What is the nature of Loss and Grief in Addiction Recovery?

A Structured Literature Review and Review Article

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Abstract

Background:

Change is an inevitable part of life and there is always an element of loss associated with that change. When loss becomes too difficult for some people to bear, alcohol and drug use becomes an immediate remedy in 'taking out the edge' from fully experiencing the significant loss. And consequently, grief becomes suspended and unresolved, and substance use generates a host of problems for the substance user, their family, friends and society. Such losses, and subsequent grief, may be either mortal or non-mortal in origin.

Objectives:

The aim of this study is to obtain an overview and analysis of effective loss, grief and substance abuse interventions to inform future planning and work within alcohol and drug services in New Zealand. Three questions guided this review: (1) is there a relationship between, loss, grief and substance abuse? (2) Does addressing loss and grief in alcohol and drug counselling help reduce substance use and associated harms? and (3) What interventions are most effective in assisting alcohol and drug clinicians working with bereaved clients (Māori and non-Māori)?

Methods:

A structured literature review was conducted, searching CINAHL Plus, PsycINFO, Scopus, Medline, DRUG, and Social Work Abstracts Plus databases, commencing from start date of each database, and month the search were conducted in, October 2014. The search terms were grouped into three main search categories: 'Grief', 'Substance Abuse' and 'Interventions'. Eligible studies included: (1) interventions for loss, grief and addictions (2) measurement instruments used for examining grief and or addictions, and (3) full text articles published in English or Māori.

Results:

Despite searching the 6 databases and finding 11,963,418 references, only 7 articles were extracted that fit the inclusion criteria. In analysing these articles, 5 themes emerged and were explored: (1) the nature of loss and its relationship to substance abuse (2) socio-demographic factors of the bereaved (3) the use of assessment and screening instruments (4) grief interventions (individual and group therapy), and (5) the nature of specific populations (gender differences, mental health and substance abuse disorders, and indigenous populations).

Overall, the studies showed grief interventions helped to decrease symptoms of grief, substance abuse and mental health problems, and increased self-esteem, spirituality, confidence, and personal growth among the bereaved.

Limitations identified in the studies included limited demographic data, a lack of control groups, small sample sizes, and studies based primarily upon Caucasian and African-American individuals living in North America with one exception in Hungary.

Conclusion:

Despite abundant research on loss and grief, and on substance abuse, there is a paucity of studies being conducted on their co-existent relationship. It is clear from the findings that grief interventions are useful in helping the bereaved identify their losses, and help them to find purpose and meaning to their sorrow. Appropriate interventions led to an increased self-esteem, and reduced symptoms of grief and substance abuse. The findings guided fifteen recommendations for future research, practice and policy, including: (1) To explore the impact of strength based instruments and interventions of resiliency enhancement on grief and substance abuse relapse, (2) To explore and develop more culturally appropriate screen and assessment instruments, models, tools, and interventions related to loss, grief and addictions in Maori, Pacific Nations and other populations in Aotearoa New Zealand, and (3) that alcohol and drug clinicians, health professionals and social work practitioners be provided with specialized training in loss and grief.

Dedication

To my Heavenly Father and the Lord, I dedicate this paper and my life to you. Every day, every experience and every loss has turned out to be a wonderful blessing. My life has meaning and purpose because of you. I will always be eternally grateful. Thank you for always being there and granting me opportunities to live, love and grow.

To my beloved parents, Te Haupuru and Raiti and beloved brother Maru, I also dedicate this paper to you. I will always be indebted to your years of sacrifice, love and unwavering faith. Thank you for believing in me and watching over me. I live each day in honour of you. I love and miss you dearly.

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Chapter 1

1.0 Introduction

This dissertation explores the literature relating to adult clients presenting with loss and grief issues in Addiction counselling and rehabilitative settings. The results of a general review examining the literature relating to loss and grief and addiction are presented followed by a more structured systematic review. This topic was chosen for both personal and professional reasons as explained below.

The writer is a Māori woman from Tai Tokerau (Northland) nurtured by traditional Māori parents who raised approximately 30 tamariki (children); 27 were whangai, fostered from within the whanau whakapapa (family genealogy). The author's personal interest in learning about loss and grief first began after experiencing a major loss when my brother aged 40 years died suddenly of a heart attack 17 years ago. Since then there has been a series of significant deaths within the family totalling thirty; nine were unexpected and twenty one were anticipated deaths, eleven from cancer and ten due to elderly related illnesses. The writer observed that grief can be very debilitating on individuals, and it can either diminish or strengthen whanau (family) relationships. The writer also observed several surviving family members had increased their substance use to cope with their loss and grief, whilst others found comfort in embracing their spiritual beliefs and values.

