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Walden University

College of Social and Behavioral Sciences

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Carroll A. Beverly

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Walden University
2020

Abstract

Stigma and the Life Experiences of Recovering Counselors

by

Carroll A. Beverly

MA, Central Michigan University, 2011

MA, Saginaw Valley State University, 2009

Dissertation Submitted in Partial Fulfillment

of the Requirements for the Degree of

Doctor of Philosophy

Human Services

Walden University

August 2020

Abstract

Stigmatization, labelling, and stereotyping have been recognized through historical literature as categories that classify recovering counselors with the status of a second-class citizen. One of the subtle impacts of stigmatization on recovering counselors has been the reluctance of these counselors to share their substance abuse histories or admit they formerly used alcohol and other drugs. The purpose of this qualitative, multiple case study was to explore the impact of stigma on the life experiences of recovering counselors in the addiction and counseling fields. The social identity theory was the theoretical foundation of this study. Four participants (3 recovering counselors and 1 nonrecovering counselor) were recruited and interviewed through the snowball sampling method. Data collection included both e-mail and face-to-face semistructured interviews. Data analysis consisted of hand coding and case study analytic strategies. The findings of this study provided an understanding of recovering counselors' experiences from their perspectives in their own words. The emergent themes were stigma, salient experiences, recovery, helping others, and gratitude for research participation. The audiences that could benefit from the results of this study are other counselors, social psychologists, and policy makers who can consider the study findings in light of the social identity theory problems of in-group bias, subordinate status inequality, stereotyping, and intragroup homogeneity. By reducing stigma and addressing credentialing, the professionals can promote positive social change in their practice in the addiction and counseling fields as well as the counseling profession in general.

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Dedication

This dissertation is dedicated to my family, friends, and colleagues who have encouraged and supported me in this study. I am also dedicating this dissertation to all wounded healers who became recovering counselors and assisted others caught in the throes of addiction and alcoholism but have been unrecognized for their contributions to the addiction and counseling fields and the counseling profession.

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Chapter 1: Introduction to the Study

Introduction

Stigmatization in the field of addiction can be traced back to the 1700s and 1800s when the field did not exist and when state licensing boards or credentialing were not realized (Doukas & Cullen, 2011; White, 2000). Stigmatization, during this time, referred to recovering counselors as second-class citizens who were considered uneducated, incompetent, and less effective than nonrecovering counselors in the addiction and counseling fields (Doukas & Cullen, 2011; Lloyd, 2013). This type of stigmatization has forced many recovering counselors to go underground with their substance abuse histories and recovery identities (Doukas & Cullen, 2011). Although there is much quantitative research regarding recovering counselors' age entering the field, their educational status, and competence (Rieckmann, Farentinos, Tillotson, Kocarnik, & McCarty, 2011), scholars have not used a qualitative approach to explore the experiences of recovering counselors. Furthermore, although many researchers have discussed stigmatization associated with recovering counselors, they have not explained the phenomenon itself (Doukas & Cullen, 2011). I designed this qualitative study to shed light on the many assumptions made about recovering counselors' competences and their effectiveness in the addiction and counseling fields. Using the social identity theory (SIT) as the theoretical foundation of this study, I explored how a specific group, the recovering counselor population, was affected in the addiction and counseling fields. The perspectives of recovering counselors, through education, credentialing, and practice,

have contributed much to the field, but they have had little voice (Doukas & Cullen, 2011).

Background of the Study

Stigmatization is a universal phenomenon in human societies: It varies across cultures, species, places, and time and is described as a long-lasting mark of disgrace (Lloyd, 2013). Stigmatization is based on negative assumptions, perceptions, and generalizations where derogatory terms are used that have a negative impact on individuals (Lloyd, 2013). Use of these terms results in prejudice, discrimination, avoidance, and rejection, which can harm individuals' self-esteem and affect their personal, social, and professional lives (Lloyd, 2013). Doukas and Cullen (2011) suggested using a qualitative research approach to determine whether stigmatization has an impact on recovering counselors practicing in the addiction and counseling fields today. Curtis and Eby (2010) used the SIT to describe "how recovering counselor's recovery status provided identity, meaning, and commitment to the counseling profession" (p. 248). In the social cognitive (SC) theory, Bandura (2001) described how an individual's beliefs have an impact on his or her motivations, emotions, and actions. Rieckmann et al. (2011) showed the development and evolution of recovering counselors through education, preparation, certification, and licensure processes. While stigmatization has been addressed in the literature, researchers have not explored its impact on recovering counselors. In this study, I addressed this gap in the literature by speaking directly with counselors about the impact.

Statement of the Problem

In the counseling profession, a prevailing belief system has existed since the early 1700s–1800s that perpetuates the stigma that one group of counselors is better than another group of counselors (Doukas & Cullen, 2011). During the early 1900s, when the addiction field was not developed and credentialing had not yet been established, nonrecovering counselors viewed recovering counselors as uneducated and incompetent, forcing many of them to hide their recovery status and the fact that they were recovering from substance abuse and addiction (Doukas & Cullen, 2011). Since the early 1900s, there have been many changes in the addiction and counseling field that established the following: (a) the creation of the 20th-century addiction field; (b) the development of addiction and counseling credentials; and (c) the educational development of recovering counselors with advanced degrees, such as masters and doctorate degrees (Rieckmann et al., 2011).

In comparing recovering versus nonrecovering counselors, Curtis and Eby (2010) reported pay variations as well as divergence in personalities, effectiveness, methodologies, attitudes toward addiction, and how clinical decisions were made. Scholars have examined recovering counselors as a research topic but have not explored the impact of stigmatization on them. The purpose of this study was to fill the gap in the literature and explore the impact of stigmatization on the personal and professional experiences of recovering counselors in the addiction and counseling fields.

Research Questions

The following research questions guided this study:

RQ1: How do recovering counselors describe the impact of stigma on their professional experiences?

RQ2: How do recovering counselors describe the impact of stigma on their personal experiences?

RQ3: For recovering counselors, what are the real-life experiences of stigmatization in the addiction field?

Purpose of the Study

The purpose of this qualitative, multiple case study was to explore the impact of stigma on the life experiences of recovering counselors in a midwestern state in the United States.

Theoretical Frameworks

I used Bandura's (2001) SC theory and the SIT as theoretical frameworks to understand the experiences of recovering counselors. Although there are many versions of SIT, Tajfel's (1982) version, focused on the moral, social, and political thoughts pertaining to individuals and social groups in the United States, such as the American Medical Association (AMA) and the National Association of Social Workers (NASW), as the foundational theory for the current study. In SIT, Brown (2000) and Tajfel (1984) exposed the inherent problems of bias, subordinate status inequality, stereotyping, and intragroup homogeneity that created legitimate stigmatization in social groups.

Using SIT, Curtis and Eby (2010) described how recovering counselors' recovery status provided identity and meaning in their personal, social, and professional lives and in their commitment to the addiction and counseling profession. In the SC, Bandura (1996) described how an individual's beliefs have an impact on his or her agency and motivations. The goal of this study was to provide insight from the perspectives and experiences of recovering counselors by using the above-mentioned versions of SIT to effect social change in professional practice and in the counseling profession itself.

The Nature of the Study

In this study, I employed a qualitative, multiple case design that involved a purposive sample of three recovering counselors and one nonrecovering counselor from a midwestern state in the United States. Semistructured interviews using open-ended questioning were used to gather the responses and experiences of these counselors. Three interviews were conducted via social media e-mail technology, while the other interview was conducted face-to-face, using an audio-recorder and transcription. Field notes were also part of the data collection. I discussed confidentiality with the participants, then protected and maintained it throughout the research.

Definitions

The following definitions and concepts contributed to the addiction and counseling fields:

Inebriety: Habitual drunkenness (Levine, 1978).

Lay therapist: A recovering alcoholic counselor engaging in the treatment of other alcoholics in a treatment setting (White, 2000).

Personal agency: A person's belief in their own capabilities to exercise control over his or her level of functioning and environmental demands to influence aspirations, level of motivation and strength of goal attainments, perseverance in the face of difficulties and setbacks, resilience to adversity, the quality of analytical thinking, the casual attributions for successes and failures, and any vulnerability to stress and depression (Bandura, Barbaranelli, Caprara, & Pastorelli, 1996).

Recovering alcoholic: When an alcoholic is sober from alcohol without attending mutual help programs (Benton, 2010).

Recovering counselor: A counselor in recovery from addiction working in the addiction field (Curtis & Eby, 2010).

Recovery: A process by which the addicted person is moving toward abstinence and a positive adaptation in life (Galanter, 2007).

Recovery identity: A personal accomplishment that extends down into the core of the individual that can affect all aspects of his or her life; its influence should not be overlooked (Curtis & Eby, 2010).

Recovery status: A state of achieving sustained sobriety and recovery (Curtis & Eby, 2010).

Reformed men: A man or woman who recovered from alcohol and other drugs during the 1700s and 1800s (White, 2000).

Social cognitive (SC) theory: A theory describing how an individual's beliefs impact his or her personal agency and motivations (Bandura, 2001).

Social efficacy (SE) theory: A theory describing an individual's belief in "their ability to exercise control over their internal psychology and external demands" (Bandura et al., 1996, p. 67).

Social identity theory (SIT): A theory describing how recovering counselors' recovery status provided identity and meaning to their personal, social, and professional lives and to their commitment to the counseling profession (Curtis & Eby, 2010).

Spirituality: A mystical phenomenon that gives people meaning and purpose in life (Galanter, 2007).

Stigma: A long-lasting mark of disgrace that has influences on the interactions between the stigmatized and the nonstigmatized (Lloyd, 2013).

Stigmatization: The perceived danger and blame associated with a person who is stigmatized (Lloyd, 2013).

Wounded healer: The notion that people who have faced and overcome adversity might have special sensitivities and skills in helping others experiencing the same adversity; it has deep historical roots in religious and moral reformation movements and is the foundation of modern mutual aid movements (Nouwen, 1972).

Assumptions

I made the following assumptions regarding the participants of this study: (a) recovering counselors have, in one form of another, experienced stigmatization in their

personal, social, and professional lives and (b) recovering counselors are willing to honestly share their experiences regarding this sensitive topic. An assumption of stigmatization was necessary to establish an exploration of participants' experience even though its forms may vary. The assumption of participants' willingness to share honestly was necessary because the study relies on collecting accurate data.

Scope and Delimitations

The sample size for this study was small, potentially making generalization of the findings difficult. The specific research problem addressed by this study were to explore the impact of stigma on the personal and professional life experiences of recovering counselors working in the addiction and counseling fields today. This focus was inspired by Doukas and Cullen's (2011) recommendation for future research that included "the use of narratives … and a qualitative approach to determine whether the counselor in recovery has been widely accepted since they first entered the field decades ago as an paraprofessional, or is there still animosity between the two camps" (p. 5).

The boundaries of the study included both recovering and nonrecovering counselors. No other subpopulation was considered. After 15 months of no response to my initial efforts, I extended my recruitment efforts to supervisors, executive directors, administrators, and college professors on the social media platform of LinkedIn to participate in the study. I received no response. Individuals who did not meet eligibility criteria to participate in my study were excluded. Four participants who responded to the social media page and who met criteria were selected to participate in my study.

I chose the SIT as the theoretical foundation of my study. In conjunction with the SIT, the SC theory was also used because it provides information regarding recovering counselors' identification with the counseling profession through their self-concepts, cognitive processes, and their sense of belonging (see Bandura, 1996; Brown, 2000; Tajfel, 1982, 1984; Turner, 1982). The SIT also provided information about the inherent problems in the theory that led to stigmatization against the subpopulation group of recovering counselors in the counseling profession (see Brown, 2000; Tajfel, 1984). The current study was not designed to explore recovering counselors' education, competence, or their effectiveness in the addiction and counseling fields; therefore, it may have limited transferability of study findings to other subpopulation groups.

I also considered identity theory for inclusion in the theoretical framework of this study but set it aside in favor of SIT and SC theory. Identity theory, aligned with the discipline of sociology, "sets out to explain individuals' role-related behaviors" (Hogg, Terry, & White, 1995, p. 255). While the concepts of the theory are similar to those of SIT, they do not extend to intergroup dynamics that relate to the stigmatization issue.

Limitations

I identified the following limitations of this study:

- I had difficulty in recruiting participants, implying sampling bias, which may have been due to the sensitive nature of the research topic on stigma. The sample I wanted to recruit was unavailable. In response to this challenge, I extended recruiting in both time and scope. I persisted in initial recruiting

plans for 15 months, then broadened outreach to additional professionals in the counseling field.

- The sample size was limited to four participants. Due to the sensitive nature of the research topic, use of the social media platform of Facebook, use of snowball sampling, and working with a marginalized group, the sample size was small. To enlarge the sample as much as possible, I extended recruiting to social media platforms beyond initial professional contacts and promoted snowball sampling among those I spoke with. While initially planning for face-to-face interviews, I expanded data collection to e-mail to recruit participants.
- The use of e-mail technology to conduct semistructured interviews with open-ended questions via participants' personal computers in their home environments versus the standard oral interview implies methodological weakness. The responses might have been short or participants might not have understood the questions. To mitigate this potential weakness, I used the same interview protocol for all participants. The home environment for participants helped to provide security of data and assured the participants of having control over continuing in the study. The home setting also afforded participants a flexible time frame to answer the questions in the interview protocol; again, they had control over how and when they responded.

- The findings may not be generalizable because the study sample size was small. This is a limitation common to qualitative research. In response, I developed and followed procedures that addressed trustworthiness.
- Due to the subjective nature of this study and working with a marginalized group, transferability of the study findings to other marginalized groups may be difficult. To support transferability, I detailed procedures and wrote thick descriptions of participant recruitment and selection as well as data collection methods.
- To remain objective throughout the study, I used reflexivity to bracket my biases and prejudices accordingly. Researcher bias can distort research findings (Merriam, 1998). The concrete efforts I took to reduce bias were to self-examine my role as the researcher, consistently rely on the case study interview protocol, and create a case study database to track my own activity much like an audit trail.

