous, 1972).

AOD treatment. Using the models of addictions as a basis, there are several AOD treatment interventions and techniques to help those who suffer from AOD misuse (Fisher & Harrison, 2013). Some of the most widely used forms of treatments or interventions include mutual-help groups, cognitive-behavioral therapy, motivational interviewing, contingency management, pharmacotherapy, and family therapy (Fisher & Harrison, 2013; Walters & Rotgers, 2012). One of the most popular interventions is mutual-help groups, often known as twelve-step programs [i.e., AA or Narcotics Anonymous (NA)] (Fisher & Harrison, 2013). These mutual help groups usually follow the disease model suggesting that addiction is a disease and that one is always "recovering" from the disease.

While twelve-step programs exist across the U.S., within outpatient and inpatient treatment settings, cognitive-behavioral therapy (CBT) and motivational interviewing (MI) are widely used treatments (Walters & Rotgers, 2012). CBT is based on the premise that human

behavior is largely learned rather than determined by genetics, and that one can use the same learning process used to create the problem to solve the problem (Walters & Rotgers, 2012). Motivational interviewing is based on the idea that those who misuse drugs are ambivalent about change and that questioning can be used to enable individuals to explore and resolve their ambivalence (Miller & Rollnick, 2013). Contingency management is another popular form of treatment whose purpose is to reduce reinforcement derived from drug use and to increase reinforcement derived from healthier alternatives, particularly in activities where drug use is not compatible (Walters & Rotgers, 2012). Recent strides in medicine have also proved effective the use of prescription medications combined with psychotherapy. To this date, however, prescription medications are only used in the treatment of opioid addiction and alcohol withdrawal (Walters & Rotgers, 2012). Currently, family therapy models which address substance misuse are also increasing (Walters & Rotgers, 2012). Family therapy models that have empirical evidence of their effectiveness with AOD misuse include, but are not limited to, Behavioral Couples Therapy, Brief Strategic Family Therapy, and Multidimensional Family Therapy (Rowe, 2012).

Grief and Loss Literature

An explanation of grief. Research has shown that most people recover from uncomplicated grief without the need of any outside help (Worden, 2009). Uncomplicated grief is any normal physical, emotional, behavioral, cognitive, or spiritual reaction that occurs in response to a loss. While there are many similarities in the experiences of those who are grieving, most experts would agree that since there are a wide range of grief symptoms, grief is experienced differently by each person. Feelings associated with grief include: sadness, anger, guilt, anxiety, loneliness, fatigue, helplessness, shock, yearning, emancipation, relief, and

numbness. Physical sensation associated with grief include hollowness in the stomach, tightness in the chest, tightness in the throat, oversensitivity to noise, a sense of depersonalization, breathlessness, muscle weakness, lack of energy, and dry mouth. Cognitive responses associated with grief include disbelief, confusion, preoccupation, sense of presence, and hallucinations. Behaviors associated with grief include sleep disturbances, appetite disturbances, absentmindedness, social withdrawal, dreams of the deceased, avoiding reminders of deceased, searching or calling out, sighing, hyperactivity, and crying. Uncomplicated grief generally happens when these feelings, cognitions, or behaviors are or become chronic, delayed, exaggerated, or masked (Worden, 2009).

Theories of death-related grief and loss. According to Worden (2009), grief is defined as the feelings, behaviors, and cognitions that occur in response to a loss. Harvey (1996) notes that a loss can be something material, personal, or symbolic. In other words, according to these theorists, you can experience grief from the loss of many different things or people. Jerga, Shaver, and Wilkinson (2011) report that the stronger our attachment is to something or someone, the greater our grief is when that person or thing is gone. Bowlby (1969) explains that we build attachments with other people or things in an effort to feel safe and secure. According to Worden (2009), a loss may violate feelings of safety and security. Even in death-related loss, Worden explains that grief is not always associated with the loss of the person themselves, but may be for the loss of time, memories, or other objects or places related to that person.

Grief treatment. Four of the most common forms of treatment for uncomplicated grief are the stage model, phase model, task model, and dual-processing model (Worden, 2009). The stage model of treatment posits that people go through grief from one stage to the next in a linear fashion. The most common stage model of grief is Kubler-Ross's (1969) stages of dying, which

include: denial, anger, bargaining, depression, and acceptance (Worden, 2009). The phase model posits that people go through various phases in the mourning process. For example, Sanders (1999) concludes that the bereaved go through five phases: shock, awareness of loss, conservation withdrawal, healing, and renewal. In contrast, Worden's task model puts emphasis on what others can do for the bereaved, in a more active form of grieving. Worden describes four tasks of grieving: accept the reality of the loss, process the pain of grief, adjust to a world without the deceased, and finding an enduring connection with the deceased in the midst of embarking on a new life. Finally, one of the more recent grief and loss model is the dual-process model, where Stroeb, Schut, and Stroebe (2005) posit that individuals vacillate between loss orientation and restoration orientation while grieving. In loss orientation, the person is focused on grief work, or processing the grief. In restoration orientation, the person is focused on things such as skill mastery, identity change, and other psychosocial skills to help them moved through the grief. For all of these models, grief treatment can be done in individual, couple, family, or group formats (Worden, 2009).

Synthesizing AOD and Grief Literature

Drug-related grief and loss theory. Drug loss, as defined in this current study, is any loss associated with the relinquishment of drug use whether that loss includes the drug itself, drug-related rituals, friends, self-identity, or any other drug-related loss. According to Jennings (1991), drugs have been described as "cathexis objects - objects that humans invest with psychic energy" (p. 222). Because psychic energy is invested in these objects, emotional attachment has been shown to occur between individuals and their drug (Flores, 2001). Yearning to be with someone with whom attachment has formed is a common symptom for those who suffer the loss of a family, friend, or loved one (Worden, 2009). Yearnings and cravings have also been

associated with the relinquishment of drug use (Nees et al., 2012). Jennings explained that drugs can take precedence over human relationships, and that powerful feelings of loss may occur as drugs are surrendered. Jennings continues by stating that drug loss has been typically seen as something that one celebrates, and that grieving is not necessary in losing something that is perceived as destructive. Because individuals who enter into a drug treatment program can usually only anticipate a life without the drug, it could make the grieving process over the loss of their drug that more difficult.

According to Streifel and Servanty (2006), alcohol loss often includes other kinds of losses in correspondence to the loss of the drug itself. Drinking-related losses may include a loss of identity, way of life, friends, patterns, and hangouts along with the attachment loss of the alcohol itself (Flores, 2001; Streifel & Servaty-Seib, 2006). Other common grief responses to alcohol loss include preoccupation with alcohol-related thoughts, painful repetitive ruminations of drinking and drinking experiences, and making sense of completely giving alcohol up. Pittman and colleagues (2007) explains that withdrawal symptoms from those who misuse alcohol include sleep disturbances, poor appetite, depression, alcohol craving, headaches, irritation, and dysphoria. Anxiety, withdrawal phobic symptoms, panic-related symptoms, grief over the loss of another person, stigmatization, major depression, and abnormal grief reactions have also been seen as symptoms of alcohol withdrawal (Blankfield, 1986). Other symptoms of alcohol withdrawal that have been noted include pathological mourning over object loss, loss of love, longing, neediness, guilt, malignant affect, and sadistic love (Miller, 1994) as well as anger, aggression, perceptions alteration, and psychomotor skill difficulties (Williamson, 2001). Many of these same reactions have also been seen in individuals grieving the death of a loved one (Worden, 2009).

Grief treatment for AOD misuse. Until recently, there has been little to no research done on drug loss and the grief experience associated with its loss. In 1984, Denny and Lee conducted a study in which they added a grief group procedure to their substance abuse program. The intervention began by administering the Beck Depression Inventory (Beck et al., 1979). After completing the inventory, the participants began five three-hour long group therapy sessions. In the first session, participants were asked to write a letter which answered the following question: "What I felt when I lost you, what has happened to me since you left, and what am I doing now?" They were then asked to share their letters to the group. This session concluded by providing psychoeducation about the stages of grief and a discussion about what stage the participants felt that they were at. Session two included continued discussion of the letter, sharing memories of the loved one, and role plays. Session three included guiding the participants through the stages of grief and expressing emotions. Session four included a discussion of early losses, including non-death related losses. Finally, session five included the re-administration of the Beck Depression Inventory as well as the writing of a "good-bye" letter. In this study, however, researchers were looking at the grief associated with the death of a friend or family member and not from the drug itself. Results from this study found that those involved in the grief procedure had fewer symptoms of depression and better coping skills than others who were also recovering from drug addiction but did not receive the intervention.

In 1986, McGovern and Peterson found that their patients experienced some reduction in grief reaction and significant reduction in depressive symptoms after a 28-day inpatient AOD program. In this study, depression was measured using the Beck Depression Scale and grief was measure using the Grief Awareness Measure (GAM) and the Loss Identification Measure (LIM) which look at physical, cognitive, emotional, and spiritual expressions of grief. The purpose of

this study was to examine the differences between depression and grief of those people in an in-patient treatment center, and to see how treatment influenced the reduction of depression and grief. The measures were administered to the 50 individuals after detoxification and then again at the conclusion of 28 days in treatment. In another study by McGovern (1986), two groups were compared: one using the first three steps of AA and the other using a grief curriculum. The grief curriculum consisted of three individual counseling sessions in weeks two, three, and four of treatment. While the authors did not elaborate much on the curriculum used, they did report discussing the nature of loss, the dynamics of alcohol misuse and loss, and the resolution of grief through appropriate mourning (McGovern, 1986). It was found that there were no significant differences between these two groups on loss identification and grief awareness according to the LIM and GAM.

These studies regarding grief among individuals in AOD recovery, however, have several limitations as well as strengths. First, their sample sizes were limited in only studying the grief of 100 individuals. Second, their models for helping people work through grief were not consistent with more effective practices that are used today. Third, no prior research was conducted to evaluate the specific mechanisms which explain the grieving process of those giving up drug use. These research findings suggest a greater need for more research in this area because they have demonstrated that grief may play an important role in helping individuals work through the addiction recovery process.

More recently, Streifel and Servanty (2009) conducted a study which examined grief as it relates to AOD misuse. In this study, the authors used Rando's (1995) grief and mourning theory to show that AA and NA may help alcohol users break through denial, work through emotional pain, and adjust to a new world. The authors implemented this study by giving

surveys to 128 interested individuals at 12-step recovery centers as well as online. This study demonstrated a partially mediated relationship between AA/NA involvement (how often they went to AA/NA meetings) and obsession-compulsion to drink or use, and an association between higher program participation in AA/NA and lower scores on the painful reaction measures. The painful reaction measures looked at a participant's despair, panic, blame, anger, detachment, disorganization, and personal growth through six subscales. Likewise, this study showed an association between individuals involved in AA/NA and fewer symptoms of anger, resentment, anxiety, and other grief symptoms as well as lower obsession-compulsion to drink or use. Although there was an association, the researchers note that causal interpretation cannot be made from these results. One major limitation to this study is its lack of pre and post-test, which would be important in evaluating what mechanisms inherent in the AA model are helping these individuals work through their grief. This study was effective in that it demonstrates that those in substance misuse treatment, such as AA, do experience some level of grief, and that grief treatment is essential for helping people move through the addiction and mourning process.

Overview

AOD misuse has been categorized as a mental disorder for over 60 years. Many theories have emerged to help explain this phenomenon, including psychological, sociocultural, moral, neurological, and disease models. The process of ending a relationship with one's drug of choice can be a painful and anguishing process, often accompanied by many vacillations between recovery and relapse. Although grief has been seen in drug-related losses, most grief research has been targeted at death-related grief. Attachment theory is often used to explain the grief associated with losing a family member or loved one. Many treatment strategies are available for both AOD misuse and grief. The most common treatments for AOD misuse are mutual-help

groups, cognitive-behavioral therapy, motivational interviewing, contingency management, pharmacotherapy, and family therapy (Fisher & Harrison, 2013; Walters & Rotgers, 2012). The most common treatment strategies for grief are the phase, stage, task, and dual-processing models of treatment, which can be implemented in group, individual, family, or couple formats. Emerging research has suggested that those who give up AOD use may experience significant loss. However, only two studies to date have implemented a grief and loss portion to their substance abuse treatment (McGovern, 1986; McGovern & Peterson, 1986). More research is needed to further explain the significance of grief in drug treatment.

Theoretical Framework

Theories provide conceptual understanding to complex problems or social issues such as grief and loss (Reeves et al., 2008). Three of the most prominent theories in the field of grief and loss are attachment theory, continuing bonds, and Worden's task theory (Rothaupt & Becker, 2007). Traditionally, these theories have only been used to compare the grieving process of those experiencing a death-related loss. However, recent research has demonstrated that people can experience grief from non-death related losses such as drug loss. These theories will be triangulated to inform the current study.