The writer is also an Alcohol and Drug Clinician currently employed by the Community Alcohol and Drugs Services (CADS) where a high number of referrals are received from Department of Corrections, Mental Health Services, Hospitals, General Practitioners, Department of Child Youth and Families, other health and social services, concerned whanau members and clients. Many clients (Māori and Non-Māori) present at CADS with unresolved loss and grief issues, such as: death of a partner, child, family member, friend or pet; separations and divorce; loss of child/children custody; loss of employment and opportunities; declining health; loss of limb, organs or bodily functions; infertility, miscarriages, abortions; loss of role or position; loss of accommodation, drivers licence and transport; loss of freedom, privileges and rights; loss of respect, trust and support; loss of cultural identity, deprivation and oppression; and the loss of lifestyle connected to their substance use.

As a result of these experiences, I came to learn that going through losses really does hurt, and that talking about loss and grief helps to ignite the healing process (Gordon & Klass, 1979). This view was further supported by authors of *"Listen to my words, give meaning to my sorrow"*, claiming that talking about grief experience matters to the griever because it gives their story validity and transforms the healing process (Danforth & Glass, 2001).

The writer's own journey through the grief process grew into curiosity about *"what do Māori and Non-Māori clients of alcohol and drug services consider to be helpful during their times of loss and grief".* It is very difficult to be effective in addressing substance abuse first before grief or vice versa as both issues is often integrated. Therefore, in order to treat clients effectively and improve their long term prognosis, practitioners will need to be familiar with therapeutic interventions for both co-existing issues; grief and substance abuse.

1.1 Research rationale

According to the Business and Economic Research Limited (Berl, 2009), between 600 to 1000 people die each year from alcohol and drug related causes. More than half of the deaths are due to injuries (Connor, Broad, Rehm, Hoorn, & Jackson, 2005). In 2008, driving under the influence of alcohol and drugs had contributed to 103 fatal car accidents, 441 serious and 1156 minor injuries (Ministry of Transport (MOT), 2009).

In 2010 there were 21,235 cancers registered and from that total 2,015 were Māori and 19,200 Non-Māori. Lung cancer accounted for most of the deaths, followed by prostate, colorectal and breast cancers (Ministry of Health (MOH, 2013a). Alcohol and drug abuse are also linked to other health problems such as: chronic cardiovascular and liver diseases, emphysema, acute alcohol and drug toxicity, diabetes, gout, renal failure, arthritis, foetal alcohol syndrome, dementia, anaemia, insomnia, pancreatitis, seizures, Wirnicke-Korsakoff Syndrome, depression, anxiety, schizophrenia, paranoia and other mental health disorders. In 2013, 1.1 million people were identified as disabled with 26% being Māori (Statistics New Zealand, 2013).

The New Zealand Police Department completed a New Zealand Arrestee Drug Use Monitoring (NZ-ADUM) study amongst 828 police detainees across the country investigating the role alcohol

and drugs played in criminal offending. Forty per cent of the detainees were Māori, 39% European, 16% Pacific and 3% Asian. The results showed that 41% had been drinking, and 21% had been using other drugs at the time of their arrest. The detainees had also been arrested an average of three times within the previous year. Fourteen per cent were in the care of Child, Youth and Family (CYF) when growing up, with 46% not completing compulsory years of high school. Nineteen per cent had a parent who was violent 'often' or 'all the time'. Fifty five per cent of the detainees reported being unemployed or on a sickness benefit. Thirty-two per cent had dependent children and 52% were living in shared accommodation with others (Shore & Whariki, 2012).

Our total prison population recorded in 2012 was 8,618, which was made up of 51% Māori, 33% European, and Pacific peoples at 12 % (Statistics New Zealand (SNZ), 2012).

In 2013 there were 8,279 divorces granted and 40 civil unions dissolved (SNZ, 2014).

All clients referred to CADS have been struggling to cope with their legal, medical, psychiatric, and social or relationship problems and have relied on alcohol and drugs to relieve their emotional pain and suffering. A study that supports this observation was conducted by Bessel van der Kolk (1987) on soldiers who experienced some form of trauma. He discovered that one of the common factors amongst the soldiers was their desire to self-medicate using alcohol or other drugs.

I have also observed in my clinical practice that abusing alcohol and drugs during time of loss and grief can lead clients to experiencing more losses.