Significance of the Study

The findings from the study provided evidence and support to promote social change for recovering counselors' professional practice in the addiction and counseling fields. The professional identities of recovering and nonrecovering counselors, their commitment to the profession, and a sense of mutual empowerment may be facilitated by promoting an atmosphere of mutual respect. The results of this study may provide information to help policy makers and social psychologists understand the life

experiences of recovering counselors from their perspectives. Recovering counselors have contributed much to the counseling profession but with little voice (Doukas & Cullen, 2011).

Summary of Chapter 1

In this study, I addressed the impact of stigma on the life experiences of recovering counselors in a midwestern state in the United States. The intent of the study was to fill the gap in the literature using a qualitative, multiple case design to gather recovering counselors' responses, perspectives, and experiences of working in the addiction and counseling fields today. I used the SIT as the theoretical foundation of the study to help describe how recovering counselors' recovery status provided identity, meaning, and commitment to the counseling profession. SIT was also used to develop the research questions.

In this qualitative, multiple case study, I conducted semistructured interviews via e-mail technology as well as one face-to-face interview to gather information from three recovering counselors and one nonrecovering counselor. In this study, I focused only on recovering and nonrecovering counselors. I made several assumptions about the interviewed counselors: (a) they were recovering counselors, in one form or another; (b) they had experienced stigmatization in their personal, social, and professional lives; and (c) as recovering counselors, they would honestly share their experiences. The results of this study may prove to be beneficial to policy makers and social psychologists involved

with enhancing the quality of professional practice in the addiction and counseling profession as well as the counseling profession itself.

Chapter 2 includes a review of historical and current literature that supported the topic under study as well as literature that addressed the theoretical framework and methodology. I also discuss the impact of stigmatization on the life experiences of recovering counselors and address the gap in the literature that supported the need for this study.

Chapter 2: Literature Review

Introduction

This chapter includes a review of historical literature beginning with the lost era of addiction treatment in the United States. The lost era of addiction treatment can be traced back to the wounded healer temperance movements of the 1700s and 1800s that consisted of debates on the nature of alcoholism; descriptions of reformed men, recovering alcoholics, and inebriety asylums; and the first sign of stigmatization against reformed men. The reconstructed second era of addiction treatment included many controversial schools of thought that led to outreach services for alcoholics (White, 2000). Stigma prevailed during that time: Current literature pertaining to the personal and professional growth of recovering alcoholics/counselors denoted how stigmatization existed in the addiction field despite an awareness of the commitment among recovering and nonrecovering counselors to the profession (DePue & Hagedorn, 2015; Doukas & Cullen, 2011; Green, 2015; Lloyd, 2013; Rieckmann et al., 2011). In this review, I introduce the *Journal of Inebriety* and the American Association for the Study and Cure of Inebriety (AACI; see Crothers, 1897a). I discuss how these two entities addressed alcoholism and the first sign of stigmatization against recovering alcoholics in the 1700s–1800s (White, 2000). Several definitions and concepts are addressed in this study, including reformed men; recovering alcoholic; recovering counselor; lay therapist; nonrecovering counselor; recovery; recovery status; spiritual awakening; stigma, stigmatization; and the SI, SE, and SC theories.

Literature Search Strategy

I conducted multiple searches to find sources for the literature review using the following databases: Academic Search Complete, Psych Articles, Psych INFO, SOCINDEX with full text, Cinahl, Medline, Eric, SAGE Premier, Education Research Complete, Dissertation and Theses at Walden University, and Google Scholar. A review of references from historical literature led to additional resources. The Walden University Library and librarians assisted in locating historical articles for this review as well as articles in the disciplines of social work, health sciences, psychology, and education. I found no peer-reviewed articles that directly referred to stigma and the life experiences of recovering counselors. The following key words were used in these searches: *reformed men; recovering alcoholic; recovering counselor; lay therapist; ; recovery status; spiritual awakening; stigma; stigmatization; and the SIT, SE*, and *SC theories*.

Literature Review

The Lost Era of Addiction Treatment

The story of alcoholism and the recovering counselor can be traced back to the unknown era of addiction treatment during the 1700s–1800s (White, 2000). In the United States, during the lost era of addiction treatment, popular medical thought regarding alcoholism consisted of (a) the progressive nature of alcoholism, (b) the experiences of the alcoholic, (c) their public loss of control over drinking, and (d) the importance of abstinence from all substances (Levine, 1978). Rush (1943) presented early essays regarding the effects of alcohol on the human body and mind as well as prevention

methods and cure remedies. Woodard (1838) described the experiences of alcoholics in asylums for the purpose of finding a cure from the disease of alcoholism. Rush and Woodard also advocated for the medicalization of the abuse of alcohol and other drugs through the development of institutions for the cure of the alcoholic. Other movements such as the Native American cultural movement, the Washingtonian movement, the Emmanuel Church movements, and the development of rescue missions also contributed to the cure of alcoholics (Levine, 1978; Rorabaugh, 1979; Rush, 1943; Woodard, 1838).

The *Journal of Inebriety*, the first journal on alcoholism, was established by the AACI (1897a) and was authored and funded by Crothers, whose writings consisted of perspectives and thoughts on the nature of alcoholism and how to restrain alcoholics in treatment as well as the benefits of withdrawal, liberty, and best practices in asylum management. *The Journal of Inebriety* was also published to inform the general public about the nature of alcoholism, the symptoms and signs of the disease, and cure remedies (White, 2000). The professional principles of inebriety established by the AACI, directors of asylums, addiction cure institutes, and state legislators consisted of the following: (a) "defining intemperance as a disease, (b) promoting the cure of the disease, and (c) explaining physical susceptibility to alcohol and whether it was inherited or acquired" (AACI, 1897a, p. v).

During the social and political climates of the 1700s and 1800s, the work of asylums and addiction cure institutes flourished briefly; however, these bodies were unable to gain support or scientific credibility (White, 2000). Economic downturns

resulted in unethical clinical practices, violations, unethical technologies, de-medicalization, criminalization of alcohol and drug problems, and the collapse of the unknown lost era of addiction treatment in the United States (White, 2000). All knowledge of this era, its history, the wounded healer movements, and reformed alcoholic helpers was lost to the second reconstructed era of addiction treatment.

The Reconstruction of the Second Era of Addiction Treatment

The reconstructed second era of addiction treatment consisted of two salient schools of thought during the 19th century temperance movements: (a) the gospel temperance movement, which contended that alcoholics could not be saved and (b) the therapeutic temperance movement, in which recovering alcoholics sought to save fellow alcoholics by sharing their experiences, strengths, and hopes regarding their own experiences with alcohol (White, 2000). The therapeutic temperance movement included the Washingtonian and Black temperance movements that prevailed; recovering alcoholics carried their message of recovery to other alcoholics through public speaking, the lecture circuit, and storytelling to help them also achieve sobriety (White, 2000).

Reformed Men and the Recovering Alcoholics

During the second era of addiction treatment, reformed men and/or recovering alcoholics, who had recovered from alcoholism, began to participate in temperance work to help other alcoholics achieve sobriety (White, 2000). The hiring of reformed men and/or recovering alcoholics can be traced back to inebriate asylums and addiction cure institutes where these individuals (and alcoholic physicians) sought positions as managers

and attendants (McKenzie, 1875). These reformed men were employed at these institutions because they understood the plight of alcoholics and responded to their stories and experiences more quickly than nonalcoholics (McKenzie, 1875; White, 2002). The use of reformed men and/or physicians as asylum managers led to Crothers' (1897a) controversial statement regarding the incompetence of reformed men:

> Physicians and others who, after their being cured, enter upon work of curing others in asylums and homes, are found to be incompetent by reason of organic defects of the higher mentality… the strain of treating persons who are afflicted with the same malady from which they formerly suffered is invariably followed by relapse if they continue in the work for any length of time. (p. 79)

It was this statement by Crothers that led many researchers to scientifically research the competence, age, educational status, and effectiveness of reformed men who worked in inebriate asylums and other treatment program settings. Crothers conveyed the first sign of stigmatization against reformed men and/or recovering alcoholics and/or recovering physicians.

Reformed men and/or recovering alcoholics traveled throughout the United States searching for alcoholics to feed and clothe as well as to challenge them "to live and die sober" (Hiatt, 1878, p. 1). Temperance work not only included feeding and clothing alcoholics but also provided the opportunity for reformed men to share their experiences, struggles, and recovery from alcoholism with them. The lecture circuit helped reformed men not only to help others but also to help themselves maintain their sobriety and

recovery (Ferris, 1878; Hiatt, 1878; Vandersloot, 1878). Carrying the message of recovery to other alcoholics was not always an assurance of sobriety because some of the reformed men relapsed while participating in extensive work with other alcoholics (White, 2000). Relapse was also considered an incompetence criterion, signaling that reformed men had an addiction problem (Doukas & Cullen, 2011; Kurtz, 1979; White, 2000).

Due to professional public criticism, the practice of hiring reformed men and/or physicians declined, and the practice of paying them with only a small salary carried over into the 20th century (White, 2000). The Emmanuel Church Clinic was the first to call recovering alcoholics lay therapists, and they created the first treatment program for alcoholism that consisted of the following procedures: (a) a biopsychosocial assessment, (b) counseling, (c) psychotherapy, (d) individual therapy, (e) participation in support groups, (f) service to other alcoholics, (g) education, (h) the use of recovery mentors, and (i) social services (White, 2000).

Quantitative Research Studies

Although I found no research that stemmed directly from the words of Crothers' (1897a) competency statement, many quantitative studies have been conducted by researchers to explore the competence of recovering alcoholics with recovery status. Aiken, LoScuito, and Brown (1984); Austin (1977); Doukas and Cullen (2011). Stoffelmayr, Mavis, and Kasim (1998); and Stoffelmayr, Mavis, Sherry, and Chiu (1999) researched the educational status of recovering counselors and found that the person in

recovery entered the field at an older age and was less educated than nonrecovering counselors. In several quantitative studies, researchers found that compared to nonrecovering counselors, recovering counselors were resistant to new learning and were overcommitted due to personal preference for the 12-step approach (Dalali, Charuvastra, & Schlesinger, 1976; Humphreys, Noke, & Moos, 1996; Shipko & Stout, 1992; Siassi, Angle, & Alson, 1977; Stoffelmayr et al.,1998). Other scholars revealed that recovering counselors operate from a limited time frame of reference because they all viewed clients as either addicted or nonaddicted, which led to overdiagnosis (Lawson, Petosa, & Peterson, 1982). Campbell, Catling, and Melchert (2003) found that certified alcohol and drug counselors were eager to integrate best practices into their counseling tasks to prevent overdiagnosis. The results of these quantitative studies added credibility to the notion that recovering counselors were not ignorant, less educated, or mentally incompetent. Despite the older literature portraying recovery counselors in a negative light, several more recent researchers pointed to the advantages of hiring recovering individuals with a substance abuse history to work in methadone clinics because they provided street credibility to the program and acted as role models for suspicious clients (Ball, Graff, & Sheehan, 1974; Bell, 1973; Brown, Jackson, & Bass, 1973; Gay & Vegas, 1973; Gerber, 1972; Louria, 1972).

Additional scholars found that when compared to nonaddict counselors, exaddict counselors were able to spot abuse and provide more helpful opinions and guidance to clients (Aiken & LoScuito, 1985; Bell, 1973; Brown et al., 1973; Brown & Thompson,

1976). Culbreth and Borders (1999) also found bias when clients' preferences involved listening to recovering counselors versus nonrecovering counselors. Hattie, Sharpley, and Rogers (1984) found that recovering counselors could be useful in the field of social work and found no differences between the ex- and nonaddict counselor when patients were asked to rate performance (Brown & Thompson, 1976) or perception of empathy (Kirk, Best, & Irwin, 1986). There have been only two quantitative studies conducted since 2000 on the provision of clinical tasks distributed among recovering and nonrecovering counselors (Culbreth, 2000; Knuden, Gallon, & Gabriel, 2006) and on the determinants of intrinsic job motivation (Curtis & Eby, 2010). Curtis and Eby (2010) presented findings that counselors in recovery were more committed to the profession, attached greater meaning to day-to-day tasks, and experienced a greater sense of meaning in the workplace than counselors not in recovery (p. 248). With an overall focus on treatment effectiveness, Culbreth (2000) also focused on the use of treatment methods, attitudes about addiction, clinical decision-making, and personality in that work. One year earlier, Culbreth and Borders (1999) had focused mainly on clinical supervisors' preferences between recovering and nonrecovering counselors.

The majority of the studies were quantitative, and survey based. The leading data analysis instruments used in the studies were analysis of variance (ANOVA) and multiple regression, which varied in methodology between agencies and interview-based surveys to questionnaires that varied across substance abuse treatment agencies (Aiken et al., 1984; Aiken & LoScuito, 1985; Bell, 1973; Humphreys et al., 1996; Juhnke, Vacc,

Curtis, Coll, & Paredes, 2003; LaRosa, Lipaius, & LaRosa, 1974; Lawson et al., 1982; LoScuito et al., 1984; Shipko & Stout, 1992).

Qualitative Research Studies

Qualitative scholars used various methodologies in their research pertaining to recovering/nonrecovering counselors. Cannan (2003) used qualitative interviews to analyze the pursuit of professional jurisdiction that concentrated on entry and socialization processes. McGovern and Armstrong (1987**)** interviewed alcoholic counselors in an attempt to gather qualitative and quantitative data to explore areas regarded by counselors as potential pitfalls to substance abuse relapse. Crabb and Linton's (2007) semistructured interview findings "suggested that substance abuse counselors regardless of their recovery status may be willing to change their beliefs regarding practice" (p. 18). Lastly, in their study, Ham, LeMasson, and Hayes (2013) found that "recovering substance abuse counselors' tendency to self-disclose reduced over time as well as their rationale to disclose their recovery history" (p. 373). There was also limited research from the European community on the topics of dual relationships, counselors' interactional styles, recovery status, nonverbal behaviors, and the use of self-disclosure. Hecksher (2007), who examined dual relationships among recovering counselors, found evidence that "those working as counselors, experienced specific ethical dilemmas and problems" (p. 1253). Three European survey-based studies included (a) Toriello and Strohmer (2004), who examined addiction counselors' credibility with their interactional styles, recovery status, and nonverbal behavior, found "no significant

differences between recovering/non-recovering counselors' interactional style and recovery status, but recovering counselors' use of nonverbal behavior had its advantages" (p. 46) (b) Toriello and Benshoff (2003), who examined the influence of substance abuse counselors' recovery status and educational level on ethical dilemmas, found "significant differences between substance abuse counselors with graduate degrees and those with associate degrees or high school diplomas, the latter being more sensitive to ethical dilemmas" (p. 83) and (c) Gomez, Harant, and Clerc (2005), who examined and reduced the use of self-disclosure in their experiences as recovering counselors. Hecksher also reported that in Denmark, the employment of addiction counselors with past substance abuse issues represented a new development of increased interconnectedness in recent years between 12-step organizations and the public treatment services. The European substance abuse treatment community followed the evolution that occurred in North America decades ago beginning with the Alcoholics Anonymous (AA) movement, the 12-step recovery process, and the Minnesota Model of Chemical Dependency (Cook, 1988). Despite the results of these studies that many recovering counselors have had successful recoveries, stigmatization and stereotyping continues to plague recovering counselors.