Attachment theory. Attachment theory is a theory developed by Bowlby (1969) in which he posits that humans strive to develop strong affectional bonds with others in order to feel secure and safe. Attachment theory also posits that conditions that endanger attachment bonds, such as a loss, may provoke strong grief-related reactions (Worden, 2009). William Worden (2009) conceptualized the concept of loss using the framework of attachment theory. Gervai (2009) notes that the greater the bond is, the greater the sense of loss is when that bond is broken. Most researchers suggest four types of attachment styles: secure attachment, anxious,

avoidant, and disorganized (Gervai, 2009; Worden, 2009). Gervai's (2009) research demonstrated how those with secure attachment styles are less likely than those with anxious or avoidant attachment styles to experience complicated grief. Other studies have shown how attachment insecurity is a risk factor for more intense grief experiences (Jerga, Shaver, & Wilkinson, 2011) and how attachment style is associated with one's ability to recover from a loss (Worden, 2009) and effectively go through the mourning process (Jerga et al., 2011). Intense or complicated grief experiences may manifest itself in different ways, but is usually evident when there are prolonged, delayed, exaggerated, or masked grief reactions (Worden, 2009). Disorganized attachment, on the other hand, has been shown to invoke both positive and negative emotional reactions to loss (Judit, 2009). Disorganized attachment is most commonly demonstrated by role confusion, communication errors, extreme withdrawal, and signs of neediness toward caregiver (Gervai, 2009). While a majority of people do recover following a loss (Worden, 2009), an estimated 9% of bereaved people experience chronic grief after the death of a loved one (Jerga et al., 2011). Jerga and colleagues (2011) suggest that one's attachment style is influential in helping someone go through the mourning process without complicated grief. Flores (2001) suggests that addictions are a form of attachment disorder, a disorder associated with an insecure attachment style. He posits that individuals form emotional attachments to their drugs of choice and that addiction is more likely to occur when an individual has an insecure attachment style.

Theories of grief and loss.

Continuing bonds. Recent research has suggested that attachment relationships are continuous and that relationships are not severed by death (Bell & Taylor, 2010; Worden, 2009). Under this premise, because we develop a continuous bond with those whom we love, it is

suggested to not emotionally disengage from the deceased, but to help individuals form a secure base when grieving (Worden, 2009). In Steffen's and Coyle's (2008) study they demonstrate how meaning reconstruction and on-going attachment to a loved one has been used to improve bereavement outcomes, and that meaning-making through relevant spiritual frameworks, such as continuing bonds, may lead to better coping along with post-traumatic growth. The authors add that continuing bonds with the deceased are usually described as a sense of presence, a nearness, a connection, or an intense warmth, which is difficult to describe with known senses. Relating to drug loss, AA theorizes that people are always "recovering alcoholics," suggesting a continual pull towards alcohol through the remainder of that individual's life. AA also suggests that change is transformative and that the relationship with alcohol must move away from alcohol dependence. The theory of continuing bonds suggests that one's relationship with AOD is continuous, and that one stays connected with their drug, to some degree, even after AOD recovery has been accomplished for years.

Worden's tasks of grief. Because William Worden (2009) has studied reactions to grief for over 30 years, his theory has given many a way for treating grief. Consequently, his theory of grief and loss will be used as a guiding framework for this current study as well. According to Worden, there are four tasks of mourning: to accept the reality of the loss, to process the pain of grief, to adjust to a world without the deceased, and to find an enduring connection with the deceased in the midst of embarking on a new life. According to Worden, the first task is to help the individuals come to the full realization of the loss. Part of this process is coming to grips that reunion is not possible. The opposite of this task is some form of denial. In the field of substance misuse, it can be very difficult for those who misuse AOD to imagine their drug of choice no longer being a part of their life (Miller, 1994). Also, the prevalence of drugs in society

may affect one's ability to fully accept the reality of drug loss. In addition, it is common for drug users to have a sense of denial at the seriousness of their drug addiction (Williamson, 2001). This task may be necessary in overcoming the strong cravings, yearnings, and ruminations that often occur as someone strives to overcome a substance addiction (Miller, 1994; Nees et al., 2012).

Worden's (2009) second task is to process the pain of grief. This includes physical, emotional, and behavioral pain that is associated with a loss. According to Worden, many people go out of their way to suppress such strong feelings. Also, many people hear statements about "getting over it," which may push people away from expressing their real emotions. In dealing with substance misuse, those who are striving to overcome an addiction often feel both physical and emotional pain at the absent of the drug (Williamson, 2001). In order to cope with the pain, many either go back to the drug or move to another drug. If the task of grieving is applied to drug abuse, experiencing social, emotional, and physical pain are all part of this process (Worden, 2009). Researchers suggest that people who are addicted must go through the pain directly instead of sidestepping it through other means of coping.

The third task of grieving, according to Worden (2009), is adjusting to the world without the deceased. This task includes both external and internal adjustments to not having that person around in your life as well as spiritual adjustments of how they view the world and why this has happened to them. In the field of substance abuse, researchers suggest that many external and internal adjustments must be made as well and that overcoming substance abuse takes a complete lifestyle change (Goldberg, 1985). Many who are addicted to substances have to end social relationships with those who continue to use the drug, or have to go to different places in order to avoid being around the drug. If they have an anxious attachment style, they may have to make

internal adjustments of not needing the drug to make them happy. Many "recovering alcoholics" find meaning in overcoming the substance or become active in helping others overcome the addiction (Streifel & Sevaty-Seib, 2009).

The fourth task to grieving is to find an enduring connection to the deceased in the midst of embarking on a new life (Worden, 2009). In this task, people do not need to give up their relationship with the person who has died, but needs to find an appropriate place for the deceased in their emotional life. According to Worden, this must take place in a healthy way so that individuals can move on effectively in a new world without their loved ones. AA suggests that you are always a "recovering alcoholic" and that you will be for the rest of your life (Streifel & Sevaty-Seib, 2009). This task suggests the need to stay connected to the drug of choice while embarking on a new, healthier life without the drug present.

Summary

Substance misuse is considered a financial and relational epidemic in the United States (NIDA, 2000). Current models of drug treatment have not substantially helped in reducing relapse and drug-related recidivism rates in the United States (NIDA, 2000; DOJ, 2002). However, research has suggested that people who give up drug use experience a host of losses including loss of identity, loss of friends, and loss of the substance itself (Streifel & Sevaty-Seib, 2006). Despite the research that has studied the cycle of addiction, grief, and alcohol loss, studies measuring grief as it relates to AOD loss are almost nonexistent. To date, only two studies have demonstrated the use of a grief and loss curriculum on those recovering from AOD misuse (McGovern, 1986; McGovern & Peterson, 1986). These studies did, however, show us that people do experience substantial amounts of grief when going through drug recovery, and

that there is a great need for more research on this topic. Streifel and Servaty-Seib (2009) reported that grief counseling plays an important role in the recovery process of those overcoming alcohol addiction. The purpose of this study is to shed more light on this important topic.

Chapter 3: Methods

Because limited research has been done on the grief reactions of drug loss, a grounded theory approach is appropriate. While there are many grounded theory approaches, the approach taken by Corbin and Strauss (2008) was used. No hypothesis was tested, but rather, the data was gathered and then analyzed to produce themes representing similar concepts. From these concepts, workable categories were created which formed the basis of my results. The grounded theory approach uses a systematic way of sampling and analyzing data until a theory emerges (Corbin & Strauss, 2008). Worden's (2009) tasks of grief were used as a guiding framework for the interview questions, and was used in analyzing and organizing the data in the result section. Before beginning this study, I sought and received approval from Colorado State University's Institutional Review Board in order to conduct research on human subjects.

Researcher Biases

The idea of grief as an experience of those who are giving up their drug use was first introduced to me in my graduate-level "Grief and Loss" class at Colorado State University by my thesis advisor, Dr. Jenn Matheson. While discussing non-death related losses in class, Dr. Matheson stated how little research had been done on the subject of drug loss, and that she would be interested in having students join her in studying this topic more in-depth. We both felt that this could be a missing link to helping improve drug treatment and recovery rates. Dr. Matheson and I also shared an interest in studying individual experiences through qualitative research. Because there is little extant research on the subject of drug loss, we determined that a grounded theory approach would help us understand the process of losing one's drug of choice most effectively.

We began this project by exploring the literature in the area of drug treatment success rates and rates of relapse and recidivism as well as theories of grief and loss. Next, we identified an inpatient population of patients who had given up drug use within the past three months. This was so that we could examine the earliest weeks of drug loss. We chose in-depth interviewing because it allows for the greatest depth of information about the lived experiences of the participants.

Our training in family systems theory and other systemic processes allows us to view people and their relationships through a systemic or relational lens; hence our interest in grief and loss, a theory grounded in relational processes. This, of course, makes us somewhat bias towards relational processes over individual processes. Because I have received my Bachelor's Degree in Sociology, I also tend to view human processes from a more global perspective. This, coupled with my training as a Marriage and Family Therapist, has prevented me from being completely neutral during this study. As a therapist, I tend to view things from a narrative, post-modernism perspective as well as from an emotionally-focused/experiential perspective. In addition, I am a 27-year old Caucasian male who has had little to no drug use experience personally and who is also active in religious services. I am heterosexual, a husband, and a father as well as being a son and brother. All of these social locations have influenced the way I view drug use, relationships, and mental health problems, as well as the way I interviewed the participants who volunteered for this study at North Range Behavioral Health.

Participants and Recruitment

Because this is a qualitative study, based in individual experiences, and is guided by grounded theory, participants were recruited using convenience sampling from North Range

Behavioral Health; a mental health agency located in Greeley, Colorado and specializing in intensive in-patient substance abuse treatment. I created flyers about participation in the study and posted them within the agency (see Appendix A). With the help from the clinical director at North Range, Jenn Matheson and I met with the counselors and other personnel at North Range to discuss the purpose and procedures of the study. The counselors were very excited and willing to help in this study. In discussing the study with North Range employees, we created a recruitment strategy that worked both for them and us. I gave the receptionist at North Range 15 packets and a schedule. Counselors announced the need for participants in their group meetings with residents. The residents were told that in order to participate in the study, they needed to come to the front desk, fill out an informed consent, and to schedule an interview time with me. Recruitment continued until 10 adults in the inpatient program at North Range who used alcohol or other drugs and were in the first 90 days of recovery volunteered to participate in this study.

Procedures

The process began when participants came to the front desk and requested a research packet. Each packet contained an informed consent form, a demographics survey, a grief and loss survey (see Appendix B, C, and D) and an unmarked envelope. Upon receiving the packet, the receptionist asked the residents to read, sign, and place a tear-off portion of the informed consent into the enclosed, unmarked envelope. The receptionist then placed the envelope into a cardboard box behind her desk that was given to her by the interviewer for safe, confidential keeping of the tear-off portion. After placing the envelopes into the box, the receptionist asked each resident to write their name by a 1.5 hour time slot that worked for them (see Appendix E). The available times were from 9am to 6pm, for three consecutive Saturdays. The receptionist then assigned each participant a number that was written by their name on the schedule. This

number corresponded with a number (1-15) that was written on the packet they received. The receptionist then asked the volunteers to fill out the survey and questionnaire before coming to their in-person interview at their appointed time. During the week, North Range staff posted a schedule of the participants' interview times, using only their assigned numbers and no names for purposes of confidentiality. This was done as a reminder for each of the volunteers.

On the day of the interview, the volunteers came to the front desk with their packets in-hand. I greeted each of the participants and guided them back to a private interview room. Because a couple of the participants either lost or misplaced their packets, I gave them new packets at that time. Because many of the participants volunteered on the day of the interview, many did not have a chance to fill out the survey/questionnaire beforehand. Therefore, many of the participants filled out the informed consent, survey, and questionnaire with me prior to the interview. All of the paperwork took approximately 10 minutes for each of the participants to fill out. For those who did not fill out their paperwork beforehand, I wrote in their ID numbers for them.

I began the interview by introducing myself and explaining the purpose of the study. After that, I reviewed the informed consent form and asked if they were OK with me digitally recording their interview. Nine out of ten participants agreed to have the interview recorded for transcript accuracy. For the one participant who opted not to be recorded, I took brief notes of what she said, and quoted her on significant information discussed.

I used an interview script to guide the interviews (see Appendix F). Because this was a semi-structured interview, I occasionally deviated from the script to ask other pertinent questions or for clarification. Interviews ranged from 16 to 38 minutes in length, depending on how much the participants chose to elaborate on the questions and the speed at which they spoke. I ended

each interview by thanking the participants for their time and debriefing with them about how the interview was for them and if they were having any difficult or uncomfortable feelings. I then reminded each of them to please visit with a counselor or personnel at North Range if any difficult feelings or thoughts persisted.

Measures

Two instruments were used to collect quantitative data for this study, though these were only used for the purpose of better describing the sample. Participants filled out a demographics questionnaire prior to the in-person interview. The questionnaire asked for year of birth, gender, ethnicity, all drugs ever used, drug of choice, age that the participants first used their drug of choice, how long they had been in treatment for, the longest they had been without the drug, and if they were currently court-mandated to be in treatment (see Appendix C). The second instrument was an adapted version of the Texas Revised Inventory of Grief (TRIG) **(**Faschingbauer, 1981) (see appendix B). The TRIG has research-based evidence of its effectiveness in measuring grief reactions among those who experience death-related losses, but was adapted to drug loss.