Furthermore, there is some evidence that up to 90% of alcohol (Polich, Armor & Braiker, 1981) and other drug users (Hunt, Barnett & Branch, 1971; Marlatt & Gordon, 1980) experience relapse at least once over the 4 year period after receiving treatment. By treating grief in the process of ending or reducing one's substance use may have major benefits for those in recovery. Therefore, learning more about the losses, grief and addiction recovery, we will be able to better support all our clients, their families, concerned friends, and other professionals within health, education, justice and social services.

1.2 Study population

The study population for the literature reviews will be Māori and Non-Māori adults presenting with co-existing loss, grief and substance abuse issues as this is the core group I mainly work with.

The majority of the Evidenced-based treatment approaches regarding loss, grief, and addictions originated from Westernized theories and models which are predominantly created by and for Non-Māori. Although these approaches have been substantiated through worldwide research studies, this does not automatically mean they will be effective for Māori, the indigenous people of this land, Aotearoa (New Zealand).

According to the 2006 census, there was 565,329 Māori living in Aotearoa, New Zealand. That is 15% of the total population (Robson & Harris, 2007). Also, in comparison to any other ethnic group here, Māori have the highest rate of mental health and addiction disorders (MOH, 2006).

Therefore, as a Māori alcohol and other drug (AOD) counsellor, and to be inclusive of relevant literature from a Māori perspective was included.

According to Mason Durie (1985), a Māori perspective on health and wellbeing is the caring of the "whole Person". This means paying special attention to all four key areas of the person's life, which includes the spirit, mind, body and family dimensions. Durie addresses these four dimensions in his Te Whare Tapa Wha Model which will be further expounded upon in Chapter 2, Section 2.2.6.

1.3 Aims and objectives

The purpose of this study is to identify specific interventions that would assist alcohol and other drug (AOD) clinicians to gain a greater understanding of the importance of considering loss and grief experiences by their clients (Māori and Non-Māori) of alcohol and drug services. Three questions guided this literature review process:

1. Is there a relationship between loss, grief and substance abuse?
2. Does addressing loss and grief in AOD counselling help reduce the harm of substance abuse or relapse?
3. What interventions would assist AOD clinicians in working with bereaved clients?

In order to answer these questions appropriately loss and grief (LG) literature will be reviewed along with alcohol and other drug (AOD) abuse literature and organised into five sections. The second section following this will provide an overview of theories, models, and measurements for LG and AOD, with a Māori perspective included. The third section will describe the methodology used in this review, which includes the review search question, search strategy, inclusion and exclusion criteria, and the data extraction. The fourth section considers the results, provides a summary of the included studies, discusses several themes that emerged from the findings, and present answers to the three research questions mentioned above. The final section will conclude with an overall summary, followed with a brief discussion on the strengths and limitations, and provides 15 recommendations for future research, practice and policy.

Chapter 2

2.0 Literature review on loss and grief, and addictions

2.1 Introduction

In terms of structure, this section presents an overview of the most important theories and debates on two specific themes, grief and addiction recovery. A Māori perspective will also be provided.

This review discusses the definition, terminology, theories, models and measurements of loss and grief (LG), as well as alcohol and other drug (AOD) abuse and recovery; and particularly, the connections reported between the two sets of literature.

2.1.1 Loss and Grief

Loss and grief are terms commonly used when we talk of death or loss of someone or something dear to us. Whilst searching through the database for literature in this area I found other terms such as bereavement and mourning were also used in specific scenarios as well as used interchangeably with loss and grief. Therefore, to avoid any ambiguity I will attempt to clarify these commonly used terms.

2.1.2 Definition of Terms:

Loss

The majority of people think grieving usually happens only after you lose someone through death. But there are many other types of losses apart from death of a loved one. There are *tangible losses*, for example: loss of mental, physical or sexual capacity; infertility; violence, abuse, neglect or rape; chronic pain or illness; or political maltreatment. Examples of *interpersonal losses* are: relationship breakup, divorce, or death of a loved one. *Material losses* include losing a home, job, licence to drive or work, material possessions lost in natural disasters or war, lifestyle. *Symbolic losses* relates to discrimination, role redefinition or adjustment to home culture. An *intangible loss includes* harassment at work, loss of identity, self-respect, trust, control, dreams, faith, hope, and opportunities. Loss is when you lose something or someone of value or significance (Murray, 2003).