Stigmatization in the Addiction Field and Other Disciplines

Despite the recovering counselors' recovery and growth in the fields, social, psychological, and political thought continues to focus on the labels of "addict," "recovered," "ex," or "former" that imposed negative connotations on recovering

counselors. Doukas and Cullen (2011) provided information that people in recovery chose to keep the past a secret because of the stigma associated with their former addiction (p. 1). Doukas and Cullen as well as Strachan (1973) found that the role of the alcoholic in recovery was furthered distorted within the field by the second-class citizen status that forced many counselors in recovery to go underground with their past and drop all reference to their former addictions and recovery. Fewell and Lewis (1990) documented the prevailing influence that the psychiatric profession had over substance abusers; they mentioned how psychiatrists were more likely to rate alcoholic patients as difficult, annoying, and less in need of admission. This theme continued as researchers pointed to former addicts facing barriers when trying to access treatment for Hepatitis C (Stephenson, 2001). These views were supported by social and political thought that rated drug addiction as the primary disorder in terms of danger to the public and lowest on the priority list for accessing health care (Ritson, 1999). Besides social and political thought, there were other disciplines that subjected recovering counselors to constructed ways of behaving and talking that removed agency from them (Aiken et al., 1984; Doukas & Cullen, 2011; Olmstead, Johnson, Roman, & Sindelar, 2007; Stoffelmayr et al., 1998). Aiken et al. (1984) and Stoffelmayr et al. (1998) found that when comparing job-related activities, “the recovering counselors had less decision-making influence than non-recovering counselors in pay, staffing, policy, and agency clinical matters where they were employed” (p. 1).

Historically, those in the substance abuse treatment sector wielded power over recovering counselors working in the addiction field when compared to non-recovering counselors (Brawley, 2014). Grosser, Henry, and Kelly (1969) reported analyses of the role functions of indigenous paraprofessionals in human services compared to the role functions of associate degree technicians. Brawley (2014) provided findings on how the commitment to recovering counselors eventually diminished as those in social work pursued education credentials for their workers. Rhodes and Johnson (1996) reported how the field of substance abuse was too much of a challenge for the social work profession. The stigma associated with methadone maintenance patients (who later became counselors) has been well documented (Ball et al., 1974; LaRosa et al., 1974). Scholars reported how recovering counselors felt stigmatized; knowing they had a history of using prescribed methadone, they kept their histories a secret (Ball et al., 1974; Brown et al., 1973; Murphy & Irwin, 1992). When methadone clients were later hired as counselors, non-recovering counselors saw them as undesirable and inferior (Brown et al., 1973; Strachan, 1973). Many non-recovering counselors held moralistic attitudes toward their recovering counterparts. As paraprofessionals began to enter the field, moral and social thought began to regulate their counseling behaviors by defining what was good, and proper, and what it meant to be educated with professional knowledge. (Doukas & Cullen, 2011). There were also resentments and resistance in the workplace between recovering and nonrecovering counselors (Doukas & Cullen, 2011). To provide a more comprehensive understanding of the moral, social, and psychological thought that

existed in the addiction field and counseling profession, the SIT undergirded this study and provided pertinent information on social perception of social groups and the stigmatization of recovering counselors.

Theoretical Foundation

The SIT, social identity theory, was the foundational basis of this study. The theory is about the forming of social groups and how an individual identity with a particular social group (such as counselors) caused individuals to want to be a part of its membership (Bandura, 1996, 2001; Curtis & Eby, 2010; Tajfel, 1982, 1984). The premise of SIT is that the self is multifaceted and created by the interaction of the individual with society (Bandura, 1996, 2001; Hogg, et al. 1995; Stets & Burke, 2000). According to SIT, people are not independent of the world around them but are shaped by the experiences and relationships they have (Bandura, 1996). Identity is formed based on cognitive processes of comparing a person's self to others based on established social categories (Tajfel, 1982), or classifications (Bandura, 2001; Brown, 2000; Curtis & Eby, 2010; Haslam, Jetten, Postmes, & Haslam, 2009; Tajfel, 1982). According to Brown (2000), Hogg et al. (1995), Stets and Burke (2000), and Tajfel (1982, 1984) versions of SIT, people classify themselves with social groups they identify with. Once identity is established, it can influence attitudes and behaviors (Doosje, Ellemers, & Spears, 1999). Curtis and Eby (2010) also found that counselors in recovery identify more with the counseling profession and reported higher professional commitment than their nonrecovering counterparts. The recovering counselors' recovery status or recovery

identity represented an anchor for their self-identity due to their unique connection to addiction and recovery (Curtis & Eby, 2010). This information will provide the foundation for recovering counselors' sense of social identity in connection with the social groups in the field of addiction treatment and the counseling profession.

Tajfel's (1984) version of SIT, which was the foundational theory of this study, defined social identity as "the individual's knowledge that he/she belongs to certain social groups together with some emotional and value significant group membership" (p. 563). In SIT, Turner (1982) stated that, "individuals structure their perception of themselves and others via abstract social categories by which they internalize these categories and social cognitive processes as aspects of their self-concept, which produce group behavior" (p. 16). Haslam et al. (2009) further stated the following about social groups:

> groups have (a) capacity to be a source of personal identity, (b) social companionship, (c) emotional bonding, (d) intellectual stimulation, (e) collaborative learning, (f) having qualitative advantages as they allow individuals to achieve goals and levels of agency that would otherwise be unattainable. (p. 2)

Brown's (2000) version of SIT also focused on the classic social psychological problem of the relationship of the individual to the group, with four problems inherent in the theory regarding the relationship: (a) "in-group bias, (b) subordinate status inequality, (c) stereotyping, and (d) intragroup homogeneity" (p. 745). A review of SIT with its inherent problems provided me with insight into the moralistic attitudes of the 1700s and 1800s,

the social thought during the last era of addiction treatment (White, 2000), and the moral and social thought that exists today. Tajfel presented the following insights regarding SIT's inherent problems and collective behaviors:

> The point of departure in the study of collective behavior must be an adequate theoretical approach to the social psychological issues of intergroup relations … social identity is not enough … strategies to … preserve the status quo must be considered. (p. 713)

Tajfel also stated,

> None of this can be properly understood without considering …the interplay between the creation or diffusion of social myths and the processes of social influence as they operate in group affiliations. (p. 713)

Brown (2000) stated that, "the goals for social change should be to restructure our environments so that the racist, sexist, and other dangerous ideologies lose their functional and psychological appeal and become devalued as legitimating forces" (p. 769).

There are no studies that show recovering counselors have their own social identity or the opportunity to fully participate in a social group or social affiliation as outlined by SIT. It is imperative that recovering counselors have a positive social identity, social support, and legitimate professional group affiliation. The recovering counselor identifies with the addiction and counseling fields and the counseling profession. Recovering counselors have acquired the appropriate education, academic

degrees, counseling skills, licensures, certifications, decorum, and have signed the counselors' code of ethics to meet the requirements to be a legitimate professional recovering counselor (Mulvey, Hubbard, & Hayashi, 2003; Rieckmann et al., 2011). The counselor's self-identity, licensure, and credentialing should not be based on the criteria of in-group bias, subordinate status inequality, stereotyping, or intragroup homogeneity (Brown, 2000; Tajfel, 1982, 1984) but on their past contributions (White, 2000) to the addiction and counseling fields, and to the counseling profession itself (Doukas & Cullen, 2011).

The Gap in the Literature

Throughout my research of the literature, I found no pertinent data that addressed the impact of stigma on the life experiences of recovering counselors. The goal of my qualitative multiple case study was to glean pertinent professional and personal knowledge regarding the impact of stigma on the life experiences of recovering counselors. This qualitative study has filled the gap in the literature by providing pertinent data that addressed the impact of stigma on the life experiences of recovering counselors in the addiction and counseling fields. Goffman (1968) stated that, "stigmatization is a universal phenomenon observed in all cultures and across species" (p. 1). Dugatkin, Fitzgerald, and Lovoie (1994) described "stigma as a mark of social disgrace with associated factors of perceived danger and blame that have effects on the interactions between the stigmatized and the non-stigmatized" (p. 85). Link and Phelan

(2001) described stigma as "labeling, stereotyping, separation, status loss, and discrimination that occur together in a power situation that allowed them" (p. 337).

Crothers' (1897b) moral, social, and medical thoughts continue to be the prevailing influence in the addiction and counseling fields. This influence has seeped into the moral and social thoughts and attitudes of individuals in the counseling profession. These moral, social, and medical thoughts have led to the stigmatization and degradation of recovering counselors without presenting a clear picture of the contributions they have made to the field.

During the lost and reconstructed eras of addiction treatment, there were other professionals, such as physicians, who experimented with alcohol and drugs, and became addicted to the substances they experimented with (Baldisseri, 2007; Council on Mental Health, 1973). According to the Council on Mental Health (1973), the AMA formally recognized alcoholism and drug addiction among physicians as a problem and designed Physician Health Programs for their rehabilitation. In addition to physicians who had substance abuse problems, there was a host of other professionals in the healthcare industry who were documented as impaired, such as social workers, psychologists, nurses, pediatricians, pathologists, radiologists, obstetricians, gynecologists, dentists, pharmacists, anesthesiologists, and veterinarians (Baldisseri, 2007; Bissell, Fewell, & Jones, 1980; Coombs, 2007; Fewell, King, & Weinsten, 1993; Lawson & Venart, 2003; Pooler, Sheheen, & Davidson, 2009; Reamer, 1992; Sheffield, 1998; Siebert, 2003; Strozier & Evans, 1998).

Even master-level college students being educated and trained to be licensed substance abuse counselors have become addicted to alcohol and drugs while in college (DePue & Hagedorn, 2015). Green (2015) presented information about the perceived impact of addiction treatment and recovery on master-level college students and discussed whether or not recovery programs should be developed on college campuses to help them. Although impairment has occurred among these professionals and master-level students of social work, there have been no negative connotations or stigmatization attached to their use of alcohol and drugs compared to recovering counselors. In addition, they have not been labeled "addict," or "alcoholic," or "declared incompetent by reason of organic defects of a higher mentality" (Crothers, 1897b, p. 79). It was the NASW (2005) and the AMA (1973) that first developed professional programs to assist their members with their substance abuse problems while working in the field.

The general public may not be aware of the substance abuse disorders that have affected physicians, nurses, and other healthcare professionals (Baldisseri, 2007; Coombs, 2007). The general public does not know of the past contributions made by reformed men, recovering alcoholics, and/or counselors from the wounded healer movements of the 1700s and 1800s (White, 2000), before credentialing, before the establishment of state licensure boards, and before the establishment of the master of social work degree as the lone degree that makes an individual or recovering counselor a legitimate professional counselor. Recovering counselors have been labeled, stigmatized, and disgraced by the moralistic attitudes of the past and have felt forced to go

underground to avoid all reference to their past addiction and recovery status (Doukas & Cullen, 2011). To create social change in the addiction field, it is imperative that counselor educators, social psychologists, and policymakers revisit SIT and its inherent problems, and begin to restructure the relationship between the individual and the group (Brown, 2000; Tajfel, 1984), eliminate these problems, and allow for more inclusion (not exclusion) and nonbiased requirements for membership.

The Transformation of the Recovering Alcoholic

According to Green, Fullilove, and Fullilove (1998), as researchers searched for answers pertaining to recovering counselors with recovery status and recovery identity, they overlooked the role that religion, beliefs (in a Higher Power), and spiritual practices have played in preventing alcohol/drug use and relapse. Green et al. reported "how recovering people underwent life altering transformations as a result of embracing a Power greater than themselves which led to spiritual experiences and sustained abstinence" (p. 325). The transformation of recovering alcoholics and recovering counselors can be traced back to the spiritual temperance movement of Alcoholics Anonymous (AA), the 12 steps of recovery, the Emmanuel Church Clinic Movement, and the Minnesota Model of Chemical Dependency Treatment (Kurtz, 1979; White, 2002). The spiritual temperance movement of AA was established by founders, Bill W. and Dr. Bob S. (Kurtz, 1979; White, 2002). AA is a worldwide fellowship of men and women who have an estimated membership in excess of 1,000,000, who meet regularly to help each other achieve sobriety and recovery from alcoholism, using a 12-step format

(AA, 1976; Kurtz, 1979; White, 2000). According to Kurtz (1979) and White (2000), although all steps are essential for recovery, the most important aspect of the 12-step recovery process is the spiritual awakening alcoholics experience as a result of applying the 12 steps of recovery (Appendix C) to their lives and after having a spiritual awakening, discovering that certain spiritual promises will come true in their lives (Appendix D).

As stated in AA (1976), "the alcoholic has tapped an unsuspected inner resource of a Power greater than themselves which has infused them with inner strength" (p. 569-570). Jung (1993) described the alcoholic's spiritual awakening as "spiritually-oriented psychology" (p. 586-587). Maslow (1970b) described it as "a peak experience of self-actualization" (p. 4). Kurtz (1979) described the spiritual awakening as "living through the dark night of the soul … screaming the first prayer, God help me" (p. 126); James (1902) defined the spiritual experience as "a conversion where alcoholics self-divided and consciously wrong, inferior and unhappy, becomes unified and consciously right, superior and happy, as a consequence of their firmer hold upon religious realities" (p. 126).