Data Preparation and Analysis

The team involved in data preparation included my advisor, an undergraduate research assistant, and me. My research assistant and I transcribed the digital recordings, using NCH software's Express Dictate (NCH Software), a program used to assist us in the transcribing process. These transcriptions were also reviewed twice by the research team for accuracy. After the transcriptions were complete, all digital files of the interviews were destroyed by digitally erasing all files from the two audio recorders used as well as from any other recordings that were saved on computer files or drives. This included deleting the files from Express Dictate (NCH

Software). Once the data was transcribed into Word documents, the electronic transcript files were then imported into the qualitative analysis package, NVivo 10 (N10) (QSR International, 2012). N10 is a qualitative data analysis program used to organize qualitative data and help to code documents such as interview transcripts. Using this program, my advisor and I began co-coding the interviews. The co-coding process was done strategically to ensure coding reliability (Corbin & Strauss, 2008). Each of us (Jenn Matheson and I) coded the data separately. We then came together to compare what we each had coded. Differences in coding were discussed and compromises were made as to what should be coded where. We meticulously went through each interview, one at a time. At first, we had many differences in our coding schemes. By interview eight (out of ten), our coding schemes were virtually the same. During this time, I used a journal to record any insights that came up while analyzing the data such as the need to create concrete definitions of each of the codes. Because we were using Strauss and Corbin's (2008) coding method, we let the data direct the themes of the research. While, in general, we allowed the data to direct our analysis, we also looked for specific themes based on the theory of attachment, continuing bonds, and Worden's (2009) four tasks of grief.

Chapter 4: Results

The purpose of this research was to look at the grieving process of those who are currently in a treatment facility for substance abuse or substance dependence as defined by the DSM-IV-TR. In this results chapter, I begin by describing my sample in terms of their demographic data and their responses to the TRIG grief and loss survey (Faschingbauer, 1981). I then present the themes that the researchers pulled from the study as well as the themes that seemed to most closely correspond with theories presented in this paper, namely attachment theory, theory of continuing bonds, and Worden's tasks of grief. Using these themes, I create a portrait of the experiences of the three men and seven women who volunteered to participate in this study.

I structure the themes of this study in a chronological fashion, starting with the participants' early drug use experience and ending with their expectations for future use. Their early drug use experience include the ages at which they first started, what they enjoyed about the drug in the beginning, and their thoughts and feelings toward the drug at that early stage. I dedicate a larger portion of the results section to reporting on the theme of participants' experiences in the middle phase of their drug use since this spans the largest amount of time for these individuals during which they were developing "a relationship" with their drug of choice. I include a summary of their thoughts and feelings toward the drug, how the drug took precedence over human lives, and the process that these participants took to end the relationship with the drug. Next, I report on the participant's current thoughts and feelings toward the drug, what they expect their relationship with the drug to look like in the future, and what they have learned from this experience of separating from their drug this and past times. Throughout this section, I also report on the physical, emotional, cognitive, or relational reactions to separating from their drug

of choice. The last part of this section will focus on relating the participants' responses to the theories of attachment, continuing bonds, and Worden's (2009) tasks of grief.

Quantitative Results

Demographic information. The use of quantitative data in this study was only for the purpose of giving context to the in-person interviews. The age range for these 10 participants was from age 23 up to age 53 with an average age of 35. 70% percent of the participants reported being female while 30% of the participants reported being male. 50% percent of the participants reported being court mandated to be in treatment while 50% report not being court mandated.

Ten percent reported not using their drug of choice in 2 to 3 weeks, 20% for 4 to 5 weeks, 40% for 6 to 7 weeks, 20% for 8 to 9 weeks, and 10% for 12-13 weeks. For ethnicity, drugs used, and drug of choice, participants chose more than one answer on the survey. All ten participants reported having used or abused marijuana, followed by alcohol (9), methamphetamine (9), cocaine (8), LSD (5), ecstasy (4), and prescription drugs (4). Fewer participants reported using or abusing heroin than any other drug (3). Four participants reported alcohol and methamphetamine as their drug of choice while marijuana, cocaine, prescription pills, and heroin were also reported by one participant each as their drug of choice. See Table 1 below for more results.

Table 1: Demographic Information
(N=10)

	Range	Mean
Year of Birth	1960-1990	1978
Age First Using Drug	4-22	16
Months Without Drug	2-144	37.4
Days in Treatment	6-55	26.5

Court Mandated	
Yes	5
No	5
Gender	
Female	70%
Male	30%
Ethnicity	
White	8
Hispanic	2
Greek	1
Last Time Using Drug	
6-7 weeks	4
8-9 weeks	2
4-5 weeks	2
12-13 weeks	1
2-3 weeks	1

Drugs Used	
Marijuana	10
Alcohol	9
Methamphetamine	9
Cocaine	8
LSD	5
Ecstasy	4
Prescription Drugs	4
Heroin	3
Drug of Choice	
Alcohol	4
Methamphetamine	4
Marijuana	1
Cocaine	1
Prescription Drugs	1
Heroin	1

Grief and loss survey. The mean response for all items in Section 1 (Previous Relationship with Drug) was 2.85. The mean response for all items in Section 2 (Current Relationship with Drug) was 2.1. The total mean for all items in the questionnaire was 2.32. The items that had the highest scores were "Things and people around me still remind me of the drug" at 3.7 and "I found it hard to sleep after giving up drug use" at 3.4. The items that had the lowest scores were "At times I still feel the need to cry for the loss of my drug" at 1.2, and "I am unable to accept the loss of my drug," "I cannot accept the loss of my drug," and "I still cry when I think about losing my drug" at 1.4. See Table 2 below for more results.

Table 2: Adapted TRIG Scale
(1-Completely False, 5-Completely True)

Section 1: Previous Relationship with Drug		Section 2: Current Relationship with Drug	
Revised Item Wording	**Mean**	**Revised Item Wording**	**Mean**
I found it hard to sleep after giving up drug use.	3.4	Things and people around me still remind me of my drug.	3.7
I was unusually irritable after giving up my drug.	3.1	Even now it's painful to recall memories of when I used.	3.1
I couldn't keep up with my normal activities for the last 3 months since giving up drug use.	3	I still get upset when I think about my drug.	3.1
After giving up drug use, I found it hard to get along with certain people.	2.8	I can't avoid thinking about my drug.	2.7
I found it hard to work well after giving up drug use.	2.67	I am preoccupied with thoughts (often think) about my drug.	2.1

I was angry with having to give up drug use.	2.6	Sometimes I very much miss my drug.	2
After giving up drug use, I lost interest in my family, friends, and outside activities.	2.1	Nothing will ever take the place in my life of that drug.	1.6
		I hide my tears when I think about my drug.	1.5
		I feel it's unfair that I had to give up using my drug.	1.5
		I still cry when I think about losing my drug.	1.4
		I cannot accept the loss of my drug.	1.4
		I am unable to accept the loss of my drug.	1.4
		At times I still feel the need to cry for the loss of my drug.	1.2

Qualitative Results

Drug of choice. I started each interview confirming what each participant reported on the survey as their drug of choice. They had a range of responses to their drug of choice, all of which matched the answers they entered on the demographics survey and reported above. Three participants (Max, Julie, Sarah) reported that their drug of choice was alcohol alone. One participant (Tyler) reported that his drug of choice was both alcohol and heroin, three people

reported that their drug of choice was methamphetamine only (Katie, Karen, Tonya), and one person (Megan) reported that her drug of choice was both marijuana and methamphetamines because marijuana "always seems to lead to that" [methamphetamine]. Another female participant (Jessica) reported that her drug of choice was prescription drugs which included "Perceset…Vicodin, morphine, [and] any pain pills." Lastly, one male participant (Jared) reported that his drug of choice was cocaine. Throughout the interview, two participants mentioned other drugs of choice that were not mentioned as a drug of choice at the start of the interview or on the survey such as stimulants or alcohol. Two women mentioned their drugs of choice as selling drugs and her husband.

Age of first use. I confirmed participants' age of first use by confirming their response to the age of first use question on the demographic questionnaire. Three participants changed their response by clarifying that they either started using drugs in general at that age (not their drug of choice) or that the age they entered was a "one time thing." Max, for example, described how his father first gave him beer when he was four years: "It was Christmas Eve, and I was out chopping fire wood with my dad and after we got done, he started drinking beer and poured me a little glass of it, and I spent all Christmas day in bed puking all over myself."

Max later explains that he did not start drinking regularly until he was 17 years old. Another theme regarding age at first use was that all participants who reported using marijuana or alcohol used those drugs at younger ages than those who used methamphetamine, cocaine, or heroin. The ages at which the participants first started using their drugs of choice ranged from four years old up to 22 years old, with an average age of 16 years old.

Other addictions. Six of the 10 participants cited other people or things that they were addicted to besides their drug of choice. Some of them mentioned these addictions in passing, while others made a clear emphasis on the importance of this addiction in their lives. Megan repeatedly described how it was the "lifestyle" associated with her drug use that was harder for her to give up than the drug itself. From the beginning, she emphatically mentioned how her marijuana use "always leads" her back to methamphetamine use which in turn leads her back to the "lifestyle" of drug use and drug dealing. She explains it this way: "Mine just leads back to the lifestyle. I don't, it's just the lifestyle. Do I miss the lifestyle sometimes? Yes, I struggle with that because that's all I know."

Megan followed this comment by explaining how she misses "going to the clubs, hanging out, being the center of attention…and selling drugs." Megan said she liked selling drugs because of the power, control, and financial stability. When asked to clarify, she reported: "Yeah, mostly just the money. If I wanted to go to Red Lobster, I could go to Red Lobster…Being financially stable, I miss that. And I like to have nice things. I have a lot of shoes. I have a lot of shit…I miss going to the clubs and dancing...Yeah, the lifestyle, the action lifestyle."

Similarly, Jared, who also admitted to selling drugs, reported that he missed the money he could make from selling as well as the "sense of being God-like." He reported it this way: "… in the beginning you have a lot of money if you're selling. Sometimes I'll think back and sometimes think about how nice it was to have money and buy whatever I wanted." Katie described repeatedly that her addiction was more for the needle than the drug itself. She reported that she grieves more for the needle than she does for the methamphetamines. She explained how her drug counselor once asked her to "say goodbye to the needle" using the empty chair

technique, a technique used in grief counseling where the counselor asks the client to pretend their deceased loved one is sitting in a chair placed in front of them and to speak metaphorically to their loved one.

Tonya explained how her first drug of choice was her husband. In the following statement, she makes a direct comparison with the relationship she had with her husband and the relationship she had with her drug. "I became dependent on him just as much as I became dependent on the drug. I mean, if anything, he is my first drug of choice and then meth is my second." In other words, she felt dependent on both her husband and methamphetamines in a similar way. Tyler reported that his experience with heroin was mostly a negative one. He explained that when his addiction was at its worse, he experienced "existential fear" and "terror." However, he noted the part he enjoyed about using heroin was "the prospect of it, procuring it, seeking it out. I enjoyed that. That was sort of a thrill." In essence, he enjoyed trying to find heroin more than actually using the drug. Karen explained that the part she missed the most about her drug of choice was the weight loss that came from using methamphetamine.

Early Relationship with Drug

After inquiring about the participants' ages of first use and drugs of choice, I asked the participants, "What was it like for you when you first used [drug of choice]? What did you enjoy the most about using? What did you not enjoy about using?" Eight out of ten of the participants described their early relationship with at least one of their drugs of choice in a positive light. Tyler described his experience with heroin as dark; a time of "real serious depression" and a time where he was "borderline suicidal." He reported he did not "particularly enjoyed the experience

of using heroin," even when he first started. Max reported feeling physically sick when he first started using alcohol.

Besides the above mentioned negative experiences, all other participants reported positive aspects of first using their drugs of choice. Common words that were used to describe their early experiences with drugs were "fun" (Julie, Karen, Megan, and Tyler), "euphoric" (Jared), "amazing" (Katie), "laughed a lot" (Megan), and "loosened me up, I'd become more social" (Max). Eight out of the ten participants mentioned how they enjoyed the social part of when they first used their drugs of choice. Julie explained that she first got started because it was a "rebellious thing to do" and that she liked all of the parties she would go to while in high school. Tyler described his relationship with alcohol at the beginning as "rowdy, wild, boys being boys kind of thing." Jared describes it in this way: "Euphoric…of course the adrenaline high and the ability to think and talk…it seems to make me be able to focus. And that age you want to be the life of the party in that whole scenario. It did its purpose, it suited its purpose."

Three out of the 10 people discussed how the energy they received from using their drug of choice helped them with daily activities such as sports (Karen) and taking care of their children (Katie and Tonya). Katie described it this way: "It made me feel good. I had energy. I could take care of my kids. I could deal with my husband. I could deal with stress. Bills and all this stuff." One of the individuals (Jessica) described how she first used her drug of choice (prescription pills) because she was sick. She reported, "I felt that they [pills] comforted me when I was in a lot of physical or emotional pain."

Enjoyed about drug use. In response to the specific question "What did you enjoy the most about using [drug of choice]?" some participants reported that it was the social aspect of their drug use that they enjoyed the most, some reported they enjoyed the energy it gave them, and others discussed the sense of euphoria or the relief from physical or emotional pain. Julie explained, "Mostly the parties. Like going out to the bar and playing pool. And what not. Just more of the social thing for me…It was definitely the social aspect that attracted me to [the drug]." Megan reported that it was "the lifestyle, like just ripping and running, stuff like that."