Grief

Grief is a natural reaction to loss. It can affect us physically, emotionally, cognitively, socially, and spiritually (Sabar, 2000). Every person experiences grief in their own way and according to their gender, beliefs, culture, personality and relationship to the loss, and that is generally acceptable. Grief can be anticipated or sudden. Eventually, many of us find a way to carry on after experiencing a loss. The process we go through to achieve this can be confusing, emotionally challenging and edifying. Generally the griever does not require clinical or psychological intervention (Zisook & Shear, 2009).

However, some people find their losses too overwhelming and too difficult to accept. They become stuck or immobilized in taking steps to address it. Thus, their grief becomes abnormal or complicated. There are different types of complicated grief, such as:

- **Chronic Grief:** the griever is experiencing intense sorrow for a prolonged period of time; feeling stuck in their grief, having great difficulty accepting the loss, inability in connecting with others and returning back to usual activities or responsibilities. Chronic grief is also known as Prolonged Grief Disorder (PGD). People who have an overly dependent attachment to someone or something of significance are more likely to suffer from this disorder. Normal grief differs from PGD in that it is not so disabling, life-altering and it does not involve damage to the griever's identity, self-esteem, security, or hopes for a brighter future and the intensity of the grief dissipates in time (Zisook & Shear, 2009).

- **Delayed Grief:** the reaction to loss is delayed for a time or several years, and may be triggered by a recent event, such as unemployment or relationship breakup, indicating the past and or present grief issues needs to be addressed (Zisook & Shear, 2009).

- **Disenfranchised Grief:** the grief that is marginalised or not acknowledged by society (Worden, 2009; Murray, 2003; Reder, 1999). Examples include loss of a culture or language, loved pet, infertility, abortion or miscarried pregnancy, adoption or child placed in State custody, suicide, homicide, disabilities, sexually transmitted infections,

incarceration, relationship breakup with a homosexual or transgender partner, or end of an extramarital affair.

- **Exaggerated Grief:** the intense reactions of grief that may include nightmares, delinquent behaviours, phobias (abnormal fears), and thoughts of suicide (Zisook & Shear, 2009).

- **Sudden Grief:** when death takes place very suddenly without warning. Sudden grief can lead to exaggerated reactions and posttraumatic stress disorder (PTSD). The Diagnostic and Statistical Manual of Mental Disorders (5th ed.; DSM-5; American Psychiatric Association, 2013) defines PTSD as exposure to a traumatic event that resulted in death (often violent deaths), serious injury or sexual violation. The trauma causes the survivor major distress and impairs their capacity to function or work (APA, 2013, Worden, 2009).

When complicated grief is left untreated it can interfere with their day-to-day living, relationships with others and general well-being (Prigerson, Frank, Stanislav, Reynolds III, Anderson, Zubenko, Houck, George, & Kupfer, 1995).

Bereavement

The literal meaning of the root word "bereaved" means to be robbed from something valuable (Reder, 1999). Bereavement occurs after the loss during which grief and mourning has already taken place, and it usually resolves spontaneously over time (Buglass, 2010). Bereavement is the state used to describe someone who is experiencing a significant loss. It includes the period of adjustment in which the bereaved may experience feelings of loneliness, frustration, anger, emptiness, yearning and longing, deprivation, abandonment and rejection (Sabar, 2000).

Mourning

Mourning is referred to as the public process of grief. It recognizes the outward and active grief experienced by the bereaved, family; or community, and it includes social, cultural, and religious customs and rituals (Buglass, 2010; Murray, 2003). It is usually through the mourning process that grief and bereavement are acknowledged and social support is strengthened (Sabar, 2000; Reder, 1999).

The extent which one grieves, bereaves or mourns will be different from person to person, culture to culture, and from situation to situation. Therefore, it is vital to remember that there is no one way that a person "should" greave or mourn. Also, one would need to have an open heart and an open mind in order to embrace and accept the values and beliefs of the bereaved, even if it contradicts their own (Murray, 2003).

2.1.3 Loss and grief theories:

I will introduce and discuss the work of eight theorists': Sigmund Freud, John Bowlby, Colin Murray Parkes, Elizabeth Kubler-Ross, J. William Worden, Robert A. Neimeyer, Margaret Stroebe and Henk Schut, as each present a slightly different viewpoint of the grief process.