It was recovering alcoholics' spiritual experiences that enabled them to overcome their alcohol problem and inspired them to work in the addiction field to help other alcoholics achieve sobriety. Lay therapists not only helped other alcoholics to achieve sobriety, but they practiced lay therapy to maintain their own sobriety and self-cure (White, 2000). It was the Minnesota Model of Chemical Dependency Treatment that first

called recovering alcoholics lay therapists and set minimum requirements of a high school diploma and two years of sobriety in order to be able to practice as a counselor in treatment settings (Cook, 1988; White, 2000).

Blume (1977) outlined the following advantages of using recovering alcoholics as counselors in the treatment of alcoholism:

> (a) they are living examples of hope, (b) they are role models, (c) they can communicate better and understand the alcoholic's experiences, (d) they are more patient and tolerant and less prone to moralistic judgment, (e) hard to fool or con, (f) have personal experience in handling practical day-to-day problems associated with abstinence in a drinking society, and (g) they have an understanding of the AA program. (p. 744)

Some lay therapists were not affiliated with AA or attended meetings; others had no access to supervision; some relapsed; and still others left the field believing that the work they were doing was detrimental to their sobriety and recovery (White, 2000). It is through the process of recovery, the application of 12 steps, and having a spiritual awakening or experience of transcendence beyond the original self (Kurtz, 1979) that recovering alcoholics/counselors overcame their personal adversities, developed personal human agency, and SE to become productive members of society. Although there are many definitions of SE, Bandura et al. (1996) described SE as "the individual's belief in their ability to exercise control over their internal psychology and external demands" (p. 67). Bandura et al. also described personal agency as "the individual's belief in their

ability to produce desired outcomes and exert considerable power over their personal development, thinking processes, motivations, vulnerabilities, adaptations, aspirations, goals, and determination to face adversity" (p. 1206). Bandura et al. further stated that, "it is inevitable that the psychological processes and SE beliefs of the individual are intimately involved in the development of cognitive competencies" (p. 1206). Sias, Lambie, and Foster (2006) provided evidence of recovering counselors' conceptual and moral development and found that higher levels of formal education was positively related to high levels of moral reasoning. Rieckmann et al. (2011) reported that the substance abuse counseling workforce of today consists of recovering counselors with masters and doctorate degrees. Mulvey (2003) reported that the substance abuse workforce consisted of certified and licensed counselors with bachelor and master's degrees. These scholars dispel the myths stemming from historical literature that recovering counselors were incompetent and ignorant with less education (Aiken et al., 1984; Culbreth, 2000).

Culbreth (2000) and Stoffelmayr et al. (1999) discovered no differences between treatment effectiveness, treatment methods, attitudes about addiction, clinical decision making, and personalities of substance abuse counselors with and without recovery status. Campbell et al. (2003) presented findings about how the majority of certified alcohol and drug counselors integrated evidenced-based practices into their counseling tasks just like their nonrecovering counterparts. Juhnke et al. (2003) outlined the assessment instruments. Finally, Kerwin, Walker-Smith, and Kirby (2006) and Miller,

Scarborough, Clark, Leonard, and Keziah (2010) argued for the minimum state requirements and national credentialing standards for addiction counselors while Culbreth and Curtis and Eby (2010) provided evidence of recovering counselors' social identification with the addiction field and the counseling profession based on their unique experiences and social identities associated with addiction and recovery. All of this is recent research of recovering counselors' history and contributions to the field that have been lost to the 20th century generation of counselors.

Summary and Conclusions of Chapter 2

In Chapter 2, I reviewed historical literature that addressed the quantitative and qualitative studies pertaining to the plight of recovering counselors and the phenomenon of stigmatization that existed in the United States during the 1700s-1800s (White, 2000). Literature search strategies and key words were used to find sources to address stigmatization and the experiences of recovering counselors in the addiction and counseling fields. There were no current qualitative studies in the literature pertaining to the impact of stigma on the personal and professional experiences of recovering counselors. My qualitative, multiple case study will fill the gap in the literature pertaining to the impact of stigma on the life experiences of recovering counselors working in the addiction and counseling fields today. SIT provided the theoretical foundation for my study and support for recovering counselors' identification and commitment in the addiction and counseling fields and in the counseling profession. Implications for social change were presented.

In Chapter 3, I will describe the research design and rationale, participants of the study, methodology, assumptions, research questions, and the procedures used in data collection and analysis.

Chapter 3: Research Method

Introduction

The purpose of this qualitative, multiple case study was to explore the impact of stigma on the life experiences of three recovering counselors and one nonrecovering counselor in a midwestern state in the United States. In this chapter, I discuss the qualitative methodology research design and rationale, the role of the researcher, participants of the study, instrumentation, procedures used in data collection and analysis, issues of trustworthiness, and ethical considerations. The chapter concludes with a summary. The SIT, as the theoretical foundation of the study, was used to shed light on the stigmatization associated with recovering counselors' counseling experiences.

Research Rationale and Design

In this study, I used a qualitative, multiple case design that involved a snowball sample of four recovering and nonrecovering counselors from a midwestern state in the United States. The following three research questions guided the study:

RQ1: How do recovering counselors describe the impact of stigma on their professional experiences?

RQ2: How do recovering counselors describe the impact of stigma on their personal experiences?

RQ3: For recovering counselors, what are the real-life experiences of stigmatization in the counseling profession?

I employed a qualitative, multiple case design in this study. Case study refers to the study of a phenomenon within a real-life context (Yin, 2009). The qualitative approach is defined as an inquiry to answer research questions about experience, meaning, and perspective (Hammarberg, Kirkman, & de Lacey, 2016). The perspectives are gathered from the standpoint of the population under study, presenting subjective meaning (Hammarberg et al., 2016). Because I identified a gap in the literature on the impact of stigmatization on counselors, a qualitative approach was appropriate to capture counselors' perspectives on this topic. In contrast to the qualitative approach, quantitative researchers use well-understood variables that can be expressed in hypotheses before data are collected and can support statistical analysis (Hammarberg et al., 2016). I did not use the quantitative method in this study because I wanted to explore the counselors' perspectives of stigmatization to come to an understanding of its impact on them. Similarly, I rejected the use of mixed methodology, in which qualitative and quantitative methods are combined either sequentially or in parallel as long as they are undergirded by compatible theories (see Hammarberg et al., 2016). Because the aims of this study were not suited to the quantitative approach, it would have been inappropriate to introduce a mixed method approach.

Scholars use a multiple case design to describe a phenomenon from several points of view rather than tell one individual story; therefore, the description highlights the phenomenon rather than a single person (Yin, 2009). I selected the multiple case design for this study to (a) focus on multiple cases instead of on a single case, (b) answer the

how and why questions about a contemporary phenomenon, and (c) use a real-life context (see Yin, 2009). The multiple case approach also allowed me to glean meaningful, holistic, and rich description from the recovering and nonrecovering counselors.

Another design considered for this study was the phenomenological design that is used to attempt to understand a phenomenon through the life experiences of a group of individuals who have common meanings (see Moustakas, 1994). I did not choose the phenomenological approach because I wanted to study the phenomenon of stigmatization from multiple individuals or cases, seeking a complexity of views (see Yin, 2009). I also considered the narrative approach where “an account of events or actions were given through spoken or written text in chronological order, through life stages” (Czarniawski, 2004, p. 17). I did not choose the narrative approach due to this orientation of accounting across time and through life stages; rather, I sought multiple perspectives regardless of stage of life instead of a single trajectory. The multiple case study design was the most appropriate choice for this study.

Role of the Researcher

As primary data collection instrument, I had neither personal nor professional relationships with the participants before or at the time of the interviews. There were no supervisory or instructor relationships involving power over the participants. Clarification of my own personal bias was important because a researcher’s bias can threaten the validity of a study (see Mantzoukas, 2005). Because I selected a posture or reflexivity, I aimed to clarify my bias rather than “to strive for the elimination” of biases (Mantzoukas,

2005, p. 279). My commitment to reflexivity required making my bias and prior experiences transparent. In this section, I explain my own history as a recovering counselor.

As a recovering counselor myself, I have experienced stress, anxiety, and stigma in the counseling profession while trying to maintain my professional and recovery identities. For example, I have felt marginalized and out-of-place. I realized the potential impact of my experiences on how I would conduct my study; specifically, I was cognizant of my own biases, prejudices, and presumptions. I relied on Morrow's (2005) definition of reflexive bracketing: Researchers' self-awareness of their possible influence on a study and the decision to set aside prior suppositions about the phenomenon under study. There were two phases of bracketing in this study: (a) first, those aspects of my personal experience that could possibly emerge as bias as I conducted the study were identified, and (b) second, my decisions and actions were tracked so that I listened to participants' perspectives without inserting my own. Specific to this step, a professional colleague reviewed the data collection process and provided me with feedback. To formalize the commitment to reflexive bracketing in the study, I created a case study database in which I recorded my position as researcher and tracked my activity. The database is further described in the Dependability subsection falling under Issues of Trustworthiness section later in this chapter.

As the primary data collection instrument, I also collected and gathered raw data through the participants' responses in semistructured interviews. The data were analyzed

and coded to determine emergent patterns, themes, and generalizations. After data collection and analysis, I saved the e-mailed interviews to my computer and placed the transcribed face-to-face interview and audio recorder in a manila envelope in a locked box with a combination password in my home office for safety and future reference. After data collection, all participants were thanked for their participation in the study. Although there was no compensation for participation in the study, a copy of the findings was offered to each participant upon request; all participants requested a copy of the study findings.

Methodology

Participants of the Study

The participants of the study were three recovering counselors and one nonrecovering counselor recruited through snowball sampling, social media, and e-mail technology. Based on literature regarding saturation and sample sizes in qualitative research (Crouch & McKenzie, 2006; Mason, 2010; Townsend, 2013), saturation was achieved when no other participants from social media responded to my social media message. After exhausting all recruitment efforts, I began the study with a sample size of four participants. All participants met the following eligibility criteria to participate in the study: (a) be licensed or credentialed in their state as a professional or counselor, (b) have worked in the addiction and/or counseling or related fields, and (c) have worked with recovering counselors.

Instrumentation

As the primary data collector, I used a case study interview protocol guide (see Appendix A) that consisted of the research questions, interview questions, probes, follow-up questions, and prompts to stay on target and focused on the topic of the study. I used the guide throughout data collection to ensure that I prepared for each interview in the same way.

I created the protocol and wrote the interview questions to generate sufficient data to answer the research questions. For each of the three research questions, the protocol provided two main interview questions and one follow-up interview question. As open-ended items, the questions invited participants to respond fully. All questions were phrased neutrally. As professionals in their field, the participants did not require additional definitions or guidance to form their responses.

I developed interview questions based on existing literature, drawing concepts from Curtis and Eby's (2010) survey research because they relied on SIT for the premise of their study. The key concept of stigma was explored in the interview questions based on Link and Phelan's (2001) definition of the term. By developing the interview questions based on strong theoretical concepts and definitions, I assured the content validity of the instrument. I also consulted with colleagues on the appropriateness of the instrument. Before conducting interviews, my supervising chair and committee reviewed the interview protocol and suggested revisions. Additionally, I asked a professional colleague to review the data collection process. Following interviews, this colleague

reviewed and verified the results. The feedback I received confirmed my own assessment that I collected sufficient data to answer the research questions.

The Procedures

Across 15 months and after using multiple techniques and methodologies, four recruiting efforts failed to secure participants. I repeated the first recruitment effort in 21 counties. Following four rounds of outreach in the 21 counties in a midwestern state in the United States, no participants emerged. Following these unsuccessful attempts of outreach, I expanded my efforts to the social media platform of LinkedIn using a snowball sampling strategy to build a sample. No participants emerged from these efforts either. Following these unsuccessful efforts, I reached out to the 12-step communities of AA, Narcotics Anonymous (NA), and Cocaine Anonymous (CA) using social messaging and e-mail technology. No participants emerged from the 12-step communities. Finally, using social messaging on Facebook, snowball sampling, and e-mail technology, I recruited four professionals to participate in the study.

After the screening and selection of participants for the study and receiving their written consent to participate, I scheduled individual interviews. Three participants received a telephone call and were e-mailed a copy of the research questions 24 hours prior to the interview to allow time for contemplation. At the start of each interview session, each participant was asked whether he or she had any questions or concerns about the study or the informed consent form. No participants needed clarification. Three interviews took place in the participants' homes through use of their personal computers

and e-mail technology that provided a safe environment for them. The face-to-face interview took place in my home office for privacy and was recorded using an audio recorder. The interview was later transcribed verbatim to text.

I conducted semistructured interviews with open-ended questions (see Appendix A). Each participant was interviewed for approximately 60 minutes. The case study interview protocol guided me to stay on topic and take notes during the interview process (see Appendix A). I used member checking to verify the accuracy of participants' saved e-mail responses to the interview questions. The three participants who used e-mail technology and their personal computers were satisfied with their responses to their interviews. The face-to-face interviewee listened to their audio-recorded interview and was satisfied with what they heard. Each participant was thanked for their participation in the study. Although there was no compensation for participation, a copy of the research findings was offered to them upon request, and all participants requested a copy of the findings (see Appendix B).

Data Analysis

Based on the nature of the research design, an inductive data analysis was used, using hand coding presented by Taylor and Gibbs (2010) and Yin (2009), and several case study analytical strategies. According to Taylor and Gibbs, "coding is a process of combing through the data looking for themes, ideas, and passages and marking passages with a code label to easily retrieve at a later stage for comparison and analysis" (p. 1). Other things that could be coded during data analysis process were the "participants'

specific acts, behavior, and activities" (Taylor & Gibbs, 2010, p. 1). The second phase of hand coding consisted of reading and rereading the raw data in the e-mailed interviews, searching for five or six themes, categories, ideas, expressions, or passages, and assigning codes labels to each (Taylor & Gibbs, 2010; Yin, 2009). In addition to hand coding, Yin also recommended four analytic case study strategies for data analysis. For my case study, I chose the three following analytic strategies to compare and analyze the multiple cases: cross case analysis, pattern matching, and rival explanations. Cross case synthesis was used to analyze each individual or case, individually and collectively, looking for themes, ideas, passages, specific acts, behaviors, or activities from the raw data (Taylor & Gibbs, 2010; Yin, 2009). Pattern matching was used in the same manner, looking for similar patterns, within and across the multiple cases, individually and collectively, to discover emerging themes, similarities, categories, ideas, expressions, or passages, or differences to analyze and compare to the study findings (Taylor & Gibbs, 2010; Yin, 2009).