Three of the respondents reported they enjoyed the energy their drug of choice gave them to party and get things done at home. The following statements show the types of details some participants gave about the energy their drug of choice gave them: "It gave me a boost. It didn't make me tired," (Megan) "Just getting thing done," (Karen) "I would get real revved up and real wild." (Tyler) Tonya reported, "Well at first it started helping me with the everyday things like staying on top of the cooking, cleaning, taking care of the kids, and, I guess, just being wide awake and alert; being able to do a lot more."

Besides giving some more energy, four participants described how the drug made them feel euphoric and that it would help with both physical and emotional pain. "It just made me feel numb, made me feel euphoric. It made me feel like my thoughts were racing, and I didn't have to think about one thing" (Megan). Sarah reported that she enjoyed the sedated feeling helped her "get out of her head." Katie reported that it would give her a sense of relief from anxiety and stress, and Tyler reported, "It would be nice to escape for an hour or two at a time." Max reported that the alcohol use would kill the nerve pain he had in his feet. He also admitted that the alcohol was probably what caused the pain in his feet in the first place.

Did not enjoy about drug use. Two central themes emerged from the answer to the question "What did you not enjoy about using [drug of choice]?" One theme focused around the physical pain of using or not using, and another themed focused on the emotional or relationship problems that occurred while using or after quitting. Words they used to describe the physical pain included "blacking out," (Julie), "throwing up, DT's, shaking, delirious, anxious" (Sarah), and "hangover…feeling very, very sick" (Tyler). Others described the lack of energy that occurred after the "come down." It was described with words like "drag, drag, drag your butt to work," (Karen) "sleeping for a week or two after I came down," (Megan) and "being lethargic…being slowed down, inhibited mentally, dull." (Tyler)

Besides physical effects of using or quitting their drug of choice, some participants described the emotional or relational damage the drug did to them. Megan reported, "I didn't enjoy my horrible parenting skills when I was on drugs. The disconnection with my children, I hated that. Not keeping my promises and just the chaos." Other words that were used to describe the relational problems were "all of the broken relationships," (Max) and "I hate cocaine for destroying my marriage" (Jared). Tonya reported, "I didn't like how it made me lose focus of the main things of my life like paying attention more to my kids. I didn't like that. I didn't like how it took time away from me so quickly with my family, my immediate family."

Middle Relationship with Drug

After inquiring about the participants' early drug use, I asked participants about how their relationship with their drugs changed and evolved from their early experiences with using. The middle relationship, as defined in this research, includes any time between early experiences with their drug and their present relationship with the drug, as they say with me in the interview room. Nine out of ten of the participants reported that the middle of the relationship was when

their relationship with their drug of choice was at its worse. One participant (Julie) reported that her use was always recreational and social. She explained how she was called the "weekend warrior" by her drinking friends because she would drink excessively only on weekends. Megan explained that during this time, people that she used with began stealing from her. She reported how she began to have an unhealthy relationship with methamphetamine. Before last quitting, Max reported drinking at least a gallon of whiskey a day. During this time of extreme use he reported that he would drink again as soon as he was released from jail for charges stemming from his use.

For most of the participants, their drug use increased during the middle stages of their drug use. Jessica, who used prescription pills, reported that she began increasing the amount of opiates that she would use, and that it would go beyond what was prescribed to her, usually 2 or more pills a day. She reported that the more she became tolerant, the more she would use and the more control it had over her. She said that at this point she had a very unhealthy relationship with the drugs. Tyler explained that when his drug use was at his worse, he was drinking nearly three quarters of a gallon of whiskey a day and would spend about 50 dollars a day on heroin. He explained that for him it was a "typical" progression from oxycontin, slowly to more powerful drugs like heroin. Jared reported that using cocaine became a "hundred dollar day habit" during this time. He explains his progression with the drug like this,

> "At first it was recreational. Of course like any drug we used a couple times a month, then once a weekend, then Friday/Saturday, and then it went to Friday/Saturday and then maybe Wednesday. Then after about a year and half, [it was] about 18 months before our lives came to a crashing halt. The first three or four months it did the purpose by medicating ourselves; it did its job and then we became addicted to it and then you want to spend more time with it than your spouse."

The middle relationship for most of the participants was time of increased drug use. This was a time when their drug use was at its worse. Towards the end of their drug use, they began to notice the control the drug had on them and how it took over most aspects of their lives.

Bond of safety and security. According to Bowlby's (1969) Attachment Theory, individuals form attachments with others as a way to feel safe and secure. Likewise, I noticed a theme of safety and security in the interviews, especially as they spoke about the middle part of their relationship with their drug of choice. When asked if he thought he had a relationship with alcohol, Max reported, "Oh, I definitely had a relationship with it. I'd wake up drinking. I'd drink all day. I'd sleep with my dang bottle laying right next to me. Oh yeah, I had a relationship. It was my best friend." Jessica exclaimed that the prescription pills "comforted me when I was in a lot of physical or emotional pain." When asked, "What other kinds of feelings or thoughts were going through your head when you stopped?" Jessica responded, "All of my thoughts, the, things that I ran away from. The fear of not being loved. Being abandoned." She reported, "[the drug] made me feel happier and less sadder or less pain," and that she felt a loss of comfort when she did not have it. She continued by saying that it was, "kind of like a friend that listens to you, says nothing to you" and that "I always feel that I'm missing something because I'm so used to carrying it around. I always feel like something is missing or I'm forgetting to do something."

Sarah reported that alcohol was her "cure all" and that it became her "friend" because it was "always there" and "consistent." She knew she could always "count on the alcohol." Katie further explained, "I wanted more, I needed it, 'cause at the time it was giving me the sense only the drug, minus anybody else, cared about me. It was almost as if it was a part of me and I just lost it." She further explains that the drug would give her an:

> "overwhelming warm feeling in her body…I felt I wasn't out of place anymore at my home. I felt wanted. I had a lot more self-esteem…It really made me feel a sense of belonging…It was like a full-time relationship, pretty much. I depended on it, you know. I always made sure that I had one. I took more care of those [drugs] then I did myself…It was there 24/7. I could call on it. I could do whatever I needed to it and it would be there just like a friend was."

Tonya reported that she "doesn't like being alone, so maybe that's why I missed it. I don't enjoy just being by myself and that's something that I'm trying to work on right now, being in treatment." She further explains her attachment to methamphetamines in this way:

> "I was really dependent on it. I compare it to my husband and my drug. I'm very dependent on it. It helped me through all my bad times. It was, yeah, it was always there for me, you know, when I needed it. When I needed to feel better when I was feeling sad it was right there. You know, it never left my side. It didn't matter what I looked like, who I was, it just took me right in. So, I had a relationship, yeah."

Not only did all of the participants report having a relationship with their drug, many of them said that it was their "best friend," that it was "always there for them," or that they could always "count" on the drug. Three of the participants made direct comparisons with their drug of choice and a relationship with another person. Several made clear examples that their drug of choice gave them a sense of safety and security as described in Bowlby's Theory of Attachment (1969).

Unhealthy or disorganized attachment. Disorganized attachment is an attachment style that is typically associated with abuse (Hesse, & Main, 2000). This attachment style is associated with both clinginess and distance in children, for example (Hesse, & Main, 2000). The participants were asked if they felt their relationship with the drug was an abusive relationship. Six out of ten of the participants reported it was similar to an abusive relationship. Others explained how they felt "dependent" or "co-dependent" on the drug, a term usually associated with relationships with other people. The first theme I will discuss is that of having a "dependent" relationship with the drug. I will then show the similarities and differences that

were expressed about having an "abusive" relationship with their drug. Megan made a direct comparison of her dependence on men and methamphetamines in this way:

> "Well yea I was very co-dependent on meth. I was co-dependent on men but now I broke up with my boyfriend I don't have a boyfriend, I don't even know…I'm just getting to know who I am. I think I did have a very close relationship with meth, marijuana, and anything else that I depended on, even selling stuff. The relationship with using meth, like I depended on it to numb my feelings. I depended on it to make me happy. I depended on it make me get up…you know? I would call it a relationship…an unhealthy one."

In essence, Megan felt that she had unhealthy or dependent relationships with both men and drugs. Several other participants echoed her sentiments, such as Tonya when she compared her relationship with her husband and methamphetamine: "So, I became dependent on him [her husband] just as much as I became dependent on the drug. I mean, if anything, he is my first drug of choice and then meth is my second" (Tonya). Jessica explained her unhealthy relationship with prescription pills a little bit differently. She reported that her drug was "tricky" and that it pretended to be one thing but was another. Jessica reported: "It was… I thought it was my best friend. I thought it was OK. I thought it was a good thing. I had relationships too that made me think everything they do is OK and then turns on me…Even though it is a thing, it brought the same emotions that an unhealthy relationship would bring."

In other words, she felt that her drug both helped her and hurt her at the same, a common theme of those who experience abuse and those who suffer from disorganized attachment (Hesse, & Main, 2000). Building on what Jessica reported, Katie discussed how at first her drug of choice was her "number one," and later it took control over her and made her fear it. She reported, "I didn't think that I was…it was unhealthy. I didn't think anything about it, but now I do [think it's unhealthy]."

Eight out of 10 of the participants in the study also agreed that their relationship with their drug was an "abusive" one. Tonya reported, "[The drug] would abuse me. I felt like I was hurting my body and it would allow me to. It'd be right there to be like 'here ya go, ya know, this is the life. This is the way you need to cope with things.'" She lamented how it made her think it was good, but in the end, it was abusive both mentally and physically. Without being asked, one individual (Katie) made a direct comparison with methamphetamine and a domestic violence relationship with another person that she had in the past. She reported:

> "That's what I've always reported when I came in here, addiction is a domestic violence cycle only it's on yourself… Oh, yea. I was in an abusive relationship. He broke my nose and my eye socket and I still stayed with him, so then the reason I say it's like domestic violence is that I look at that situation and I look at what the needle's done to me. You know, it was hard to leave it, it was hard to not want it, you know."

Jared made the most poignant comparison of the drug to an unhealthy or abusive relationship:

> "My wife would call it the 'White Bitch' because it's a mistress [the drug]…there's a strong sexual connotation in it. She used to say that you're cheating on me, but then I would say 'no I'm not'. 'Well you're on cocaine…you're high.' And I'm like 'oh'. Yes there is, something [the drug] that we used to strengthen our relationship put a wedge between our relationships…Yes, you are a slave to your drug. So it's like an abusive relationship. Yea, totally…It seems like the drug is a band aid, a false mistress to try and cover internal problems. It can be abused, loved, lack of love…it became my purpose. It becomes that thing and then it takes everything, the band-aid ends up becoming the wound."

In essence, he expressed that his relationship with the drug was so unhealthy, that his wife felt as if he was having an affair with the drug. The drug appeared to be helpful (like a band-aid), but in the end it only hurt him and his relationship with his wife.

Drugs taking precedence over human lives. Jennings (1994) explained that drugs often take precedence over human relationships. She suggested that there must be a strong pull toward the drug if users are willing to put the drug over other relationships. In the current interviews, a theme emerged that indicated times when a participant's drug of choice took over human

relationships, in particular with the participants' children. Julie explained that because of the drug, she began going to work late or picking up her children late. Megan reported that she did not enjoy her "horrible parenting skills when I was on drugs" or "the disconnection with my children…not keeping promises and just the chaos." She explained that one of the reasons she decided to quit using was because she lost her children to foster care. Similarly, Jessica lamented, "my children…my children…I lost them. I just wasn't a good mom anymore. I lost them. They had to be removed." Katie exemplified this point by saying, "When I was using heavily that was my everything. I didn't care if I had my kids. I didn't care if I had a boyfriend, friends, as long as I had that needle and the drugs. That was all I needed. Just like a boyfriend or my kids now, you know. That's all I need now. It wasn't then, it was that." In other words, when she was using methamphetamines heavily, she cared more for the drug then she did for other important relationships in her life. Tonya reported that she took better care of the drug then she did herself. She also exclaimed that methamphetamines made her "lose focus of the main things of my life like paying attention more to my kids." She continued by saying that one of the reasons she decided to quit was that she continued using while she was pregnant. She reported that it was a sign for her that she needed outside help. A common theme emerged from the data that drugs can often take precedence over human lives. For many of these participants, especially the mothers, this was signal that they needed outside help in overcoming their drug problems.

Reasons for ending relationship with drug. I asked each of the participants, "How did you decide to stop using your drug of choice?" All of the individuals were at different places in the process of ending the relationship with the drug and all had different reasons for wanting to end the relationship. Themes that emerged from the data were that they stopped using because

they realized that their priorities were not how they wanted them and that they stopped using because of legal problems. In terms of responses that indicate quitting drug use due to unbalanced priorities, Julie reported that she decided to quit because it got in the way of her "responsibilities." She reported, "That's ridiculous. A couple of beers isn't worth losing my job." In response to my question, Megan reported, "well my kids are in foster care," and Jessica said, " [my children] had to be removed." Sarah reported that she decided to end the relationship with her drug of choice because her mother and boyfriend wanted her to. Katie reported, "I didn't have anywhere to go, none of my family wanted me around, I lost my kids, my husband went to prison." Tonya reported deciding to quit because she was pregnant, and Jared decided to quit because he and his wife would become violent with each other and that they would end up in "huge fights."