Freud's Grief Work Perspective

The study of loss and grief first started with Sigmund Freud (Mallon, 2008; Wright & Hogan, 2008; Dent, 2005). Freud was the founder of psychoanalysis and the use of talk therapy. His article 'Mourning and Melancholia' published in 1917, argued that grief is a psychodynamic concept of grief work and in order for a bereaved individual to move on with their lives enabling them to form new relationships, they must let go or detach themselves from the deceased (1957). The attention given to 'detachment' in order to recover from grief and return to pre-loss emotional and cognitive functioning was later debated among theorists (Hogan & DeSantis, 1992; Klass, Silverman & Nickman, 1996). However, if the bereaved chose instead to hold on to the decease through the process of "hallucinatory wishful psychosis", the condition was then diagnosed as melancholia and pathological (Wright & Hogan, 2008). Melancholia is seen as a type of depression which includes a complete loss of pleasure and interest in all or almost everything.

However, on the contrary, in 1929 Freud sent a letter to his grieving friend Ludwig Binswanger whose son had died, which read:

> *"Although we know after such a loss the acute state of mourning will subside, we also know we shall remain inconsolable and will never find a substitute. No matter what may fill the gap, even if it be filled completely, it nevertheless remains something else. And, actually this is how it should be, it is the only way of perpetuating that love which we do not want to relinquish" (Freud 1960: 386, as cited in Mallon, 2008).*

Freud's words here highlight the importance of continuing bonds with loved ones, which was later echoed by modern theorists (Attig, 2000; Klass, Silverman, & Nickman, 1996; Hogan & DeSantis, 1992; Silverman, Nickman & Worden, 1992). It is important to note that Freud's theory was primarily based on his clinical experience with patients who suffered depression. Therefore his research on loss and grief was limited to this specific group which the wider population may not be able to relate to (Buglass, 2010).

Attachment Theory

In the 1960's, John Bowlby, a British psychologist and psychiatrist studied the effects of separation between children and their mothers (Mallon, 2008). Bowlby together with his student Mary Ainsworth was particularly interested in studying the different styles of attachment, alongside the different reactions of fear, protest, sadness, grief and mourning expressed by children in relation to the temporary or permanent loss of their mother or caregiver. From the findings, Bowlby emphasised that in order to foster and increase emotional security, self-esteem and resiliency in children, the bonds of attachment between mother/caregiver and child are imperative, and they must be established early (Buglass, 2010; Mallon, 2008). The new idea of attachment was a crucial discovery as it was initially believed that attachments were mainly stimulated through a reward system. Bowlby then became known as the founding father of the attachment theory (Mallon, 2008; Hendry, 2008; Wright & Hogan, 2008).

Eventually, Bowlby's attachment theory allowed him to draw parallels between a child's response to being separated from its significant attachment figure to loss and grief (Clark, 2004). He asserted that when the attachment bonds are severed, the innate motivational system stirs the bereaved to go searching for that significant person, to regain proximity and care. The bereaved experiences grief when their effort to find the object of their loss fails.

Bowlby also believed that grief is a natural adaptive response when 'affectional bonds' are broken, and that early childhood experiences of separation may affect the individual's capacity to successfully respond to future losses (Mallon, 2008; Cutcliffe, 1998).

Assumptive World Perspective and Phases of Grief

Bowlby's concepts on loss, grief, mourning and bonds of attachment during childhood attracted the attention of Colin Murray Parkes (Mallon, 2008). In 1962, Parkes joined Bowlby as his student and later became his colleague. Parkes was more interested in studying how adults processed grief. He conducted a joint study (Parkes, 1970), with Bowlby on a group of widows. The findings of their study help to form the four phases of grief: (a) shock and numbness, (b) yearning and protest, (c) despair and disorganisation, and (d) reorganisation and recovery (Buglass, 2010; Mallon, 2008; Clark, 2004); which will be explained further in the next section. Parkes also became acquainted with Elizabeth Kubler-Ross whilst she was still gathering data for her book *'On Death and Dying'* (1969). Bowlby later introduced him to Cicely Saunders, the founder of the modern hospice movement. Saunders and Parkes worked together in conducting research and developing programs for people caring for the dying and the bereaved (Bretherton, 1992).

Parkes was the first to introduce the concept of the 'assumptive world' which is radically changed for the bereaved individual (Mallon, 2008). The assumptive world is when our familiar world as we know it and expect it to be, has become unfamiliar. It is when death, loss or change affects all our expectations about our world, relationships, roles, responsibilities and dreams are thrown into disarray. When the loss is sudden and traumatic, the very foundations of the bereaved's assumptive world may be completely devastating and overwhelming. Trying to help the bereaved make sense of their traumatic loss by talking about it, thinking about it and remembering the deceased may cause hyper-arousal and anxieties (Dent, 2005). Thus, an in-depth psychological or psychiatric intervention may be more appropriate than offering grief counselling or bereavement support (Jordan & Neimeyer, 2003). Parkes further revealed that in order for the bereaved to adjust to the loss, rebuild their assumptive world, and re-define their sense of identity a psychological shift and psychological change is needed (Mallon, 2008).