The last analytic strategy was rival explanation described as any discrepancies in the data. In my study, I considered P#1 as a possible discrepant case due to his/her nonrecovering status and not actually experiencing stigma as recovering counselors did. I reviewed and considered his/her e-mail interview and tried to understand his/her position toward stigmatization. I found his/her answers to the interview questions and his/her experiences working with recovering counselors to be credible. Therefore, there were no discrepant or rival cases during the data collection and data analysis processes. Data from

each interview were labeled under the following pseudonyms to protect participants' identity and confidentiality after the interviews: Participant 1 = P#1, Participant 2 = P#2, Participant 3 = P#3, and Participant 4 = P#4.

Issues of Trustworthiness

According to scholars, it is imperative that the researcher establishes confidence in the trustworthiness of his/her study by ensuring that the meanings of the study represent the authentic experiences described by the participants (Houghton, Casey, Shaw, & Murphy, 2013; Lietz, Langer, & Furman, 2006). When it comes to concepts such as internal/external validity, reliability, and objectivity that are normally found in quantitative research, the terms vary in qualitative research as qualitative researchers have developed their own concepts (Davies & Dodd, 2002; Lincoln & Guba, 1985; Seale, 1999; Stenbascka, 2001). According to Houghton et al. (2013), there are four approaches to establishing trustworthiness in qualitative research: credibility, transferability, dependability, and confirmability to judge both the quality and trustworthiness.

Credibility

It is important that readers of my study are able to trust the study findings and have confidence that the study was conducted in an ethical and appropriate manner. Credibility concerns internal validity and established believability in how the research was conducted and interpreted by its rich description (Houghton et al., 2013; Morrow, 2005; Thomas & Magilvy, 2011). Morrow (2005) stated, "rich description involves not only a description of participants' experiences of the phenomena but also of the contexts

in which the experiences occur" (p. 252). Credibility was established in my study through member checking, where at the end of each saved e-mail interview and face-to-face audio-recorded interview, each participant was offered the opportunity to verify the accuracy of his or her interview responses (see Goetz & LeCompte, 1984; Merriam, 1998; Morrow, 2005). Because I was the primary data collection instrument and it was my interest that led me to conduct this study, I engaged in reflexivity throughout the study to remain objective. I used brackets for any biases and prejudices I may have had (see Goetz & LeCompte, 1984; Merriam, 1998; Morrow, 2005).

Transferability

Transferability refers to the ability of an individual reading the study to transfer the findings to another researcher's study (Morse, 2015). Merriam (1998) added that rich, thick, description, typically and in multiple cases, improves external validity. It is important that the researcher of the original study provide thick descriptions and variations in participant selection, methods used, and presentation of results so that other investigators can decide on their own if the results are transferable (Houghton et al., 2013; Yin, 2009, 2014). In my study, I provided thick descriptions through the saved e-mail and face-to-face interviews conducted, participant variation, the methods used, and the presentation of results to aid transferability.

Dependability

Dependability, according to Merriam (1998), "explains the investigator's position, creates an audit trail, and use reflexivity to improve the reliability of a qualitative study"

(p. 172). In my study, as the primary investigator, I addressed dependability by explaining my position in the section, Role as a Researcher. Dependability is determined by keeping a chronological audit trail of my research decisions, the influences that could have affected the data collection, analysis of data that provide confirmability, and discernment concerning how the study's interpretation was made (Houghton et al., 2013; Thomas & Magilvy, 2011). In my case study, several strategies I used to establish data dependability were (a) the use of a case study interview protocol and (b) the creation of a case study database (Yin, 2009, 2014) similar to an audit trail. The case study interview protocol (Appendix A) was the instrument that contained the procedures and general rules for the researcher to follow in carrying out data collection through the semi structured interviews (Yin, 2009, 2014). Another appropriate strategy to establish data dependability is the creation of a formal presentable database so that other investigators can review the evidence directly and not be limited to a written case study report (Yin, 2009, 2014). The case study database consisted of my hand-written notes, e-mail correspondence, raw data from the interviews saved to my home computer, the audio-recorded interview/tape saved in my home office, and the narratives/transcripts of participants to compare open-ended answers to all interview questions. Therefore, dependability was established in my study.

Confirmability

Confirmability is the researcher's ability to remain objective (Morse, 2015). Confirmability is ensuring that the responses received from the interviews I conducted

were the life experiences of the participants (see Korstjens & Moser, 2018) and not mine. This is achieved by providing actual quotes from the participants of the study (Cope, 2014). To aid in confirmability, I also bracketed my biases and prejudices accordingly to ensure that the data obtained were directly from the participants.

Ethical Considerations

The participants in the study were adults (men and women) who volunteered to participate in the study. The study involved possible minor discomfort encountered in everyday life, such as stress or anxiety during interviews. The study did not pose any risk to the participants' physical safety and wellbeing due to using e-mail technology and personal computers in their home environments to conduct the interviews. The audio recorder was used for the face-to-face interview, and the interview was later transcribed. Copies of the e-mailed/face-to-face interviews and audio recorder were placed in a manila envelope in a locked box in my home computer for safety and future reference. After the interviews, member checking was offered to each participant to verify the accuracy of their interview response and interpretation. The interviews provided contextual and descriptive information, highlighting meanings, themes, patterns, and direct quotes from participants' responses.

To bring the case study to closure, I wrote a final case study report (see Yin, 2009, 2014) with a robust description of the multiple case study outlining each method of analysis. I also followed Walden University Institutional Review Board (IRB) requirements' legal framework for a study involving human subjects. Prior to conducting

my research study, I obtained approval from Walden University' IRB, where they assigned my study the IRB number: #02-20-18-0312716.

I informed all participants that they might experience minor discomfort, such as stress or anxiety, during the interviews. Three participants were informed that the interviews would be conducted via e-mail technology, using their home computers, in home environments, at a scheduled time, to be safe. The individual who participated in the face-to-face interview was also informed of the possibility of minor discomfort during the interview conducted in my home office. This audio-recorded interview was later transcribed verbatim to text. Although not required for case studies (Yin, 2009), member checking was used to verify the accuracy of participants' interview responses. Participants' names remained anonymous. They were informed that I would be the only one with access to their identity. To protect the identity of each participant, I used a numerical method of identification, such as P#1, P#2, P#3, and P#4. All participants were thanked for their participation in the study. Although there was no compensation for their participation, they were told that a copy of the findings would be made available to them upon request. All participants requested a copy of the findings.

During the semistructured, open-ended questioning, I used a case study interview protocol (Exhibit C) that contained the research questions, the interview questions, follow-up questions, sub questions, and potential prompts. After data collection, I maintained and saved all data from my study to my home computer; I also saved all data through the creation of a case study database in a locked box with combination password

in my home office according to the record keeping requirements of Walden University. The case study database consisted of all research: the data and e-mail correspondence, my hand-written field notes, the saved e-mail semistructured interviews, the transcribed face-to-face interview, the audiotape and audio recorder, the saved responses to the interviews, and other data accumulated from my research. In accordance with Walden University IRB's ethical and record keeping policy, I will maintain these documents for at least 5 years. After 5 years, I will destroy all documents through the process of burning.

Summary of Chapter 3

In Chapter 3, I described the qualitative, multiple case design, and I outlined my research rationale and design, the role of the researcher, the qualitative methodology, the participants of the study, instrumentation, procedures, data collection, data analysis, issues of trustworthiness, and ethical considerations used in the study. In Chapter 4, I will present the results from my qualitative, multiple case study. I will conclude with a table of results and a summary.

Chapter 4: Results

Introduction

Chapter 4 of this qualitative, multiple case study begins with the purpose of the study, a review of the research questions, my recruitment efforts, and the research settings. In this chapter, I also discuss the participant demographics, data collection, data analysis, evidence of trustworthiness, and research results. The chapter concludes with a summary.

The purpose of the study was to explore the impact of stigma on the life experiences of recovering counselors in a midwestern state in the United States. Across 15 months, after using multiple techniques and methodologies, four recruiting efforts failed to secure participants. I repeated the first recruitment effort outreach to 21 counties. Following four rounds of outreach, I expanded my efforts to social media to recruit professionals. Using the two large platforms of LinkedIn and Facebook, I used snowball sampling to build a sample; no participants emerged. Following these unsuccessful efforts, I reached out to the 12-step communities of AA, NA, and CA; attended the NA convention in Detroit, Michigan; and used social media messaging and e-mail technology. No participants emerged from the 12-step communities. Finally, using the social media platform of Facebook, social messaging, the snowball sampling method, and e-mail technology, I recruited four professionals to participate in the study. To participate in the study, all participants met the following eligibility criteria: (a) be licensed or

credentialed in their state as a professional or counselor, (b) have worked in the addiction/counseling or related fields, and (c) have worked with recovering counselors.

Research Questions

The following research questions guided this study:

RQ1: How do recovering counselors describe the impact of stigma on their professional experiences?

RQ2: How do recovering counselors describe the impact of stigma on their personal experiences?

RQ3: For recovering counselors, what are the real-life experiences of stigmatization in the addiction field?

Research Setting

Three of the interviews were conducted in the participants' respective home environments using their private home computers and e-mail technology to respond to the interview questions. One participant was interviewed in my home office for privacy; this interview was audio recorded and later transcribed. The three participants who were interviewed over e-mail were also e-mailed the informed consent form. They were encouraged to read it, consent to participate in the study, then e-mail the consent form back to me stating, "I consent." In the face-to-face interview, the participant read the consent form, agreed to participate, and signed the form in my presence. After the receipt of the e-mailed and written consents to participate in the study, the interviews took place with each participant, having been scheduled according to his or her professional

schedules. All interviews lasted at least 60 minutes. The interview questions were sent to each participant 24 hours before the actual interview via e-mail in order to provide time for reflection (see Flaherty, Kurtz, White, & Larson, 2014). At the end of the interviews, each participant was afforded the opportunity to add any thoughts about the nature of his or her personal experiences not addressed by the interview questions as well as for any desired revision (see Flaherty et al., 2014).

To ensure the accuracy of the participants' responses to the interview questions, I saved the three e-mailed interviews to my home computer and placed the transcribed, face-to-face interview along with the audio recorder in a manila envelope in a lock box in my home office for protection and future reference. My home office computer was password protected, and my lock box had a combination password to protect and store the raw data. The raw data from data collection, data transfer, and archives will be kept in my home office for approximately 5 years. After 5 years, the data will be destroyed by the process of burning as required by Walden University.

Demographics

The participants of the study were three recovering counselors and one nonrecovering counselor that were recruited through social media. Based on literature regarding saturation and sample sizes in qualitative research (Crouch & McKenzie, 2006; Mason, 2010; Townsend, 2013), saturation was met when no new information emerged from the data. Although not the focus of the study, each participant was asked at the beginning of his or her interview to introduce himself or herself and present his or her

demographics of age, gender, ethnicity, years in the counseling field, credentials, years in recovery, and occupations.

The ages of all participants ranged from 57 to 65 years old: 57 (male), 57 (female), 64 (male), and 65 (female). The ethnicities of the participants was: two European Americans (i.e., male and female) and two African Americans (i.e., male and female). Three participants were professional recovering counselors, and one participant was a nonrecovering professional counselor. The participants' years of counseling in the addiction and counseling fields ranged from 10 to 22 years. The credentials of each participant were the following: Licensed Bachelor Social Worker, Certified Clinical Supervisor; Licensed Master Social Worker; Certified Peer Recovery Coach- M; and Bachelor of Arts, Certified Alcohol and Drug Counselor - III, respectively.

Data Collection

I was able to invite and recruit four participants through the snowball sampling method. All participants met eligibility criteria. Three interviews took place in each participant's home environment through the use of his or her personal computer and e-mail technology to respond to the semistructured, open-ended interview questions. All interviews were schedule for 60 minutes and in accordance with the participants' professional work schedule. The face-to-face interview was scheduled and conducted in my home office; I used an audio recorder to capture the participant's responses.

As the primary data collector, I used a case study interview protocol (see Appendix A) that included the interview questions derived from the research questions,

follow-up questions, subquestions, and prompts to gather a thick description of each participant's experience. The interviews consisted of asking three interview questions along with follow-up questions and prompts to explore the perceptions, attitudes, and experiences of the three recovering and one nonrecovering counselor pertaining to stigmatization while working in the addiction and counseling fields. All participants were asked the same questions but not in the same order. I used the participants' responses to gain a better understanding of stigma in the context in which the participants lived and worked as well as the knowledge of stigmatization among recovering counselors.

Data saturation was met when no new information was gleaned from the interviews. There was no variation from the plan presented in Chapter 3, and no unusual circumstances were encountered in the data collection process. As stated previously, member checking was offered to all participants to ensure the accuracy of their responses to the interview questions. Each participant was asked to review his or her saved interview, on his or her personal computer, in order to verify the accuracy of their responses or for any revisions. The use of the case study interview protocol and proper equipment during the interviews helped to address the issues of quality assurance (see Janesick, 2011) and content validity.

Data Analysis

I conducted an inductive data analysis using hand coding and several case study analytical strategies. According to Taylor and Gibbs (2010) "coding is combing through the data looking for themes, ideas, and passages, marking those passages with labels to

retrieve later for comparison and analysis" (p. 1). Other things that can be coded and labeled are the participants' sharing of their behaviors, activities, and experiences (Taylor & Gibbs, 2010). Although Yin (2009) recommended four analytical strategies to use in case study analysis, I chose three, namely "cross-case synthesis, pattern matching, and rival explanations," to analyze and compare the multiple cases (pp. 160–161). The combined data processes and analysis consisted of the following hand-coding process: (a) organizing the raw data; (b) reading and rereading the four interviews, both individually and collectively; (c) looking for key words, ideas, phrases, passages, and sentences, line-by-line; (d) sorting through the interviews from each case, both individually and collectively; (e) using cross-case synthesis looking for themes, categories, similarities, or differences, within and across cases; and (f) using pattern matching to analyze and compare the patterns and emerging themes from the multiple cases (see Taylor & Gibbs, 2010; Yin, 2009, 2014). After thematic analysis, I identified *what* participants experienced and *how* they experienced it. After data saturation was achieved, the emergent common themes were stigma, salient experiences, recovery, helping others, and gratitude for research participation (see Appendix B).