As well as unbalanced priorities, five of the participants described legal or health issues that caused them to quit this time. Karen said that she did not have a choice but to quit because, "I wrecked the car and got a DUI. Me and my sister fought and she brought me to jail." Likewise, Jared stated that he totaled his truck and that he, "had a warrant out for not paying a traffic ticket." Max stated that he was involuntarily committed to treatment from a doctor, most likely from high levels of alcohol in his body.

Process of ending relationship with drug. For all ten participants the process of ending their relationship with the drug was both emotionally and physically painful. All participants had times without the drug followed by times with their drugs. Like previous research suggests, for all ten participants, the process of ending their relationship with their drug of choice was an agonizing and painful cycle ((Miller, 1994). Karen exemplified this when she explained that for her first year on probation she was doing well, but then began to reuse after one year. She was

then placed in a female offender program from which she eventually graduated. After her counselors reduced the frequency of her mandatory urinalyses and breathalyzers she began using again. Another participant, Megan, said that she first had to, "accept…that [marijuana is] a drug" before she could end the relationship with it. Tyler said that it has been a "conscious effort to stay abstinent," and that he has had periods of 6 to 8 months of sobriety. Jared described in great detail his own process of ending his relationship with his drug of choice:

> "I was incarcerated. And two years prior to that: 'Lord please help me! I don't want to do this anymore'…My wife and I were on and off separating and then getting back together with huge fights. She became violent and would have the hallucinations due to the extended drug use. We were fighting and separating; basically losing everything around us. My wife said she would like to separate; that she couldn't do this anymore… I knew that I just needed someone to pull me out of the situation because we were co-dependent and co-addicted. We just couldn't do it together. I would stop for three days and then she wanted to use. Then she would stop for three days and then I would want to use… My dad came down and got me, and I just needed some time away from the situation to get some sort of sobriety and my mind back...I've been praying on it and due to my faith I've found a really good script...It goes trigger, thought, craving and before it even gets to a serious thought, I replace it with another thought. I bring it into the obedience of Christ. And then it just turns it off. That's my switch."

In other words, Jared's life was spiraling out of control and he felt he needed outside help to get him out of the situation. Throughout the interview, Jared expressed how it was by "God's grace" that he has been able to end his relationship with cocaine.

Three of the participants explained the emotional pain they felt as they ended the relationship with their drug. Tyler said it this way: "I remember, one time, one experience, sitting during an AA meeting and feeling very, very sad, knowing that I couldn't or shouldn't or knowing what would happen if I were to drink again and missing a lot of the good times that I had…I was like aw shit, I miss, look at all the stuff… I was going to lose." He felt sad thinking about ending his relationship with alcohol and everything he would lose from ending it. Tonya reported, "When I'm feeling really sad, I do miss it. I wish I could just run to it and go smoke a

bowl." Jared exemplifies how emotionally agonizing it was for him to end the relationship. He exclaimed, "Hopelessness. Regret. Shame. Remorse. There were suicidal thoughts in there between my wife and I; both had them in the last three months before I sought out treatment...But what I had done and what it had done to my life was definitely sad. Not to the point of being so overwhelmed but pretty close to it." The process and the reasons for ending the relationship with drug was different by each participant. However, a common theme that emerged was that all participants ended the relationship with the drug because of unbalanced priorities, legal problems, health issues, or a combination of all three.

Comparison to death-related losses. The purpose of this section of the research was to look at the similarities and differences between drug loss and the loss of another person. The answers below were in direct response to the question, "I'm wondering whether the feelings associated with losing [drug of choice] are similar or different to the feelings associated with losing a friend or family member. What would you say to that?" All ten of the participants reported that the loss of another person is different to the loss of a drug. Many of the participants made direct comparisons to the grief they had experienced from death-related losses of their own and the grief the experienced from drug loss. Two people (Julie and Karen) were completely against the idea that these feelings of grief are similar. When asked the above mentioned question, Julie responded with "I think that's absolutely absurd, to be quite honest with you." When asked to elaborate she expressed, "It just is. It's a substance. I'm not mourning it at all…I'm not losing a grandma or anything like that…I'm not sad about it. It's just something I did." Likewise, Karen added, "No, that's totally different things." When asked why she feels they are different, she reported, "I just lost my mom three years ago and six, seven months ago

lost a sister-in-law to breast cancer so my grief for that is much, much stronger than my grief would be for meth."

The main differences that the participants reported from the interviews is that the drug is not something you love, at least not in the same way as you love a family member and the loss of a family member is permanent, something you can never get back (unlike a drug). Max elaborated by saying, "I'm glad I lost alcohol…I'll just use for instance, I lost my mom and dad, 6 years ago and 8 years ago…To me that really hurt. And it don't hurt me at all to lose alcohol. I'm happy to lose alcohol." Katie explained it like this: "Because family members don't hurt you like that [like the drug]. Family member don't manipulate like that [like the drug]… in my heart, [its] not something a family member would do to me." She reported that the loss of the drug is more like the "loss of a friend," but not a family member. Jessica reported, "No, they're different…Prescription drugs, I can replace anytime, but I've lost family and friends and…you never get that…person…back." Another theme that emerged from the data is that you choose to end a relationship with your drug and that you do not choose for your friend or family member to die. Megan reported that when she lost her dad she felt like a "victim to circumstances." In other words, she felt as if it was completely out of her control. Sarah stated that losing your drug is a "personal choice" and that the loss of her family members was completely out of her "control."

Lastly, a few of the participants said that it's both "similar" and "different" to the relationship with another person. Megan reported that "When I think about losing my dad, the feelings aren't the same, but it is a lot [the same]." She further explained that if "two people die in your family, you'll miss them in different ways." In other words, just like how you grieve the

loss of two people differently, you also grieve the loss of your drug differently than another person. Tyler explained it this way:

> "In the beginning of my sobriety, yes. Totally the same…I think that's harder [to lose his grandmother] than losing my drugs because there is a definitely finality when you lose a grandparent. I've…heard about it 3 or 4 times in group care about people not getting their one last hurrah or one last goodbye, [to their drug of choice] and I can totally see the correlation between the human relationship…Say you didn't have a good relationship with your grandfather or dad and they passed away and you weren't able to say goodbye or sorry…I [also] grieve for not getting my last hurrah [with his drug because his relationship with the drug ended when he wrecked his truck.]"

According to Tyler, losing cocaine was similar to losing a loved one, especially when he first stopped using. However, at the same time, he expressed how the grief was more intense when he lost his grandmother than when he lost his drug because of the finality of the loss.

Physical responses to quitting. There were a wide range of physical responses to being without their drug of choice; some were more everyday bodily functions such as eating, sleeping, and having energy throughout the day and others responses included more agonizing bodily pain. Julie said that she felt weak and that it messed with her sleeping schedule. She also mentioned that she started eating more as well. Karen said that she was only "a little tired" and "a little edgy," but that within two to three month your normal energy levels build back up. She also mentioned how she gained weight as soon as she stopped using methamphetamine. Megan echoed Julie's sentiment by saying she felt "tired, [and] exhausted." Tonya, who used methamphetamines, said that she "slept for about a week" after not using and that her "sleep patterns have been kind of messed up." Jared said that he slept for almost 20 days while in jail after giving up drug use.

Other more serious, more painful responses to quitting their drug use included feeling "DT's (delirium tremens), shakings, delirious, [and] anxious" (Sarah) as well as many other

physical responses. For example, Max said that he was in so much pain that within two days of not using alcohol, he "was sitting in a wheelchair" because he used the alcohol to numb the pain in his feet and joints. Jessica said that she felt "sick, not comfortable in her own skin, noxious, vomiting, pain…felt like I was dying." Katie explained that when she stopped using prescription pills she felt "horrible…like I just got hit by a bus." Tyler reported that his pain was excruciating. He reported, "Physically, I can't put it into words…just horrifying." Jared summed it up: "My whole body chemistry had just changed…becoming irritable and lethargic. Physically, it just would definitely deteriorate your mental and cognitive abilities and it's taken about 50 days to put sentences back together and in any rational form."

While all of the participants varied on their answers, all of them reported having some sort of physical reaction to losing their drug of choice. Some experienced more extreme pains, while other felt more minor discomforts like weight gain.

Emotional and cognitive responses to quitting. The emotional and cognitive responses varied by each participant as well; most were negative while some were positive. The words the participants used to describe their emotions from quitting included: "guilty," "lonely," "mixed feelings," "very emotional," "grouchy," "conflicting," 'depressed," "paranoid," "irritable," "angry," "anxious," "shame," "fear," "abandoned," "agitated," "panic," "terror," "inadequacy," "sadness," "confusion," "overwhelmed," "hopelessness," "regret," and "remorse." Other, more positive emotions expressed were "gratefulness," "gratitude," "happy," "OK," "good," and "relief."

The thoughts expressed were also more negative than positive in all of the participants. Julie said that she "beat [herself] up for being irresponsible," but then she "let go of [her] priority

for drinking." Although she felt guilty and lonely, she said that it also motivated her to do better. Karen specifically described her thoughts as "I wish I just had a little bit to help through the day" or "God, if I don't use just a little bit then I'll feel crappy the rest of the day, then the next day I'll be tired because I won't have anymore." Megan said that she would "rationalize when [she] was using," that she thought marijuana wasn't a drug, that "it's not that bad." She then reported that she thought that using was "risky for family life," and that she "didn't think about" how her drug use would "instill core beliefs in the children that it's OK." Although Jessica was not specific about her thoughts, she reported that all of the thoughts she "ran away from" came back after she quit her drug use. Katie explained that she wanted that part of her [using the drug] back. She even spoke as if she was the drug herself: "If I don't do it for you or if I don't do this, you're going to feel this." In other words, the drug would tell her that if she did not use, then she would have undesirable feelings.

Tyler reported having very serious and very frightening thoughts. He described these thoughts as "racing thoughts." When asked to elaborate, he explained how he had thoughts of "impending doom, calamity feeling, that the world was going to end, that my world was ending. Very mental and physiological torture…Anxiety beyond anxiety, panic, existential terror. Anything… identity crisis, hell,…just [the] worst." He also reported having "a lot of thoughts about death." Tonya discussed thoughts of "losing everything because of the drug." Finally, Jared reported "realizing that he was going to get help" and that brought him "gratefulness" and "gratitude."

Many of the emotions and thoughts that the participants experienced after losing their drug of choice are similar to what someone might feel if they were grieving the loss of their

loved one, most of which are negative. Emotions ranged from minor irritations to more extreme feelings guilt and anxiety.

Relational responses to quitting. All of the participants described relational responses to quitting; a mix of both positive and negative responses. Most of the participants described how they lost many friends or acquaintances. Three of the participants (Julie, Karen, Megan) said that they weren't really losing any friends, but mainly "acquaintances." Julie explained it this way: "At first, yea, I definitely missed them but at some point you realize that…they're pretty much acquaintances [more] than friends. They're just people you party with; they're not going to come to your rescue if something bad happens. They're just someone to go out and party with." Karen and Megan reported that they do not miss their friends because they [their friends] would "steal" from them. Because of that, Megan said that she had to "find new friends." She reported that they weren't her friends because "if somebody is my friend, they have my best interest at heart…They don't even…have their [own] best interests at heart so how can I expect them to have my best interest at heart?"

Jessica reported feeling confused as to why her family has moved farther away from her now that she has quit using. She reported "It doesn't make sense." Tyler said that he "didn't gain friends. I [just] lost friends." Tonya reported losing "everything." She said she lost her husband, kids, and friends. She stated: "I'm also losing 11 years of my life with my husband… I have to give him up too along with the drug because we're just two people, two addicts that can't help each other, unfortunately." She reported earlier that her husband was a drug dealer and that she had to "give him up too" because he couldn't help her with her addiction. Jared says he lost his wife and that he misses "the old us when we were in love."

On the other hand, Karen said that her "family moved closer." Max explained that he called up some old friends and they were proud of him. Sarah reported that her family and friends became closer, that they are very proud of her, and that they have more faith and hope in her now. Katie explained: "relationships grew closer, stronger, you know, their trust is coming back. They're everything." Many of the participants lost someone from end the relationship with their drug of choice. However, all except two participants (Jessica, Tyler) expressed how they have gained a closer connection to friends and family members from giving up their drug use.

Current Relationship with Drug

The purpose of this portion of the study is to look at the participants' current thoughts and feelings toward the drug. Currently, none of the participants are using their drug of choice and all have negative feelings and thoughts towards their drug. Julie strongly disagreed with the idea that drug addictions are a disease. She expressed how she chose to drink and that saying it's a disease is a "cop-out." She expressed how she has not thought about the drug as much as she has thought about it while in treatment. She exclaimed, "That's craziness…just insane to me…" that she has to talk about drug use so much while in treatment. Megan reported how she still thinks about the drug, that songs still remind her of the drug lifestyle, and that she wants to learn "how [to get] past that."