Five Stages of Grief

The 1960s brought in another traditional theorist, Elisabeth Kubler-Ross, a Swiss-born physician and psychiatrist, who spent many years working with dying patients. In her highly influential book *'On Death and Dying'* (1969), Kubler-Ross developed five stages of grief to explain how terminally ill patients seem to react universally to their own impending death, specifically: (1) denial, (2) anger, (3) bargaining, (4) depression, and (5) acceptance (Mallon, 2008). These five stages will be clarified later in this section. Since its publication, Kubler-Ross stage model has been widely applied to other types of losses (Hall, 2011; Buglass, 2010; Murray, 2003).

However, according to Rachel Naomi Remen, co-founder and medical director of the Commonweal Cancer Help Program in America, believes the final stage of grief is not acceptance. She declares:

> *I have counselled people with life-threatening illness who have lost valuable parts of their bodies, relationships and capacities. And in my experience of watching people heal from loss, the final step is gratitude and wisdom. That's the final step of healing from loss. It doesn't make cognitive sense, but it makes deep emotional and spiritual sense (Redwood, 2002:6, as cited in Mallon, 2008).*

Task-Based Model

In the 1980's, J. William Worden, an Associate Professor of Psychology at Harvard University, continued with Freud's concept of grief work and preferred to view the grieving process as a series of tasks. Tasks provide the griever with something to do, as opposed to just going through stages of emotional reactions. Worden provides four tasks that the bereaved must achieve in order to make a complete adjustment; (1) to accept the reality of the loss, (2) to work through and experience the pain of grief, (3) to adjust to the environment in which the deceased is missing, and (4) to emotionally withdraw or relocate from the deceased, move on and reinvest in a new relationship (Buglass, 2010; Wright & Hogan, 2008).

Many people have difficulty in completing task four, as they may prefer to cherish and honour the memories of their deceased, not forget them. Also, people may be afraid of moving on and forming new relationships as they want to avoid suffering another loss, and they do not want to be disloyal to the deceased (Mallon, 2008). Do people have to let go in order to move on? The authors of *'Continuing Bonds: New Understandings of Grief'* (Klass, Silverman & Nickman,

1996), argues that relationships does not end at the death of a loved one. The relationship continues in the bereaved's memories, legacies, significant events, such as birthdays and anniversaries (Mallon, 2008).

The Dual Process Model

In 1995, Margaret Stroebe and Henk Schut questioned the value of earlier theories and developed the dual process model to help identify the two types of stressors experienced by the bereaved, namely, (1) loss-orientated (focusing on the loss of the person that died), and (2) restoration-orientated (secondary stressors, such as, coping with finances, attending to household responsibilities and repairs). This model recognizes how a bereaved individual deals with the experience of death and makes necessary lifestyle adjustments (Buglass, 2010). The extent to which the bereaved will engage in either oriented processes will largely depend on several aspects, such as personality, gender or cultural beliefs and practices (Dent, 2005). This model is briefly outlined in the next section.

Meaning-making or Meaning Reconstruction

Robert Neimeyer, Professor of Psychology, Director of Psychotherapy Research at the University of Memphis, and editor of two respected international journal, *Death Studies* and the *Journal of Constructivist Psychology*, introduced a new theory called "Meaning Reconstruction". When our world as we know it is turned upside down, at a death of a loved one for example, the experience brings a sense of loss of meaning. Meaning Reconstruction is a narrative approach in healing the grief through telling, re-telling or writing our life stories, finding new meanings to our loss and grief, and re-building our lives utilising psychological, emotional, social, and cultural resources (Mallon, 2008; Neimeyer, 2006).

2.1.4 Traditional models of loss and grief:

Several grief theorists; Bowlby, Parkes, Kubler-Ross and Worden conceptualised grief as going through a series of anticipated stages, phases or prescribed tasks, as defined below (Bowlby & Parkes, 1970; Kubler-Ross, 1969; Worden, 1983).