Evidence of Trustworthiness

To judge the quality of this multiple case study, I examined its results and processes through the lens of the following concepts: (a) credibility, (b) transferability, (c) dependability, and (d) confirmability (see Goetz & LeCompte, 1984; Merriam, 1998; Morrow, 2005; Yin, 2009).

Credibility

I established credibility in this study through member checking; at the end of each e-mail and face-to-face interview, I asked the participant to verify and ensure the accuracy of his or her responses to the interview questions. Saturation occurred when no further data could be retrieved from the semistructured interviews, establishing credibility. I used cross-case synthesis, pattern matching, and rival explanation to analyze and compare the raw data from the interviews, treating each as an independent study (see Yin, 2009). I also used multiple cases to strengthen the study findings (see Yin, 2009). It was my personal interest that led me to conduct this study. As the primary data collector, I engaged in reflexivity to bracket my biases and prejudices throughout data collection and analysis.

Transferability

Transferability refers to the ability of the individual reading the study to transfer the findings to another researcher's study (Morse, 2015). It is important that the original study provide thick descriptions of and variation in participant selection, methods used, and presentation of results so that other researchers can decide on their own if the results are transferable (Houghton et al., 2013). In this study, I provided thick descriptions through the saved e-mail and audio-recorded face-to-face interviews conducted, participant variation, data collection, and the presentation of results in a Microsoft Word table so that another researcher can transfer the findings of the study.

Dependability

According to Merriam (1998), "explaining the investigator's position and creating an audit trail improves the reliability of the qualitative study" (p. 172). In this study, I addressed my position in the Role of the Researcher section. Dependability is determined by keeping a chronological audit trail (Merriam, 1998) or, for case studies, keeping a case study database (Yin, 2009). The case study database consisted of my position as a researcher, the topic of interest, how my decisions were made, hand-written notes, e-mail correspondence, responses from the interviews, interview transcripts, the recruitment and selection of participants, methods used in data collection and data analysis, and ethical considerations to establish data dependability (see Houghton et al., 2013; Thomas & Magilvy, 2011; Yin, 2009). I also used reflexivity throughout the study to bracket my biases and prejudices accordingly to remain objective (see Goetz & LeCompte, 1984; Merriam, 1998; Morrow, 2005; Yin, 2009).

Confirmability

Confirmability refers to the researcher's ability to remain objective (Morse, 2015; Yin, 2009, 2014). Throughout this study, I ensured that the responses received from the interviews concerned their life experiences and were not mine. I provided actual quotes from the participants' raw data and interviews (see Cope, 2014). I also used a peer colleague to review, verify, and confirm the data results of the study. As primary data collector of this study, I used reflexivity to bracket my biases and prejudices to remain objective throughout the study.

Research Results

This study was conducted to explore the impact of stigma on the actual life experiences of recovering counselors who are working in the addiction and counseling fields, and within the counseling profession in a midwestern state in the United States. After analyzing the data/responses from the interview questions listed in my case study interview protocol (Appendix A), and using the process of hand coding, five themes emerged: (a) stigma, (b) salient experiences, (c) recovery, (d) helping others, and (e) gratitude for research participation (Appendix B). Each description of the themes was compiled based on the responses of the participants. Several coded words were generated from the participants' responses and provided similar meaning for discovering the five themes. A discussion of each theme was supported by pages of the participants' own words extracted from the semi structured transcripts.

Theme 1: Stigma

According to the results of the study, stigma was the primary theme across all data given the focus of the interview questions. In the context of asking participants about their experiences in the addiction and counseling fields, as a recovering nonrecovering counselor, three counselors described stigma as having a significant impact on recovering counselors (P#1, P#3, P#4) while one counselor (P#2) reported a minimal impact. With the knowledge that stigma is a universal phenomenon based on negative assumptions, concepts, and generalizations (Lloyd, 2013), it is not surprising to find that individuals' personal, social, and professional lives are impacted negatively by it. P#1 said,

> as a nonrecovering counselor … stigma prevents most of us from identifying openly as wounded healers … or people in recovery from addiction …stigma prevents individuals from being their true selves and forcing them to carry a hidden burden/secret to avoid further stigmatization.

P#1 had concerns that stigma leads to negative stereotyping that devalues people. P#3 described his first experience in the addiction field as "cultural shock" where city officials and the people he worked with were very judgmental about his credentials and the role he played as a recovering counselor in helping inner city youth.

P3# felt that this type of stigma carried social disapproval based on negative connotation and stereotyping with minor slights/snubs that tried to isolate him from being accepted in mainstream society. In this incident, P#3 felt that stigma was used to exclude him from being accepted in the mainstream society, and it contributed to the pain he felt while attempting to establish social relationships. P#4 asserted, "my personal belief and experience is that stigmatization comes with anything the majority does not understand and (is) not willing to learn about." According to Jones (2018), stigmatization can be damaging in social relationships by separating those stigmatized as "us" from the majority of society classified as "them" (p. 1). Because stigma prevents individuals from being their true selves, many victims hide their true selves and may not know they are in denial regarding the effects of stigmatization (see Doukas & Cullen, 2011; Jones, 2018; Lloyd, 2013).

P#2 pronounced that her experiences (with stigma) in the addiction field as a recovering counselor was minimal over time. P#2 added,

> as with anything, the more years a person has in the field, the more respected they become … stigma appears to be lessened… stigma is not a factor when recovering people show due diligence, earn respect through due diligence and perseverance … and obtain that credential needed to become a professional.

Villa (2019) supported P#2's assertion that, obtaining the credential through education could have lessened the impact of stigma in his/her personal experience (also see Mulvey et al., 2003; Rieckmann et al., 2011; Sias et al., 2006; Stoffelmayr et al., 1999). According to Doukas and Cullen (2011), "recovering counselors decided to conceal their recovery status and substance abuse histories due to the stigma associated with addiction" (p. 1). The lack of knowledge about the addiction process, combined with negative beliefs/attitudes that stem from the stigma of addiction (Lloyd, 2013), isolates rather than includes the recovering counselor in the mainstream (Brown, 2000; Tajfel, 1984). P#1 further stated,

> Stigma is experienced throughout the workplace: mental health practitioners tend not to understand much about addiction treatment and (are) fearful of what they do not understand … colleagues and supervisors who do not have lived experiences tend to be prejudicial and unhelpful.

P#1 also stated,

> Stigma prevent us from getting our needs met in processing and releasing the difficult nature of the work which results in us having less to offer to our friends and family personally because we repeatedly experience compassion fatigue and burnout.

Thus, stigma based on negative assumptions, concepts, and generalizations pervades the lives of its victims: they are labeled, devalued, and receive unfair treatment, and are excluded by society (Brown, 2000; Lloyd, 2013; Tajfel, 1984; Villa, 2019). P#4 restated the following about stigma,

> my personal belief is that stigmatization comes with anything that a majority does not understand and (is) not willing to learn about ... I am not hopeful of its impact on recovering people's lives that could interfere with their recovery chances … I have had employers who prefer that I don't self-disclose but I do because it is my story, my truth, and my example to give … I have found that my sharing … gives my clients hope that they can recover too.

In this experience, public stigma of addiction has produced barriers for those seeking recovery; yet, help and hope are available to reduce those barriers (Ham et al., 2013). P#2 reported,

> I have experienced some counselors who are judgmental, however, for the larger picture, I have been approached from counselors who do not know about addiction and have asked me to help them … they request information about services available, want information about addictive behaviors they have witness

> in their consumers; and I have also been asked to take consumers onto my caseload because the counselor felt the consumer could be better served by my services … I have received praise for helping those same people turn their lives around.

Despite the stigma of addiction and disapproving views held over the heads of recovering counselors, recovering counselors provide invaluable information regarding their personal and professional experiences for those who are seeking help and hope (Curtis & Eby, 2010; Lloyd, 2013). P#2 explained further

> I have been requested to join medical teams to help address the opioid epidemic … as with anything, the more years a person has in the field, the more respected they become and stigmas appears to be lessened … stigma is not a factor when recovering people show due diligence, earn respect through due diligence and perseverance … obtain that credential needed to become a professional.

This experience shows that recovering counselors with credentials, who have practiced due diligence in the late 20th and in the 21st centuries, differ from those perceived as uneducated and incompetent by the moralistic attitudes of the 1940s and earlier (Curtis & Eby, 2010; Mulvey et al., 2003; Rieckmann et al., 2011; White, 2000).

Theme 2: Salient Experiences

According to Eatough and Smith (2008), salient experiences are prominent or conspicuous events that have occurred in participants' life experiences through their perceptions, feelings, and contacts of their human experience (also see Lloyd, 2013). The

participants offered personal and spontaneous responses about the delicate topic of stigmatization in their professional, social, and personal experiences in the addiction and counseling fields with no apparent upset (P#2, P#3, P#4). An individual's direct involvement with the stigma of addiction will cause a person to define "in their own words" his/her professional identity that shaped his/her professional life (P#1, P#2, P#3, P#4). P#1 asserted,

> I identify openly as a wounded healer … I do very much identify with people in recovery … I find it easy to understand clinicians but undesirable to relate to most of them because most work from a persona … my experiences with professionals who have been through addiction recovery are far more genuine than our colleagues who have not … while I have not identified as a person with a substance abuse disorder, (which is odd considering I am addicted to two drugs, caffeine and nicotine), I do find I relate very well.

Hence, the stigma of addiction on salient experiences continues to stand out between recovering and nonrecovering counselors (Lloyd, 2013). Derald (2010) reported that experiences of prejudicial attitudes and group salience influence the quality of intergroup conflict by generating negativity (see Brown, 2000; Lloyd, 2013; Tajfel, 1984). P#2 also proclaimed,

> Licensure with the state had its challenges as every time I have to renew, I have had to review my criminal history as a result of my addiction when I was younger

> …I sometimes find myself wondering why I have to continue reviewing the past when I am sure, it is documented in the files.

In this scenario, life experiences demonstrate those microaggressions defined by Derald as, “everyday, verbal/nonverbal, and environment slights and snubs, whether intentional or unintentional, communicate hostile, derogatory, or negative messages to target persons based solely upon their marginalized group membership” (p. 1), who, in my case study, are recovering counselors. P#2 added, “Another experience I have experienced is reverse stigma which is a direct result of the transference, countertransference issues… I have known counselors who have gotten into very inappropriate relationships.” While it is true that clients can transfer an unconscious feeling, desire, or expectation to the therapist, likewise, the therapist can have a strong emotional reaction toward the client, and both can be managed therapeutically without stigmatization (Derald, 2010; Toriello & Benshoff, 2003). The combination of stigma and salience leads to negative stereotyping that results in prejudicial treatment and discrimination in an individual’s life experience, based on perceived or actual membership of a marginalized/stereotyped group (Brown, 2000; Derald, 2010; Lloyd, 2013; Tajfel, 1984). P#3 said,

> There was a major setback doing an inner-city project to provide a different outlook for inner city youth called life skills … due to my involvement in the project, the program was shut down … my credentials were questioned and a great blow to my journey in doing this type of work.

The participant's perception of this life experience caused him/her to internalize the interaction within this social context that challenged him/her and reinforced the stigma of addiction at interpersonal and systemic levels (Lloyd, 2013). According to Taylor and Fiske (1978), "salience can affect the perceptions of people who are a member of a stereotyped group due to the stigma of addiction" (p. 1). P#4 elaborated,

> As a recovering counselor with 30 years of uninterrupted sobriety, working in the counseling field, the real-life experiences of stigmatization have been interesting at best … some peers expect me to be unique … some felt threatened by what I know … some question my intent and motives when sharing opinions … some treat me as though I don't need to continue attending meetings, and by doing so, discredit the recovery programs of AA/NA/CA/Me.

According to Stewart (2014), the mainstream society still does not understand the ramifications of addiction on individuals (also see Lloyd, 2013). P#4 added,

> Others act as if … I don't need sober support but should be supportive of everyone who needs a sponsor or a ride to and from meetings … when I am not seen doing what others in addiction do, I am seen as a dry drunk, arrogant, facetious, or just selfish ... the stigma has been minimal in affecting who I am and what I do … my earned integrity in the field, both overrides those stigmas of me and my past aggressions today … that's what I did, not what I do today.

Although the public's perceived lack of compassion and understanding of stigma are manifested in subtle and explicit ways, positive life experiences and earned integrity will

produce a different person from a person's past addiction (Green, 2015; Stewart, 2014; Stoffelmayr et al., 1999).

Theme 3: Recovery

According to Elkins (2018), recovery is a life-long process of improving an individual's health and wellbeing while living independently to overcome the disease of addiction: that process has developmental milestones (p. 1). Each stage of recovery has its own risk of relapse, even though the person is not cured (Green, 2015; Stoffelmayr et al., 1999). Elkins explained that "addiction is a disease that required disease-specific treatment, and those addicted must be willing to change their outlook on life, their behaviors, and their environment" (p. 1).