Another theme that emerged is that the participants "hate" the drug (Katie, Jared), and they're "glad it's gone." (Max) Karen reported it this way: "I don't have a lot of love for meth right now." Max stated "I don't even think about using, so I don't miss it one bit." When asked why he no longer misses his alcohol, he lamented, "I'm tired of beating my head on the pavement." Others (Katie, Jessica) expressed fear for the drug, because of all of the control it

had over them in the past. Jessica expressed, "I don't wish it [drug use]…on my worst enemy." Every participant reported that they currently don't use and that they don't intend to use ever again. Likely because of this, many already changed their relationship with the drug.

Miss about the drug. All of the participants were asked "When you think about using [drug of choice] now, do you miss anything about it?" Most people reported missing the social, relational aspects of using. Julie reported missing the "parties…the people, the atmosphere…the nonsense…the fun…doing something crazy…[and] the good story to tell." Echoing Julie's words, Megan reported missing the "social life…the lifestyle… going to the club, hanging out, being the center of attention." Katie reported that she missed being around others, and that when she didn't have the methamphetamine, she didn't hang out with other people. She reported missing the "sense of belonging." Similarly, Tyler said he missed "the conviviality…the friendship aspect of it." Other things that were mentioned that were missed by the participants were missing his "family and…kids" (Jared), missing the "mental escape" from negative feelings (Jessica, Sarah), being able to get "things done," (Karen) and the "weight loss" (Karen).

Future Relationship with Drug

Towards the end of each interview, I asked each participant "When you think about what's ahead of you regarding your alcohol use, what comes up for you?" In other words, what do you expect your future relationship to look like with the drug? Every participant expressed how they never want to reuse, but most still felt uncertainty and fear for the future. Karen reported: "Today, I'm only living one day at a time, so I can't say that in the future I'll pick it up again." In direct response to the question above, the answers were: "Death. If I go back to using, yeah," (Karen) "A battle, that it's going to be a battle" (Jessica), "recovery" (Sarah, Megan),

"responsibility" (Tonya), "lots of hard work, determination" (Sarah), and "fear" (Jessica, Sarah, Katie, Tyler, Tonya). Jessica expressed that "the fear is so intense about losing…and hurting my kids." Tyler expressed that he feels "fear of what I've already done to myself [and] fear of having to face the time that I've lost." Tyler and Tonya also expressed feelings of shame when they think about their future with drug use. Tyler reported it in this way: "[I feel] fear of…being judged for the rest of my life by…family and friends and high functioning folks that really cannot understand the progression of the alcoholism [how quickly he became addicted to alcohol as compared to others in his age range]."

Most vehemently opposed the idea of future use. Some of the different ways this was expressed were: "Don't need it, don't want it." (Karen), "I plan on not using any alcohol at all," (Max) "It's not in the question." (Katie), and "Never, ever, ever again." (Katie) A few participants (Megan, Tyler, Jared) expressed positive feelings about the future, not of which included future drug use. Megan discussed her plan for the future: "I'm…really passionate…[about] speak[ing] to middle school and high school kids about the seriousness and the consequences [of drug use]. I'm going to dances and campouts, and bowling." Jared reported excitement at being "set free" from his drug use and Tyler mentioned feeling some sense of "optimism" for the future.

Continuing bond. As explained earlier, the theory of continuing bonds posits that people can have continued relationships with their drug of choice even after they have physically ended the relationship with it. Although finding specific words related to continuing bonds from the participants was hard to find in the interviews, there was a subtle theme throughout each interview that these individuals still have and will continue to have a relationship with their drug of choice for the remainders of their lives, even if they never use again.

Megan reported, "Meth and that whole life style is always right around the corner. Always there." Max reported "I know that…I can always get that back [the alcohol]." Several participants discussed how they fear the control that drugs may continue to have on them. Katie explained, "I don't want it ever again, but I fear it also because of the control. That [it] can have control over you your whole life. You may not end up doing it [using the drug], but just the control still scares you." Jared reported "in the back of your mind it [the drug] was always there." Katie uses the following example of recently being in a hospital. She described the control that the drug, or in her case, the needle, still had over her. She related:

> "I went to the emergency room and like two weeks, one week ago they had to give me an IV, and I freaked out, and I wasn't sure what I was feeling. My anxiety went up. I didn't want them to do it to my arms and then after they did it, I just lost it and I realized that it…scared me so bad because something like that had never scared me before…I was happy to have it, I would crave it, and for something…I never feared or disliked to scare me so bad…that's still the control it has…I have a lot of fear about it."

In other words, Katie still had a relationship with the drug because the drug had such a powerful influence over her that it aided in her "freaking out" at the hospital. While most participants did not report as extreme of situations as Katie, most participants still felt a connection to the drug even after ending the relationship with the drug.

Lessons learned. Meaning making is an important aspect of drug recovery (Newbury & Hoskins, 2008; Worden, 2009). Likewise, many of the participants reported meanings they had made out of their drug use experiences. Below is a list of the various "lessons learned" reported by the participants:

- "A couple of beers isn't worth me losing my job." (Julie)
- "I don't really regret my experience with it because it just has given me the motivation to become a better person." (Julie)

- “I have to…change everything.” (Julie, Megan)
- “I just…want to speak out and help people, because in doing that it will hold me accountable.” (Megan)
- “I just don’t think people should focus too much or wallow when they’re missing something like drugs because that’s never good.” (Megan)
- “I found that working out releases the same endorphins…in my brain [as using the drug]” (Megan)
- “I should have educated myself more on addiction” (Jessica)
- “I’m not a thief…I’m not a horrible person.” (Katie)
- “Addiction is a domestic violence cycle.” (Katie)
- “I think some people use the drug just to numb the pains that they feel of things that they've been going through in their lives.” (Tonya)
- “My purpose is to walk and love, and to fix some things that are broken.” (Jared)
- “It’s not true control or power. Because that thing [the drug] is actually owning you and you think you have it [power or control]” (Jared)
- “The drug is a band aid, a false mistress to try and cover internal problems.” (Jared)
- “That’s the key when you’re on drugs: you end up lying so much…[you] lose track of the truth.” (Jared)
- “Addiction doesn’t discriminate.” (Jared)

Most participants were vocal about some of the lessons they had learned from their relationship with their drug of choice. However, some participants (Megan, Jared) expressed their learned lessons with more frequency throughout the interview than others.

Tasks of grief.

Task 1: To accept the reality of the loss. Many of the participants expressed both times when they were coming or have come to the reality of the loss and also times of denial of the loss. Many of the participants fought with the reality that the drug was gone. For example, both Karen and Max struggled to "give up" their drug use even after being incarcerated many times because of drug use. Both reported using their drug of choice immediately after getting out of prison, drug treatment, or probation. Others denied the loss of the drug by saying that it wasn't a drug in the first place. Both Megan and Katie described how they did not realize that the drug was really a drug, or how connected they really were to the drug. Helping them recognize their drugs of choice were actually drugs helped them accept the reality of the loss and how much they depended on it. Similarly, Jessica and Sarah said they miss the "mental escape" that came from using the drug and that they now have to handle the emotions on their own. They both expressed a lot of "fear" around having to live without the drug and having to handle their emotions on their own. Tonya described the time when she was coming to the understanding that she needed to give up the drug, but didn't want to. She expressed "I remember the last time I used it was like so hard for me to throw away my pipe, so hard for me to flush the rest…I just didn't want to." Jared expressed how he missed having "one last hurrah" with his drug." In other words, he was not quite ready to finally end the relationship with the drug.

Task 2: To process the pain of grief. Once the participants came to the realization that the drug would be gone for good in their lives, then they could feel the full effects of not having the drug in their lives anymore. As long as they continued denying the loss, then they would not be able to "move through" the pain and into recovery. As covered earlier, this task encompasses all of the emotional, cognitive, physical, and social responses to losing one's drug of choice.

From their responses, many of the participants had already gone through the pain or were currently going through the pain of the loss. Physically, some of the responses included: eating more, eating less, sleeping more, feeling lethargic, and feeling sick. Emotionally, some of the responses included: guilt, anger, irritability, shame, fear, sadness, remorse, and relief. Cognitively some of the responses included: wishing they had the drug back, rationalizing that the drug wasn't "that bad," remembering how the drug treated the user, and thinking about needing help to escape the drug. Relationally, some of the responses included: losing friends, losing family members, losing their children, and losing their partner. They also included family members and friends coming closer to them as well.

Task 3: To adjust to a world without that which has been lost. Participants reported having to make internal and external adjustments to being without their drug of choice. For example, one participant (Karen) reported taking her time without the drug by declaring "one day at a time," a cognitive adjustment to being without the drug. Megan said she was already starting to make new friends and to lose old friends, an external adjustment aimed at preventing her from affiliating with her former drug-using friends. Jessica described an internal change when she exclaimed, "it's going to be a battle" instead of her old way of giving into the drug's enticing and reusing. She made other internal changes such as a realization of how unhealthy her relationship was with the drug. Katie reported that she could now handle her problems and guilt "a hell of a lot of better sober than high," meaning she had to make the internal adjustment of handling her emotions without the help of the drug. Tonya expressed how she now has to do "everything" (e.g., dealing with her emotions and having energy) on her own, without her "significant other" [the drug]. Jared made both external and internal adjustments by "praying", and bringing "in to captivity every thought into the obedience of Christ Jesus." In other words,

he had to change his thought processes and align his thoughts with what he considered to be the will of his higher power. Through his faith in God, as he explained it, he was able to have healthier internal and external processes.

Task 4: To find an enduring connection with the deceased in the midst of embarking on a new life. Participants demonstrated that they have an enduring connection with their drug of choice but that they are making a new life for themselves without the drug. Several of the participants noted how they have had to change everything if they are going to stop using their drug of choice. Megan reported, "what I grieve[s] is the loss of my life, and…recreating a new, clean life." She lamented, "I…just… worked so hard for that title, person who I was," but then added "I'm willing to lead a better life for myself and put my recovery as my main priority." She explained how she is going to "go to NA and…camping, bowling, dances and so forth…" as well as "speak out and help people" in order to embark on a new life. Jared explained his plan for his new life in this way: "[I can] use my past experiences [to] maybe help someone in the future if I can. This way I want to pay it forward."

End of interview experience. After the interview was complete, I asked each of the interviewees if there was anything else they wanted to add to what had already been said. I then asked each interviewee, "How was this interview experience for you?" or "Did any difficult or uncomfortable feelings come up for you because of this interview?" The participants were then reminded to speak with a counselor or personnel at North Range Behavioral Health if they experienced any reoccurring feelings or thoughts that made them feel uncomfortable. Six out of ten participants said that the interview brought up some difficult or uncomfortable feelings while four reported that they felt fine and that the interview didn't bring up any difficult or uncomfortable feelings. Karen reported feeling "a little bit uncomfortable, but [that] it was OK."

Jessica reported that she felt "kind of scared" when she reported that she valued her drug more than her family members. Katie reported that it was "weird" that it brought up old feelings when she did use, and that she "hadn't had that [those feelings] for a while." Tyler reported feeling guilt, and Tonya reported that the interview brought up some sadness. Each of the participants agreed to see a counselor at North Range Behavioral Health if they had any difficult thoughts or feelings that they were unable to manage on their own due to the interview.

Summary

Although each participant differed, there was a theme of each participant enjoying the drug use when they first started as well as a theme of gradually using more and more as their relationship with the drug lengthened. During the middle of their relationship, all participants reported having a relationship with their drug much like they would have with another person. However, during this time, many reported becoming overly "dependent" on the drug, and became aware that an unhealthy relationship was forming with them and the drug. Some even described their relationship at this point as a "domestic violence" or "abuse" cycle. Each participant reported some emotional, cognitive, and physical responses similar to that of a death-related loss, but all reported that their grief for the drug was not the same as the grief that they had experienced for the loss of a loved one. Currently, many of the participants still feared the drug, while others were determined to never use again. All participants were both hopeful and fearful of their future with the drug and many learned lessons along the way.

Chapter 5: Conclusion

The purpose of this study was to look at the grief reactions of those who had recently given up drug use (within the last 3 months), and to compare these reactions to death-related grief reactions. Because there is so little research on this subject, I decided to use a grounded theory approach of investigation. I begin my discussion by integrating my findings with the published literature including attachment theory, the theory of continuing bonds, and Worden's tasks of grief. I then discuss the themes that emerged from the data followed by an evaluation of how this study was able to answer my research questions. I conclude by discussing the strengths and limitations of the study, clinical implications, future research ideas, and personal insights.