Bowlby and Parkes (1970) presented four main phases in the grief process:

a) **Shock and Numbness:** the sense of loss seems unbelievable and impossible to accept and the bereaved starts to experience distress with some common physical symptoms such as; tightness in the chest, shortness of breath, poor appetite, low concentration, restlessness, and insomnia (Dent, 2005).

b) **Yearning and Protest:** involves waves of grief, sobbing, sighing, anxiety, tension, loss of appetite, irritability and lack of concentration. The bereaved may sense the presence of the dead person, may have a sense of guilt that they did not do enough to keep the deceased alive and may blame others or themselves for the death of their loved one (Wright & Hogan, 2008).

c) **Despair and Disorganisation:** The sense of hopelessness, despair and anger that life will never be the same or how we imagined it would be. Struggling to make sense of life again without the presence of the deceased. Bowlby and Parkes articulate that grief will become complicated if the bereaved individual continues to feel depressed, angry and withdraws from others (Bowlby & Parkes, 1970).

d) **Re-organisation and Recovery:** the loss is accepted which involves letting go of the attachment to the deceased. There is a gradual return to former interests and investing in new relationships (Mallon, 2008).

At the time the four phases of grief model did not make reference to wider cultural, gender and age differences which are highly relevant in the grieving process.

Kubler-Ross (1969) arranged grief into 5 steps:

The five stages of grief commonly known by the acronym **DABDA**, is a useful model for understanding the bereaved's emotional reaction to loss and grief, irrespective of the cause. This model was initially developed to explain the experience of those dying from terminal illness, but it can also be applied to the bereaved (Schimmel & Kornreich, 1993). It is now used to cover the process of grief more broadly.

1. **Denial:** the first reaction to loss accompanied with shock. At this time the dying or concerned others refuse to accept facts or any information relating to the diagnosis or affected situation as the reality of the loss is too hard to comprehend. Denial is a natural defence mechanism, it allows people time to cope, function, survive and pace their feelings of grief. However, there is a risk that grievers may avoid or supress their feelings and overtime become stuck at this stage especially when loss is complicated or traumatic.

2. **Anger:** the emotional state we hold on to for strength or to mask the intense emotional pain. People can be angry with the deceased, themselves, others (parent, sibling, partner, child, care giver, health professionals, offender, etc.), or at a higher power. It can be voiced in different ways, for example; "Why did this happen? It's not fair!"; "For years I have been telling you to give up smoking. Why didn't you listen to me!", "Why did God allow this to happen!", or "Who is responsible for this!". To help the bereaved move through this stage it is important to remain non-judgmental.

3. **Bargaining:** involves hope for the bereaved that they can somehow undo or avoid experiencing grief. Bargaining comes with guilt and is generally spoken in "What if…" or "If only…" statements. It is usually used to negotiate with a higher power for their loved one to live longer in exchange for a converted lifestyle, or seeking a compromise to avoid a relationship from breaking up. Bargaining seldom provides a viable solution, especially when it is a matter of life or death situation.

4. **Depression:** the bereaved begins to recognize the reality of the loss and the idea of living or moving on becomes meaningless. During this stage the individual may appear silent,

tearful and withdrawn. The feelings of sadness, sorrow, regret or fear becomes a natural pathway for the bereaved to find closure and eventually arrive at the acceptance stage.

5. **Acceptance:** the last stage where the bereaved come to terms with their loss, emotionally detached themselves from the deceased or significant other, and is willing to face the inevitable future without them. In this stage the grieving individual begins to make adjustments, establish new connections and move on with their lives.

It is important to note that this grief model is not a linear process and not all the stages need to be present to progress through the grief process. An individual may die still filled with anger or depression, unable to attain the acceptance stage.

Worden (1983) categorized the grief process into four tasks:

In comparison to the stage model, Worden prefers to view the grieving process as a progression of tasks. He offers four tasks as defined below:

- **Task 1: To accept the reality of loss.**
  Similar to Kubler-Ross, Worden believes that initially the bereaved will have a difficult time coming to terms with the death of their significant loved one. He believes the first task is to help the bereaved face and accept the reality that their loved one has died and will not be returning. Denying their loss will only prolong the grief process.

- **Task 2: To work through and experience the pain of grief.**
  Many people try to avoid or supress experiencing painful feelings by: working long hours; "being strong"; moving away; declining to talk about it; refusing help from others; and misusing alcohol and drugs. Worden guides counsellors to encourage the bereaved individual to talk about their loss and help them to become aware that their feelings of loneliness, anxiety, depression, guilt, or anger are considered normal. Grief work does take time and eventually the pain will diminish.

- **Task 3: To adjust to the environment in which the deceased is missing.**
  This task may take a considerable amount of time and energy to accomplish. Many bereaved individuals like a widow may fear or resent having to take on new responsibilities and learn new skills that were performed by their loved one who died. On the other hand, the bereaved can use this time as an opportunity to reorganize their responsibilities, up-skill themselves, keep a journal or photo album, create meaningful rituals or a special memorial, journal keeping, travel, or organise family activities.