In this study, all participants shared their number of years in the addiction and counseling fields (P#1, P#2, P#3, P#4). P#2, P#3, P#4 shared their years of sobriety in recovery, and P#1, as a nonrecovering person reported no years of recovery. Recovery from addiction starts with a desire to change and the belief that a person can overcome the disease (Elkins, 2018; Green, 2015; Stoffelmayr et al., 1999). P#1 stated,

> Although I do not identify as a recovering counselor, I identify openly as a wounded healer and identify with people in recovery… my experience with professionals who are going through addiction recovery is that they are far more genuine than us colleagues who have not … the key to their success has been to find kindred spirits … who are willing to be open and honest about our experiences past and present … in general, they do not feel supported by their

> colleagues or their employers … we locate peers who are willing to share their experience, strength and hope. (p. 1)

Individuals in recovery must be able to share with others because sharing allows them to release pent-up stress and tension while providing hope to others by helping them to make sense of their internalized feelings, concerns, and problems (AA, 1976; Brown, 1985). According to Brown (1985), the first step toward recovery is acknowledging that drug abuse is a problem disrupting a person's life: those individuals seeking recovery must ask for help by attending a substance abuse program and/or a self-help group (p. 1). P#2 said, "I am a 57-year-old Caucasian female, recovering from alcohol and drugs… I have 25 years and 7 months at the time of this interview" (p. 2). Elkins (2018) proclaimed that the lifelong process of recovery is a difficult one and requires effective treatment and a safe environment of support to empower a person to overcome the disease and live a more fulfilling lifestyle (Curtis & Eby, 2010; Green, 2015; Stoffelmayr et al., 1999). P#3 stated,

> I am a 64-year-old, Afro-American male, who has been in the field of prevention and treatment for 10 years or better now …my life experiences led to a cry for help, detoxification, treatment, and the Narcotics Anonymous program that helped me turn over a new lease and outlook on life.

In this life experience, some individuals may require a drug/alcohol detoxification program as their first step toward recovery because they were unable to stop on their own prior to starting treatment: Alcohol withdrawal, for example, can lead to severe

consequences if left untreated (Green, 2015; Stoffelmayr et al., 1999). According to Talcherkar (2019), attending NA and AA meetings, based on the 12-steps of recovery, can also enhance the quality of life (see AA, 1976; Green 2015; Stoffelmayr et al., 1999). According to Baker (2017),

> addiction recovery is hard work, and the path to recovery is a long and winding road because (a) addiction is a chronic disease, (b) the user's brain produces less dopamine to compensate for the overwhelming urges he or she had experienced with drug use, (c) co-occurring mental health issues still exist, and (d) oftentimes those who have been caught up in drug abuse must change their support system and circle of friends if recovery is to work. (p. 1)

P#4 said,

> I am a 65-year old, Black, female, with two grown daughters … who got my life together after 19 years of drinking and living an illegal lifestyle … I have been in treatment once … my sobriety date was 30 years ago.

Uninterrupted sobriety, according to Fournier (2017), is

> uninterrupted sobriety requires six fundamental factors for success in addiction recovery: (a) readiness to change, (b) belief in their ability to overcome challenges, (c) maintenance of psychological and emotional wellness, (d) support that cannot be understated, (e) structure, and (f) productivity to avoid boredom from relapse potential. (p. 1)

Theme 4: Helping Others

Drug and addiction counselors believe in helping others because addiction is difficult to go through without assistance and support: they, themselves, know the long and difficult journey to recovery (Brown, 2019; Green, 2015; Stoffelmayr et al., 1999). Brown (2019) explained further that

> counselors … help those in addiction through their struggles, and provide guidance during the difficult times with their own personal experiences which provides them credibility because they have been down that road before and can carry personally the message of Step 12. (pp. 1-2)

According to Jones (2018), individuals who have an addiction are marginalized and stereotyped by the general society with markers of difference as subordinate to the dominant society: Such people have relatively low power, prestige, and economic position in society's system of social stratification, creating a classification construction of "not our kind," which is equivalent to "us" versus "them" (Jones, 2018, p. 1). P#1 said,

> I always say … "we" … that is meant to reduce stigma … when people in power speak of "populations" or worse, "those people," I immediately point out that those people are my people … I say "we" when referring to groups I cannot be part of, for example, women who survive sexual assault … I do this deliberately and only the astute notice, so, kudos to you.

Jones (2018) also stated that membership in the dominant group of society is not voluntary, and minority group members who are marginalized and stereotyped by the

dominant group based on “in-group consciousness,” experience the feeling of “us” versus “them” (see Brown, 2000; Lloyd, 2013; Tajfel, 1984). According to Jones, “the viewing of various groups as different and inferior by mainstream society, classifies these individuals as part of an out-group and have negative emotions about them” (p. 1). Recovering counselors can find a rewarding career as a substance abuse counselor as they remember how important their journey of recovery was to them while helping others with the recovery success (Brown, 2019; Green, 2015; Stoffelmayr et al., 1999). P#2 said,

> I have found my passion helping others understand the addiction and the changes that are necessary to arrest the disease … I have had disappointments when people fail, however, I did not ever give up on their ability to change their lives … I have experienced watching many successes people have had in turning their lives around as well … I have hope for people who do not have hope for themselves and I am their biggest cheerleader because I know it can be done and life can be good again.

The most important aspect of the recovery process is when recovering counselors share their struggles and past successes to help others on their journey to recovery (Brown, 2019; Green, 2015). According to Brown (2019), “sometimes the best motivation that drug and addiction counselors can provide to those in addiction is hearing what is possible and sharing their personal struggles toward recovery” (p. 1). P#3 said,

> I have a great deal of love and passion and empathy for the people I serve or work with … I help aid their recovery by encouraging them to get counseling … and

> look for better ways and means to deal with life circumstances and challenges… to help prevent things from going deeper or further out of control … which gives me the opportunity to be a vessel of hope … someone who can bring awareness when people have illnesses of addiction and substance abuse disorders.

As a vessel of hope, drug and addiction counselors develop a comprehensive plan of recovery tailored to meet the needs of the individual in recovery (Brown, 2019; Green, 2015). Recovering counselors can empathize with those caught in addiction and relate to their human experience because they have completed the 12 steps of recovery and, therefore, can help others understand why the steps are important (AA, 1976; Brown, 2019; Stoffelmayr et al., 1999). P#4 said,

> As a clinician, I have been rewarded in many ways … I am content helping others and being clean and sober … I have not found many instances as I self-disclose about my 19 years of use: drinking and drugging, living an illegal lifestyle of prostitution, stealing, lying, and neglecting my children … instead, my past has been a catalyst to help my clients and others in and out of the rooms of recovery … my self-disclosure is mine to disclose because when I do, it gives them hope and shows them that I don't have any judgments of them but instead, have compassion for their plight.

Giving back to the community because you "never want to forget where you came from" is important to recovering counselors because they are mindful that the struggles they

have faced are experiences that can help others on their journey to recovery (Brown, 2019; Green, 2015; Stoffelmayr et al., 1999).

Theme 5: Gratitude for Research Participation

According to McCullough, Emmons, and Tsang (2002), people are most likely to feel grateful if they perceive that they have had a positive personal outcome that they have either not earned, or are deserving of, as a result of the actions of another person and having a distinctive view of the world (see Green, 2015). Hence, gratitude is perceived to be the propensity to look at life in a particular way by noticing the positive things in life, such as a focus on the positive in the present moment (Green, 2015; Wood, Froh, & Gerahty, 2010).

All participants expressed gratitude for their invitation to participate in my qualitative, multiple case study. They appreciated the opportunity to share their experiences, strengths, and viewpoints while working in the addiction and counseling fields (Green, 2015; Stoffelmayr et al., 1999) According to McCullough et al. (2002), "people with a strong disposition toward gratitude have the capacity to be empathetic and to take the perspective of others; they are rated as more generous and more helpful by people in their social networks" (p. 1). P#1 said,

> This is what I would add to your questions: A person who, in any form of recovery, whether from substances, trauma, mental illness, eating disorders, or even cancer – in recovery from any form of hell – we tend to easily relate to and

> identify with others' experiences in different forms of hell… we are willingness to be supportive of each other and the possibilities are incredible.

According to McCullough et al. (2002), grateful people do not deny or ignore the negative aspects of life. P#2 also stated, "I thank you for the opportunity to be heard and to participate in your research … I would like a copy of the results when you have it completed." Gratitude is positively related to the facets of extraversion, agreeableness, openness, and conscientiousness (Wood et al., 2010). Andersson, Giacalone, and Jurkiewicz (2007) stated that "gratitude is associated with pro-social behavior and with people who display greater social responsibility" (p. 2). P#3 said,

> recovery has given us a better way of looking at every aspect of our lives … and I realize that recovery has allowed me to look at myself today, with some humor, and I'm so grateful for that … I'm truly grateful. (p. 1)

Gratitude is also associated with recovery in the 12-step programs: many sponsors suggest that their sponsees make a gratitude list (Craig, 2019). Gratitude plays a role in the recovery process and is implicated as a resultant character strength arising from such recovery (Craig, 2019; Curtis & Eby, 2010; Green, 2015; Stoffelmayr et al., 1999). P#4 said, "I thank you for the opportunity to participate in your research study … thank you and good luck." AA suggests as part of its 10th step of the 12-step program that the expression of gratitude is for blessings received (AA, 1976; Craig, 2019; Emmons & McCullough, 2003; Green, 2015; Stoffelmayr et al., 1999).

Summary of Chapter 4

The purpose of my qualitative, multiple case study was to explore the impact of stigma on the life experiences of recovering counselors in a midwestern state in the United States. All participants shared about the impact of stigma on their professional and personal experiences while working in the addiction and counseling fields today. All participants shared about salient real-life experiences, their experiences with recovery, helping others, and their gratitude for participating in my study. Five themes that emerged from the raw data were the following: (a) stigma, (b) salient experiences, (c) recovery, (d), helping others, and (e) gratitude for research participation (Appendix B).

In Chapter 5, I will reiterate the purpose and nature of the study and why I conducted it. I will discuss the interpretation of the study findings, the limitations and the implications of the study, recommendations for future study, and provide a conclusion. In Chapter 5, I will compare my study findings (Appendix B) with peer-reviewed literature described in Chapter 2. I will also analyze and interpret the findings in the context of the theoretical framework, SIT, which was the foundational basis of my study.

Chapter 5: Discussion, Conclusions, and Recommendations

Introduction

The purpose of this study was to explore the impact of stigma on the life experiences of recovering counselors in a midwestern state in the United States. In this study, I employed a qualitative, multiple case design that involved a snowball sample of four counselors. Semistructured interviews with open-ended questions were conducted with three participants using their personal computers in their home environments, while a face-to-face interview of one participant took place in my home office. A case study interview protocol (see Appendix A) consisting of the interview questions and follow-up questions to stay on track and focused on the topic of interest during the interviews was also used. The participants' responses to the interview questions provided information about the impact of stigmatization on the professional and personal experiences of recovering counselors who are working in the addiction and counseling fields and in the counseling profession itself. Confidentiality was discussed with the participants and maintained throughout the study. I saved the data and field notes collected from the interviews to my personal computer and kept physical notes in a locked box with a combination password in my home office for safety and future reference. The study was conducted to fill the gap in the literature and to provide pertinent data to shed light on the impact of stigma on the life experiences of recovering counselors in the addiction and counseling fields. Although many researchers have discussed stigma in historical studies

associated with recovering counselors, at the time of study there had been no current research conducted to understand this phenomenon.

As the theoretical foundation of the study, I used the SIT to help explain how the impact of stigma affected the professional and personal life experiences of recovering counselors in the addiction and counseling fields as well as in the counseling profession in general.

Interpretation of Findings

Due to the dynamic nature of the study and participants' responses to the semistructured interviews questions, I allowed the participants to validate their personal and professional experiences while working in the addiction and counseling fields. Participants' voices were heard through the semistructured interviews to gain a better understanding of the impact of stigma in their life experiences in their own words. I took limited field notes during the interviews and concentrated more on the participants' narratives as to what was said, how it was said, and what their actual experiences were while working in the addiction and counseling fields.

As expected, given the focus of the interview questions, stigma was the primary theme across all data. All participants used this word but held different positions about it. Three participants described stigma having a large impact, while another participant called its impact minimal. The impact of stigma was important to this study because historical literature revealed it was the first sign of stigmatization against reformed men and/or recovering counselors during the 1700s and 1800s (see Crothers, 1897a; White,

2000). The participants' responses aligned with the literature showing that stigma continues to exist today against recovering counselors in the addiction and counseling fields as it did in the 1700s and 1800s (White, 2000) despite the commitment of recovering counselors to these professions (Brown, 2000; Curtis & Eby, 2010; DePue & Hagedorn, 2015; Doukas & Cullen, 2011; Green, 2015; Lloyd, 2013 Tajfel, 1982).

Several counselors reported that stigma has had a significant impact on their professional and personal experiences, while others reported the reduced presence of stigma in their professional and personal lives. P#1 and P#3 spoke of stigma as a social disgrace or a perceived threat in the workplace and counseling profession among nonrecovering counselors, while P#2 and P#4, with the most sobriety and recovery (25 and 30 years, respectively), understood the impact of stigma in the professional and personal experiences of recovering counselors in the workplace and profession and found a way to address it. Doukas and Cullen (2011) reported that some recovering counselors who had been labeled, stigmatized, and disgraced by the moralistic attitudes of the past were forced to go underground to avoid reference to their substance abuse histories and recovery status (p. 1). Although Hecksher (2007), Gomez et al. (2005), and Toriello and Strohmer (2004) stated that recovering counselors have had successful recoveries, all four participants reported that stigmatization and stereotyping continued to plague them.

All participants identified and described at least one salient experience while working in the addiction and counseling fields, with no apparent upset. Taylor and Fiske (1978) reported that salience can affect the perceptions of people who are a member of a

stereotyped group due to the stigma of addiction. Although P#1 was a nonrecovering counselor, he or she stated, “I identify with those in recovery and witnessed the impact of stigma on recovering counselors in the workplace and the profession due to his coworkers’ and supervisors’ lack of knowledge about something they do not understand.” P#2 shared a professional experience with licensure stemming from her long past addictive lifestyle, while P#3 and P#4 shared the impact of internalized stigma as an invisible barrier that brought about shame, self-blame, and self-doubt in their professional experiences with coworkers while working in the addiction and counseling fields.

All participants shared their experiences, years of recovery, and years working in the addiction and counseling fields helping others. According to historical literature, reformed men, recovering alcoholics, lay therapists, and/or recovering counselors traveled the United States looking for other alcoholics to help achieve sobriety after achieving their own freedom from alcoholism (White, 2000). Today, through the spiritual temperance movements of AA, NA, CA, and the 12-step program of recovery, this work continues (AA, 1976; Kurtz, 1979; Kurtz & Ketcham, 1981; White, 2000). P#1, as a nonrecovering counselor, shared,

> I always say, “we” to reduce stigma … when people in power speak of “populations,” or worse, “those people,” I immediately point out that those people are my people … I do this deliberately and only the astute notice, so kudos to you.