Attachment Theory

Attachment theory posits that humans strive to form emotional bonds with others in order to feel safe and secure (Bowlby, 1969). Similarly, all of the participants described how, at some point in their lives, they felt emotionally connected with their drug of choice. Likewise, about half of the participants directly compared their relationship with their drug with a relationship they have had with another person, and all participants agreed that their relationship with their drug was at least "similar" to that of another person. Clearly, many of the participants felt a sense of security with their drug of choice as they described their drug as "always there for them," "comforting," and "could always count on it." This was evident, specifically, when two of the participants discussed the sadness they felt when they had to say "good-bye" to their drug of choice. Although most participants felt their relationship with their drug was a positive experience early on in their relationship, all participants reported that their relationship became unhealthy before coming to treatment. Because many of the relationships became so unhealthy

by the middle or end of their relationship with their drug of choice, several participants wanted to completely disengage from their drug, both physically and emotionally. They discussed how the same thing [the drug] that was helping them get through the day was also the thing [the drug] that was hurting them. This is, of course, a similar pattern that takes place with children who have disorganized attachment styles (Hesse & Main, 2000). Although many of these relationships became unhealthy, Miller (1994) posited that individuals who sever their relationship with drugs experience significant amounts of grief. Many of the participants' responses to losing their drug of choice were similar to responses of those who have experienced death-related lose. Some of the emotions that these participants expressed that were similar to emotions expressed by someone experiencing death-related losses included sadness, anger, guilt, anxiety, loneliness, fatigue, emancipation, and helplessness. Similar cognitive responses included disbelief, confusion, preoccupation, and a sense of presence and similar behavioral responses included sleep disturbances, appetite disturbances, hyperactivity, and avoiding reminders of the drug. Although many of the grief sensations from drug-related loss and death-related loss are similar, the etiologies of these emotions, cognitions, and behaviors have yet to be determined.

Theory of Continuing Bonds

This theory posits that connections with the deceased can continue even after death (Steffen & Coyle, 2008). This is often described as a nearness or closeness to the loved one who has died. Other research suggests that this continued relationship can also be frightening to the living individual experiencing it (Steffen's & Coyle, 2008). In this study, all of the participants described how they currently had a relationship with their drug of choice without the drug currently being present in their daily life. At the point of the interview, most of the participants

reported mixed feelings toward their drug of choice. Some missed the comfort and security they felt from the drug, while others seemed to fear or hate the drug. It is clear that to many of the individuals the drug still had significant control over their emotions, thoughts, and behaviors even after the drug had been eliminated from their lives. This finding seems consistent with the current research on cravings (Witkiewitz et al., 2013).

Worden's Tasks of Grief

William Worden is known to many as a leading expert in the field of grief and loss. His task theory is a well-known approach to addressing grief-related problems (Fineran, 2012; Pearlman, Schwalbe, & Cloltre, 2010; Randall, 2009). Using his theories as a lens for analyzes, we were able to find many similarities between his tasks and the experiences of the ten individuals in this study.

Task 1: To accept the reality of the loss. In this task, the goal is to help the individual accept the reality and finality of the loss. According to Worden (2009), the opposite of this would be some form of denial. Because many of the participants in this study did not recognize their drug use as problematic, it was difficult for the participants to come to a full realization that they had even "lost" something when it was gone in the way in which Worden describes. Also, many of the participants did not seem to grieve the loss of their drug because they felt as if they could always get it back at some point. According to the theory, it would be difficult to accept the reality of a loss when it is "not really gone." This could be similar to someone who keeps all of their dead loved one's possessions as a way to "mummify" them or keep their loved one metaphorically a part of their lives. Other losses that the participants were able to recognize were the loss of their children or family members. Likewise, many of the participants came to

the realization that they had lost many internal strengths such as the ability to cope with difficult emotions.

Task 2: To process the pain of grief. The purpose of this task is to help individuals to fully experience any pain they are experiencing because of the loss. According to Worden (2009), this pain can include emotional, cognitive, and physical pain associated with the loss. In this study, many of the participants described physical, emotional, and cognitive pain associated with losing their drug of choice. However, it is difficult to know if these reactions were because of grief, because of chemical reactions in their body to ending their drug use, or for other reasons. Either way, many of the emotions they expressed such as anger, sadness, shame, guilt, and anxiety were similar to emotions that someone feels when they grieve the loss of a loved one. Likewise, the "wishing I could just a get little bit of my drug" thoughts are similar to someone wishing they could have at least one more day with their loved one. While some of the physical reactions clearly came from chemical responses in the body (e.g., DT's and blackouts), it is possible that many of the physical reactions, especially the ones associated with energy loss and anxiety, were related to the grief they were experiencing from the separation from their drug of choice. Both of these reactions (energy loss and anxiety) are common physical reactions of those who experience death-related grief (Worden, 2009).

Task 3: To adjust to a world without that which has been lost. The purpose of this task is to help the individual make internal and external adjustments to not having the deceased in their lives. Content related to Task 3 was found most frequently in all ten interviews because many of the participants were in the process of making both internal and external changes in recovery. For example, many were trying to make new friends or stay away from old ones. Others were trying to make internal changes by being able to cope with difficult emotions

without using their drug. This is similar to the way in which people who lose a loved one must learn how to cope with difficult feelings on their own that they used to be able to talk about with their deceased loved one (Worden, 2009), as well as make many external changes such as changing jobs or changing where they live (Worden, 2009).

Task 4: To find an enduring connection with the deceased in the midst of embarking on a new life. Showing a lack of mastery over Task IV, many of the participants wanted to cut their ties with drug use completely instead of finding an enduring connection with their lost drug. There were some, however, who were reluctant to completely cut ties with their drug because they missed certain aspects of it such as the energy it provided or the way in which it helped them mask difficult feelings. However, many described how they wanted to go and teach others about the dangers of drug use and to stay involved in other activities (e.g., exercising and camping) in order to form a new identity and lifestyle without the drug present.

Additional Themes that Emerged from the Data

Relationship evolution. Each participant's relationship with their drug of choice seemed to change from when they first started using. In general, all of them used more recreationally at first. They began spending small amount of time with their drug, some just on the weekends. Then this grew until they were spending just about every day with their drug of choice. When they were the most involved with their drug of choice, they pushed others out of their lives, and put their drug of choice over important human relationships. Some even got to the point that they were willing to commit serious federal crimes (e.g., making and selling drugs) in order to be with their drug (whether that was the drug itself or the money derived from selling). Eventually, however, all participants came to the conclusion that they were caught in an unhealthy or abusive

relationship with their drug of choice. As the drug began to take over their lives, many of them began wanting or seeking help for their situation. In many instances, it took legal repercussions to pull them away from their drug. As they began to notice everything the drug took from them, their relationship slowly turned into one of fear and hate.

Other losses. Research has shown that there are a multitude of losses associated with drugs loss (Streifel & Servanty, 2006). Likewise, many of the participants experienced significant other losses besides the drug itself. Some of the losses mentioned by the participants included the drug or alcohol lifestyle itself, money, power, control, husband, the needle, weight loss, the social life, and energy.

Comparison to death-related losses. Although more research needs to be conducted on specific differences between death and drug-related grief, all participants described how the grief they experienced either currently or in the past was "different" than the grief they had felt from losing a family member. Many of the participants explained that death-related grief is different than drug-related grief in that giving up drug use is a choice, it is something you are glad is gone, and it is something that you can always get back if you want to. The participants also explained how they grieved "more" for the loss of their loved ones then they did for the loss of their drug of choice. The participants explained that death-related grief and drug-related grief are similar in that many of the participants still missed many aspect of losing their drug of choice such as how it masked their feelings or how it gave them energy.

Abusive relationships. Research has demonstrated that giving up drug use can be a very long and painful process (Miller, 1994). Similarly, many of the participants discussed the abusive nature of drug use and the process of ending one's relationship with their drug of choice.

It was clear, also, that many of the participants did not notice that they were in an abusive relationship. They discussed how the drug was "tricky," that it pretended to be one thing, but was another, and that the relationship was cyclical: it had both the abusive stage (e.g., withdrawals, legal problems) and the honeymoon stage (e.g., social life) of the typical domestic violence cycle (Brown, James, & Taylor, 2010). Likewise, it seemed very difficult for these individuals to "leave" the relationship just like a domestic violence cycle (Brown et al., 2010).

Strengths and Limitations

There were many strengths and limitations to this current study. The strength of this study is that it has shown a clear demonstration that people do, in fact, have relationships with their drug of choice, and that they do, at least to some extent, grieve the loss of their drugs of choice. It also provided insights into the emotional and relational aspect of drug use as well as the emotional and relational aspects toward other addictions that these individuals had. Other strengths included the rigorous nature of our data analysis. To ensure coding accuracy, I used a co-coder method (Corbin, & Strauss, 2008). To ensure internal consistency, I was the only interviewer, designer, developer, and analyst for this study. Likewise, I also did most of the coding and transcribing. Because of this, I was just about as intimately connected to the research as possible. One limitation of this study is that it was a small qualitative study which only took a small, descriptive "glimpse" into the experience of grief as it relates to drug use. While ten participants is adequate for any qualitative study, it does limit the generalizability of the data to only those 10 participants. The sample was collected from one substance abuse treatment facility located in only one part of the country, further limiting the generalizability of the results. All participants were volunteers, meaning the sample is biased by including those who were interested in discussing "grief and loss" related to their recovery as it was described on the

recruitment flyers. Lastly, the majority of my participants had more serious drug or alcohol problems than other users that I could have interviewed. Because of these limitations, quantitative research is needed to back up these findings statistically.

Clinical Implications

Although much more research is needed in this area, this study has provided insights into the ways in which people in recovery may perceive the loss of their drug of choice. By better understanding the role grief plays in the lives of those who are in recovery from AOD's, professionals will be able to create better, more effective interventions. Perhaps, with enough evidence, it could become standard practice to incorporate grief and loss therapy into every AOD treatment intervention. Because much research has already been done in understanding and treating death-related grief, better understanding drug loss may give clinicians and other helping professionals more tools for helping their clients who are struggling with substance misuse. Overall, it could greatly reduce relapse and recidivism rates of those who use or misuse substances.

Future Research

Because research in the field of drug-related grief is almost nonexistent, there are many options for future research. Additional qualitative studies need to be done to determine all of the ways in which a wider variety of people in recovery experience drug loss. Studying the grief experience of those with less serious addiction, for example, would be beneficial. One population of particular interest would be those who are recovering from cannabis misuse. Cannabis is a drug that is often used with friends and one that does not generally lead to serious physical withdrawals. This would be in direct contrast to the drugs from which the people in this

study were recovering from. In addition, a study that examines how different attachment styles influence a person's drug-related grief experiences as well as a study of addiction counselors' opinions of client drug loss would be helpful to achieve a fuller perspective of how drug loss impacts the lives of people in recovery. More research also needs to be done with college populations, adolescents, older adults, and other populations. Future research can also look at gender differences, racial differences, and cultural differences from different parts of the world. Finally, it could be beneficial to look at grieving differences between those who choose AOD moderation instead of abstinence.

Personal Insights

As a Marriage and Family Therapy student, I tend to look at most things relationally. This is no different with substance misuse, in my opinion. I believe that people develop a relationship with substances. However, from my personal perspective, relationships with drugs are not quite the same as relationships with another person. Just like the participants explained, the drug cannot connect with an individual like a person can. This difference can, in my opinion, make having a "healthy" relationship with drugs that much more difficult. While I do believe that people grieve many different things from losing their drug of choice, common losses to be aware of are relationships, the mask the drug provides for difficult feelings, the "high," their identity, and the loss of comfort and security that comes from the often ritualized process of drug use. However, it is important to note that I have a somewhat different view on drugs than a lot of other people that I associate with. I believe that all external drugs, including caffeine, alcohol, and marijuana, are best if only used for medicinal purposes, and not for recreational use. Lastly, I feel that drug use is a disenfranchised loss because it is not generally accepted to grieve the loss of a drug, something that is potentially very harmful to the user and their loved ones. Because it

is a disenfranchised loss, it may make grieving it that much more difficult. While I do not think that making drug use more "socially acceptable" will solve this problem, I do think educating people on things such as attachment and grief as it relates to drug use can help people in empathizing and assisting those who are in recovery from AOD misuse.

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Appendix A

Grief Responses to Drug Loss Study

What are we studying?

Research has shown that those who "give up" drug use may experience feelings of grief over the loss of their drug, friends, or other experiences associated with drug use. The purpose of this study is to better understand this loss process.

How will we study this?

We will be interviewing 10 people about their history with drug use and the physical, emotional, and relationship reactions they have experienced since they stopped using. This interview will be accompanied by two short questionnaires.

Who may participate?

Anyone in TRT who has a previous history of drug use, but has not used alcohol or other drugs for 3 months or less (1-90 days).

When will it be and how long will it take?

We will conduct the interviews on March 2nd, March 9th, and March 16th between 9:00am and 6:00pm. You will spend about 1-1.5 hours total.

Who is conducting this research?

David Haralson and Dr. Jenn Matheson at Colorado State University are conducting this study. David will be conducting all interviews. He can be reached at 970-491-5991.

How do I get involved?

Talk with Kris at the front desk and ask for a packet. Read and sign the informed consent and then place the tear-off portion in the envelope. Give the envelope to Kris and then sign up for an interview time. Fill out the 2 surveys in the packet before your interview.

Appendix B

Consent to Participate in a Research Study
Colorado State University

Study Title: Grief Reactions to Drug Loss

Principal Investigator:
Jenn Matheson, Ph.D, LMFT, Colorado State University
970-491-7472
Jenn.Matheson@colostate.edu

Co-Principal Investigator:
David Haralson, BS, MFT Intern
970-491-5991
David.Haralson@colostate.edu

Why am I being invited to take part in this research? You are being asked for an interview as a person who is in treatment for drug and/or alcohol abuse/dependence to talk about what it was like to stop using your drug of choice.

Who is doing the study? David Haralson is a student at Colorado State University working on his Master's Degree in Marriage and Family Therapy. Jenn Matheson is a professor in Marriage and Family Therapy at Colorado State University. They are both in charge of this study.

What is the purpose of this study? The purpose of this study is to understand the grieving process of people who have recently quit using drugs or alcohol (approximately 1-90 days). By understanding this, we can try to better help the clients, family members, friends, and mental health professionals who help those trying to quit drugs and/or alcohol.

Where is the study going to take place and how long will it last? We will conduct a one hour interview with you about your experiences with drug and/or alcohol abuse/dependence and the losses you may have felt when you stopped using. We will also ask you to fill out 2 questionnaires about yourself and about grief and loss, just so we know a little more about who you are. This whole process will take about 1.5 hours, and it will be held in a private room at North Range Behavioral Health.

What will I be asked to do? Fill out two surveys and participate in a face-to-face interview. The surveys will take about 30 minutes to fill out and the interview will last no longer than 1 hour.

Are there reasons why I should not take part in this study? You should not participate in this study if
you are under 18 years old or if you quit using drugs or alcohol more than 3 months ago. We also will ask you not to participate if you are currently using methadone/suboxone treatment.

What are the possible risks and discomforts? Risks to you are expected to be very small, even though you have used drugs in the past or may have done some things that may be illegal. You might feel a little embarrassed or feel some uncomfortable feelings when you tell us about

your past drug use or your recent recovery from drugs. Thinking about your past drug use or the recent choice to stop using drugs could possibly make you want to use again. We are not able to tell you about all of the possible risks, but we have reduced any known or possible risks to you. If you are negatively affected by this research in any way, a counselor from North Range will be provided.

 Participant's initials _____ Date _____

Are there any benefits from taking part in this study? This project might help you understand your own thoughts and feelings around the idea of "drug loss." You might feel good about yourself for helping us help others make drug and/or alcohol treatment better. You may also feel good about yourself for being a part of a study that can help others one day.

Do I have to take part in this study? No, you can choose to be part of this study or not. If you decide to be part of the study, you can decide not to at any time without any problems. The only person at North Range who will know you participated in this study will be the receptionist with whom you will schedule your interview. Whether you decide to be part of this study or not will have no effect on your treatment at North Range Behavioral Health.

What will it cost me to participate? There will be no costs to you for being part of this study.

Who will see the information that I give? The only people who will see the information you give us in the interview/questionnaires are David Haralson, Jenn Matheson, and one of Jenn Matheson's research assistants at Colorado State University. The only person at North Range that will know who participated in this study will be the receptionist who will put your first and last name on an interview schedule. No other identifying information will be given to any staff members at North Range. We will keep all of your information private, to the extent the law allows.

How will you make sure all of my information is confidential? All of the researchers are trained about how important it is to keep your information confidential. That means we know how to make sure no one knows who you are in our reports or whether or not you participated in this research. Also your real
name will never appear on any reports. The interviewer will only know your first name. The only place your name will appear is on the consent form and the scheduling form. These forms will be kept in a locked file cabinet for 3 years in Jenn Matheson's locked office on CSU's campus. The only other people who would ever see these forms are if CSU's Institutional Review Board ethics committee did an audit on our project. Even though we are going to record the interview with you, it will not have your real name. We will type up the interview as well and will not use your real name in those reports. While the only person who will know whether you are going to do this interview with us or not is the receptionist at North Range, it is possible that a fellow client or staff member might see you with the interviewer and guess that you are doing an interview with us. We will do everything we can to make sure no one sees you with the interviewer or during the interview.

How will you reduce the risks of the interview? David Haralson will conduct all the interviews and is trained to know what to do in case someone feels uncomfortable during the interview. At your request, he can offer for you to take a break, he can skip a set of questions, he could move on to a different type of question, or he can stop the interview. Remember that you can decide not to answer any part of the interview or stop at any time. We have also devised a way to have you agree to be part of this research in a way that makes sure that no one, except a receptionist, at North Range knows you are participating. Because you are currently in a treatment program working on many issues around your drug use, we think the risk to you is very small. Getting to talk to us about these issues in a place where you are have daily therapy and process group makes it even less of a risk to you. If you notice any hard feelings during or after the interview that seem stronger than you can manage, please tell the staff at North Range and a counselor will talk to you about it.

Can taking part in the study end early? Yes, if you do decide not to go ahead with the interview or if we learn that you are on methadone/suboxone treatment, we will end early.

Will I get anything from you for taking part in this study? No, there will be no direct benefits or gifts for taking part in this study. This is voluntary.

What if I have questions? Before you decide whether to take part in the study, please ask David any questions you have now. Later, if you have questions about the study, you can contact us at:

David Haralson, BS, MFT Intern, The Center for Family and Couple Therapy
719-360-8345
David.Haralson@colostate.edu

Jenn Matheson, Ph.D, LMFT, Colorado State University
970-491-7472
Jenn.Matheson@colostate.edu

If you have any questions about your rights as a volunteer in this project, contact Janell Barker, Human
Research Administrator at 970-491-1655. We will give you a copy of this consent form to take with you.

What else do I need to know? This consent form was approved by the CSU Institutional Review Board for the protection of human subjects in research on (Approval Date).

Do you give the researchers permission to audiotape the interview?

____Yes, I give you permission to audiotape my interview
____No, please do not audiotape my interview

Do you consent to participate in this study? Your signature below means that you have read

the form and willingly sign this consent form. Your signature also means that you have received, on the date signed, a copy of this document containing 3 pages.

_____ _____

Signature of person agreeing to take part in the study Date

_____

Printed name of person agreeing to take part in the study

_____ _____

Name of person providing information to participant Date

_____

Signature of Research Staff

Appendix C

Demographic Survey

Assigned Number: _____

Year of Birth: _____

Gender: Male Female Other: _____

Ethnicity: Hispanic or Latino Black or African American White

American Indian or Alaskan Native Hawaiian or Other Pacific Islander Asian

Other: _____

Please circle all of the drugs you have used/abused in the past (circle all that apply)

Alcohol Marijuana Heroin Cocaine Methamphetamine

Ecstasy LSD Prescription drug: _____

Other drug: _____

What is the "drug of choice" you were last using before entering treatment this time (circle one only)?

Alcohol Marijuana Heroin Cocaine Methamphetamine

Ecstasy LSD Prescription drug: _____

Other drug: _____

When was the last time you used that "drug of choice":

1 week or less 2-3 weeks ago 4-5 weeks ago 6-7 weeks ago 8-9 weeks ago

10-11 weeks ago 12-13 weeks ago 14-15 weeks ago 16 or more weeks ago

At what age did you first use that "drug of choice?" _____

What's the longest time you've been without that "drug of choice?" _____

Were you court-mandated to be in treatment? Yes No

How many days have you been at this treatment facility this time? _____

Appendix D

The Texas Inventory of Grief—Revised (Faschingbauer, 1981).

PART I: PAST BEHAVIOR

Think back to the time when you gave up using your drug of choice, and answer all of these items about your feelings and actions at that time by indicating whether each item is Completely True, Mostly True, Both True and False, Mostly False, or Completely False as it applied to you after losing your drug. Check the best answer.

1. After giving up drug use, I found it hard to get along with certain people.

Completely True Mostly True Both True and False Mostly False Completely False

2. I found it hard to work well after giving up drug use.

Completely True Mostly True Both True and False Mostly False Completely False

3. After giving up drug use, I lost interest in my family, friends, and outside activities.

Completely True Mostly True Both True and False Mostly False Completely False

4. I was unusually irritable after giving up my drug.

Completely True Mostly True Both True and False Mostly False Completely False

5. I couldn't keep up with my normal activities for the last 3 months since giving up drug use.

Completely True Mostly True Both True and False Mostly False Completely False

6. I was angry with having to give up drug use.

Completely True Mostly True Both True and False Mostly False Completely False

7. I found it hard to sleep after giving up drug use.

Completely True Mostly True Both True and False Mostly False Completely False

PART II: PRESENT EMOTIONAL FEELINGS

Now answer all of the following items by checking how you presently feel about the loss of your drug. Do not look back at Part I.

1. I still cry when I think about losing my drug.

Completely True Mostly True Both True and False Mostly False Completely False

2. I still get upset when I think about my drug.

Completely True Mostly True Both True and False Mostly False Completely False

3. I cannot accept the loss of my drug.

Completely True Mostly True Both True and False Mostly False Completely False

4. Sometimes I very much miss my drug.

Completely True Mostly True Both True and False Mostly False Completely False

5. Even now it's painful to recall memories of when I used.

Completely True Mostly True Both True and False Mostly False Completely False

6. I am preoccupied with thoughts (often think) about my drug.

Completely True Mostly True Both True and False Mostly False Completely False

7. I hide my tears when I think about my drug.

Completely True Mostly True Both True and False Mostly False Completely False

8. Nothing will ever take the place in my life of that drug.

Completely True Mostly True Both True and False Mostly False Completely False

9. I can't avoid thinking about my drug.

Completely True Mostly True Both True and False Mostly False Completely False

10. I feel it's unfair that I had to give up using my drug.

Completely True Mostly True Both True and False Mostly False Completely False

11. Things and people around me still remind me of my drug.

Completely True Mostly True Both True and False Mostly False Completely False

12. I am unable to accept the loss of my drug.

Completely True Mostly True Both True and False Mostly False Completely False

13. At times I still feel the need to cry for the loss of my drug.

Completely True Mostly True Both True and False Mostly False Completely False

Appendix E

Schedule

Saturday, March 2nd, 9:00am-10:30am

Number Assigned:	
First and Last Name:	

Saturday, March 2nd, 10:30am-12:00pm

Number Assigned:	
First and Last Name:	

Saturday, March 2nd, 1:00pm-2:30pm

Number Assigned:	
First and Last Name:	

Saturday, March 2nd, 2:30pm-4:00pm

Number Assigned:	
First and Last Name:	

Saturday, March 2nd, 4:00pm-5:30pm

Number Assigned:	
First and Last Name:	

Saturday, March 9th, 9:00am-10:30am

Number	

Assigned:	
First and Last Name:	

Saturday, March 9th, 10:30am-12:00pm

Number Assigned:	
First and Last Name:	

Saturday, March 9th, 1:00pm-2:30pm

Number Assigned:	
First and Last Name:	

Saturday, March 9th, 2:30pm-4:00pm

Number Assigned:	
First and Last Name:	

Saturday, March 9th, 4:00pm-5:30pm

Number Assigned:	
First and Last Name:	

Saturday, March 16th, 9:00am-10:30am

Number Assigned:	
First and Last Name:	

Saturday, March 16th, 10:30am-12:00pm

Number Assigned:	

First and Last Name:	

Saturday, March 16th, 1:00pm-2:30pm

Number Assigned:	
First and Last Name:	

Saturday, March 16th, 2:30pm-4:00pm

Number Assigned:	
First and Last Name:	

Saturday, March 16th, 4:00pm-5:30pm

Number Assigned:	
First and Last Name:	

Appendix F

Interview Script

Introduction: *I just want to thank you for taking the time to participate in this study. This interview will take about 1 hour and it will be about your past alcohol or drug use as well as possible grief reactions you may have had from not using. None of the information you give me will affect your treatment here in North Range and everything will be kept completely confidential. The only people who will have access to this information are me, Jenn Matheson (a professor at CSU), and one of her assistants. Are you ready to begin?*

1. I first want to start off by reviewing what you said on your questionnaires. So tell me what it was like for you to start using _____ at age _____?
2. How much _____ did you use when you first started? How much were you using when you quit using this last time?
3. What was it like for you when you used? What did you enjoy the most about it? What did you not enjoy about it?
4. How did you decide to stop using _____? When you first stopped using, how did it make you feel physically?
5. When you first stopped using, what kind of feelings or thoughts came up for you?
6. When you think about using _____ now, do you miss anything about it? What would you say you miss the most about using _____? Why do you think you miss that part the most?
7. When you first stopped using _____, did anything change between you and your family or friends? What changes happened? Have your relationships changed since then? What kind of changes?
8. I'm wondering whether or not someone who stops using _____ has any feelings of loss or what we would call drug loss. Would you say you experienced any kind of loss or grief from giving up _____? What was that like for you?
9. If I asked you if you thought you had a relationship with _____ sort of the way you might have a relationship with another person, what would you say to that?
10. I'm wondering whether the feelings associated with losing _____ are similar to the feelings associated with losing a friend or family member. What would you say to that?
11. When you think about what's ahead of you regarding _____ use what comes up for you?
12. Have I missed anything? What have I missed?

Debriefing: *I just want to thank you again for your time. I also want to make sure you are doing OK since we might have talked about some difficult things. How was that experience for you? Is there anything you want to tell me about it? I also just want to remind you again to please speak with a counselor here if anything comes up for you because of this interview. Thank you for your time.*