P#2 stated, “I found my passion in helping others understand addiction and the changes that are necessary to arrest their addiction.” P#3 said, “I have a great deal of love,

passion, and empathy, for people I serve or work with … which gives me the opportunity to be a vessel of hope." P#4 stated,

> My past has been the catalyst to help my clients and others, in and out, of the rooms of recovery … my self-disclosure is mine to disclose because when I do, it gives them hope and show them that I don't have any judgments of them but, instead, have compassion for their plight.

Finally, all participants expressed gratitude for research participation and the opportunity to share their experiences about the impact of stigma in their professional and personal life experiences while working in the addiction and counseling fields.

According to McCullough et al. (2002), people with a strong disposition toward gratitude have the capacity to be empathetic and take the perspectives of others; they are rated as more generous and more helpful by people in their social networks. In my interpretation of the study findings, I compared the raw data from participants' responses to the interview questions to the historical literature described in Chapter 2 and found that the study results were consistent with the historical material and will extend these findings to the knowledge base in the discipline.

The theoretical foundation of this study, the SIT, states that people are shaped by their experiences and the relationships they have formed, based on cognitive processes of comparing their self to others based on established categories or classifications (see Bandura, 1996, 2001; Brown, 2000; Tajfel, 1982, 1984; Turner, 1982). Brown's (2000) version of SIT focused on the classic social psychological problem of the relationship of

the individual to the group through the four inherent problems in the theory, which are (a) "in-group bias, (b) subordinate status inequality, (c) stereotyping, and (d) intragroup homogeneity" (p. 745). It must be noted, at this point, that the discovery of the social psychological problem in SIT caused me to pause in my research because I realized the theory provided answers to the *how* and *why* questions I was asking as a researcher. Therefore, I contend that by first-hand exploring the impact of stigma on the life experiences of recovering counselors, I have strengthened the trustworthiness of the study findings (see Goetz & LeCompte, 1984; Merriam, 1998; Morrow, 2005; Morse, 2015).

Although there is no relevant literature or studies that show recovering counselors have their own social identity or the opportunity to fully participate in a social group or social affiliation as outlined by SIT (Curtis & & Eby, 2010), recovering counselors' social identification is with the counseling profession, seeking to have a positive social identity, social support, and legitimate professional group affiliation (Brown, 2000; Culbreth, 2000; Curtis & Eby, 2010; Tajfel, 1984). According to scholars, recovering counselors have acquired the appropriate education, academic master and doctorate degrees, counseling skills, licensures, certifications, and decorum, and they have signed the code of ethics to meet the requirements to be legitimate recovering counselors (Aiken et al., 1984; Doukas & Cullen, 2011; Mulvey et al., 2003; Olmstead et al., 2007; Rieckmann et al., 2011; Stoffelmayr et al., 1998).

It is imperative that the recovering counselor has a social identity, a support group, and membership affiliation (Bandura, 1996; Brown, 2000; Tajfel, 1982, 1984).

These identities should not be based on the SIT problems of in-group bias, subordinate status inequality, stereotyping, or intragroup homogeneity (Brown, 2000, p. 745) but, instead, on professional growth, education, credentialing, knowledge of the professional counseling (Mulvey et al., 2003; Rieckmann et al., 2011), and their past contributions (White, 2000) to the addiction and counseling fields as well as the counseling profession (Blume, 1977; Culbreth, 2000; Doukas & Cullen, 2011). It is my hope that policy makers and social psychologists will consider the study findings and revisit SIT and its problems in order to promote positive social change in professional practice in the addiction and counseling fields and the counseling profession itself.

Limitations of the Study

The chief limitation of this study was that the results are not generalizable beyond the small sample. This limitation was expected during the planning of the study, and it is common in qualitative research in general. The use of e-mail technology for most of the interviews may have been a limitation; however, I sought to mitigate any methodological weakness by using the same interview protocol for all participants. The decision to use e-mail was in response to the difficulty of recruiting participants, presumably because of the sensitive nature of the topic. A benefit to the use of e-mail was that participants could respond in the privacy of their own home and at a time convenient to them.

Recommendations

This study appears to be the first, qualitative, multiple case study on the impact of stigma on the professional and personal life experiences of recovering counselors

working in the addiction and counseling fields. No study to date has captured the voices of recovering counselors addressing the impact of stigma on their professional and personal life experiences in the addiction and counseling fields and the counseling profession itself in their own words. Although the focus of the current study was primarily on the impact of stigma on the life experiences of recovering counselors:

- Future research could be conducted regarding the impact of stigma on other subpopulation groups in the United States.
- Future research could also be conducted to explore the impact of stigma on those recovering counselors who have gone underground with their secret lives of substance abuse, recovery status, and their professional and personal life experiences.
- Future research could be conducted by other researchers to challenge the transferability and generalizability of the research findings of this case study.
- Future research could also be conducted to challenge the use of semistructured, open-ended interviews with e-mail technology on participants' home computers in their home environments versus the standard oral and verbal interview.
- A replicated study with additional participants may extend the knowledge and understanding of the impact of stigma on their life experiences. It would be beneficial to extend the research to include additional studies on the impact of stigma on counselors working with marginalized populations.

Implications

Although there is existing research that addressed stigma in other contexts, this study about the impact of stigma on the life experiences of recovering counselors in the addiction and counseling fields and in the counseling profession is a first**.** There were several implications to further explore the impact of stigma on recovering counselors in the addiction and counseling fields. These implications placed in the context of the addiction and counseling fields' professional practice and policy are the following:

- Researchers should focus on how recovering counselors cope with the impact of stigma. The findings from this study provided insight into the professional and personal life experiences of recovering counselors from their perceptions and experiences in their own words. This study will extend the research to the investigation of stigma, which is the phenomenon that spans across all cultures and domains. The findings of the study provided a clear understanding that stigma, although invisible, still exists in the addiction and counseling fields. In my study, there were no significant differences in the thought, beliefs, attitudes, and perceptions of the participants regarding the impact of stigma, which also provided evidence for the five themes. The study provided detailed, rich, and meaningful data necessary for workplaces, institutions, and policymakers to create positive social change regarding the impact of stigma upon the life experiences of recovering counselors.

- Regarding the methodological implications, I used the social media platform of Facebook to recruit four participants through the snowball sampling method. I also used semistructured interviews with open-ended questions via e-mail technology on participants' personal computers in their home environments. This method or strategy could be considered a methodological weakness due to the researcher being a novice in multiple case study design.
- Regarding theoretical implications, the SIT was the foundational basis of this study. The SIT provided the rationale for the choice of this theory, which was about the forming of social groups and how an individual identifies with a particular group, such as counselors, and wants to be part of its membership. Bandura (1996) stated that people are not independent of the world around them but are shaped by their experiences and the relationships they have. The premise of SIT is that the self is multifaceted and created by the interaction of the individual with society; thus, identity is formed based on cognitive processes of comparing a person's self to others based on established social categories (Bandura, 1996, 2001; Brown, 2000; Curtis & Eby, 2010; Tajfel, 1982, 1984; Turner, 1982). Therefore, SIT is a critical theory in understanding the impact of stigma on the life experiences of recovering counselors in the addiction and counseling fields. The SIT that undergirded this study provided pertinent information on the social perception of social groups and the stigmatization of recovering counselors (Brown, 2000; Curtis & Eby, 2010;

Tajfel, 1982, 1984; Turner, 1982). In SIT, Curtis and Eby (2010) described how recovering counselors' recovery status provided identity and meaning to their personal, social and professional lives, and commitment to the counseling profession. The goal of this study and the use of SIT was to show how recovering counselors identify with the counseling profession and qualify to be part of its membership (Bandura, 1996, 2001; Brown, 2000; Curtis & Eby, 2010; Tajfel, 1982, 1984; Turner, 1982). The information found in SIT from the perspective of recovering counselors has provided insight for policymakers and social psychologists to affect positive social change in professional practice, in the addiction and counseling fields, and in the counseling profession itself.

Conclusion

I have presented an examination of the impact of stigma on the professional and personal life experiences of recovery counselors in the addiction and counseling fields. This study's investigation of recovering counselors in the addiction and counseling fields is the first to focus on this marginalized group, by using a qualitative, multiple case design. The data fills the gap in the literature regarding the impact of stigma on the life experiences of recovering counselors in the addiction and counseling fields today. The moralistic attitudes and social thought of the 1700s and 1800s (White, 2000) and the social psychological theory (Brown, 2000; Tajfel, 1982, 1984; Turner, 1982) still regulate social groups and counseling behaviors, defining what is proper and good, and what is

needed for professional knowledge (Brown, 2000; Tajfel, 1982, 1984; Turner, 1982) in the counseling profession.

The participants of this study acknowledged the impact of stigma in their professional and personal life experiences. Findings from this current study (i.e., stigma, salient experiences, recovery, helping others, and gratitude for participation in the study) can be used to enhance policymakers', social psychologists', and other counselors' understanding of the impact of stigma in the addiction and counseling fields, and in the counseling profession itself. In my current study, I have shared my concerns for the inclusion of recovering counselors in the addiction and counseling fields and counseling profession with full recognition, equal treatment, and the opportunity to enjoy full professional status, just like their nonrecovering counterparts. Scholars have acknowledged that recovery counselors have acquired and earned the necessary educational requirements, doctorate degrees, trainings, and licensures to receive full recognition as professional counselors (Mulvey et al., 2003; Rieckmann et al., 2011). Policymakers and social psychologists can use the results of my study to make a difference in the addiction and counseling fields, and in the counseling profession itself.

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Appendix A: Case Study Interview Protocol

Introductory Statement

First of all, I would like to thank you for agreeing to participate in my research study. The interview will take approximately 60 minutes using your home computer and e-mail technology for your comfort. All of your responses will be confidential. I have already e-mailed you the research questions for you to reflect on what the interview format will be like today. For the interviewee in the face-to-face interview, the introductory statement was reiterated in my home office where the interview was audio-recorded and later transcribed.

The following is the alignment of the interview questions with the research questions:

RQ1: How do recovering counselors describe the impact of stigma on their professional experiences?

Interview Questions:

1. Tell me, what have been your experiences in the addiction field as a recovering counselor?
2. Follow-up: What has been the key to your success?
3. Describe any interferences, barriers, or roadblocks to your success?

RQ2: How do recovering counselors describe the impact of stigma on their personal experiences?

Interview Questions:

1. Tell me about your experiences that led to your decision to become a counselor?
2. Follow-up: What does being a counselor mean to you?
3. What were your experiences that brought you to this point?

RQ3: For recovering counselors, what are the real-life experiences of stigmatization in the addiction field?

Interview Questions:

1. Can you tell me about your experiences in and out of the workplace as a recovering counselor?
2. Follow-up: Can you describe your experiences with co-workers and supervision?
3. Can you describe your experiences with licensure or certification?

Closing Statement:

I would like to thank you for your participation in my research study. Before we end this session, I would like for you to review your e-mail responses to the interview questions to ensure the accuracy of your responses, or any changes, or revisions. By providing me with your experiences while working in the addiction and counseling fields, hopefully, these will contribute to positive social change in professional practice in the addiction and counseling fields. Although there is no compensation for your participation

in my study, a copy of the findings will be made available to you upon request. Once again, thank you: our interview session has ended.

Appendix B: Major Themes

Major Themes:	Significant Statements	No. of Sources
Stigma	It prevents us from being our true selves Stigma lessens over time w/education It was like cultural shock It's what those in Power say it is	4
Salient Experiences	I witnessed co-workers/supervision not understand addiction Licensure w/criminal background check Self-Disclosure experience with his/her employer	4
Recovery	I'm recovering from nicotine and caffeine, not substance abuse I have 25 years and 7 months of sobriety I have 10 years in the prevention field I have 30 years of uninterrupted sobriety	4
Helping Others	I identify as a wounded healer It is my passion to help others to change their lives I have great love and passion for those I serve and work with I like sharing my experiences with my clients without any judgment	4
Gratitude for Research Participation	We are willing to help each other and the possibilities are incredible Thank you for the opportunity to be heard and participate in your research I looked at myself today…and I'm grateful I thank you for the opportunity to participate …thank you and good luck	4

Appendix C: The 12 Steps (of AA)

(1) We admitted that we were powerless over alcohol, that our lives had become unmanageable,

(2) We came to believe that a Power greater than ourselves could restore us to sanity,

(3) We made a decision to turn our will and our lives over to the care of God as we understood him,

(4) We made a searching and fearless moral inventory of ourselves,

(5) We admitted to God, ourselves, and to another human being the exact nature of our wrongs,

(6) We were entirely ready to have God remove all these defects of character,

(7) We humbly ask Him to remove our shortcomings,

(8) We made a list of all persons we had harmed and became willing to make amends to them all,

(9) We made direct amends to such people whenever possible, except when to do so would injure them or others,

(10) We continued to take personal inventory and when wrong promptly admitted it,

(11) We sought through prayer and meditation to improve our conscious contact with God as we understood Him, praying only for knowledge of his will for use and the power to carry it out,

(12) Having had a spiritual awakening as a result of these steps we try to carry the message to alcoholics and practice these principles in all our affairs. (AA, 1976, p. 59-60)

Appendix D: The Promises (of AA)

(a) We are going to know a new freedom and a new happiness,

(b) We will not regret the past or wish to shut the door on it,

(c) We will comprehend the word serenity and we will know peace,

(d) No matter how far down the scale we have gone, we will see

how our experience can benefit others

(e) That feeling of uselessness and self-pity will disappear,

(f) We will lose interest in selfish things and gain interest in our fellows,

(g) Self-seeking will slip away,

(h) Our whole attitude and outlook on life will change,

(i) Fear of people and economic insecurity will leave us,

(j) We will intuitively know how to handle situations that use to baffle us,

(k) We will suddenly realize that God is doing for us what we could not do for ourselves,

(l)Are these extravagant promises? We think not,

(m) They are being fulfilled among us, sometimes quickly, sometimes slowly,

(n) They will always materialize, if we work for them. (AA, 1976, p. 84)