- **Task 4: To emotionally withdraw or relocate from the deceased, move on and reinvest in a new relationship.**
  The final task requires the bereaved individual to emotionally detach themselves from their decease in order to move on and rebuild a new life. For many people this task is the most difficult to accomplish as it seems like a betrayal to the memory of their loved one and they may become stuck at this point. Worden (2002) expressed that the purpose of this task is not to dishonour the decease, but to help the bereaved to recognize that there are other people who need their love and attention, including themselves.

2.1.5 Modern models of loss and grief:

In this section the writer will describe two new models of working with loss and grief, the Dual Process Model (Stroebe & Schut, 1995), and the Multi-dimensional Model (Payne, Horn & Relf, 1999).

The Dual Process Model

In 1995, Margaret Stroebe and Henk Schut introduced the Dual Process Model (DPM) of loss and grief. They were the first to declare that there were no define stages or phases of loss and grief (Mallon, 2008). Instead, they proposed two types of coping processes; loss-orientated and restoration-orientated, as illustrated in the table below:

The Dual Process Model

Figure 1

Loss-oriented Processes	Restoration-oriented Processes
Working through loss and grief including ruminating and yearning for the deceased and related behaviours.	Making lifestyle changes
Interruption of grief	Distraction from grief - coping with every day responsibilities
Denial or avoiding of restoration changes	Attempting new things
Letting go of bonds/ties	Forming new roles/identities/relationships

(Adapted from Stroebe, 1998)

The DPM articulates that most bereaved individuals will need to oscillate between the loss-orientated and restoration-orientated domains in addressing their emotional concerns, then practical issues and vice versa. The degree of attention given to each approach within these two domains will largely depend on the bereaved's personality factors, the circumstances of death or loss, gender, cultural and religious background. The DPM may be criticised for placing too much importance on the bereaved's ability to cope, consequently indicating behaviours of abnormality if they are unable to cope (Buglass, 2010; Stroebe & Schut, 1999).

The Multidimensional Model

The Multidimensional Model (MDM) was created by Susan Le Poidevin in the early 1980's. Le Poidevin worked closely together with Colin Murray Parkes in providing training for grief counsellors. The MDM challenges the dominant view of seeing loss and grief primarily from an 'emotional' dimension (Walter, 1999). Instead, it provides a holistic framework for understanding the costs and challenges of loss and grief (Bonanno, 2001). The MDM is also a useful 'client centered' and 'resilient' tool in identifying and recognizing the needs and supports in the life of the bereaved. The MDM conceptualizes grief as a process of simultaneous change categorized under seven dimensions adapted by authors of *"Loss and Bereavement"* (Payne, Horn & Relf, 1999). The seven dimensions of loss are:

***Emotional*:** Characterized by the intense emotions experienced. How comfortable is the bereaved in showing their emotions? Are they at ease with it or do they believe in keeping their emotions under control?

***Social*:** Loss is also experienced within a social unit, for example; family, friends, school, and work, resulting in role or status changes. Has loss and grief affected other significant members in their life? If yes, in what way? Is quality support available?

***Physical*:** There are many physical symptoms related to loss and grief reactions. In what way has loss and grief impacted on their physical health?

***Lifestyle*:** Loss and grief can cause major lifestyle changes. How has loss and grief affected your lifestyle?

***Practical*:** Loss and grief may affect the ability to cope with everyday responsibilities. How has loss and grief affected their ability to cope with everyday living and responsibilities?

***Spiritual*:** Loss and grief may cause an individual to question their beliefs in the world or their faith in a higher power, which could affect their sense of meaning and purpose. In what ways has loss and grief affected their belief system?

***Identity*:** Loss and grief may affect the identity, self-esteem and self-worth of the bereaved individual. To what extent has the loss and grief affected their identity, self-esteem, confidence and self-worth?

The MDM is also helpful in assisting bereaved individuals and their supports to work collaboratively in identifying the affected areas of loss and grief, developing coping strategies and finding resources needed within each dimension (Payne, Horn & Relf, 1999).

2.1.6. Measurements for screening loss and grief:

There are a variety of instruments used to assess for loss and grief. For example, some instruments are population specific such as death of a spouse, child, parent, elderly, or significant others (Burnett, Middleton, Raphael, & Martinek, 1997; Prigerson, Maciejewski, Reynolds, Bierhals, Newsom, Fasiczka, Frank, Doman, & Miller, 1995). There are instruments used to assess distinctive reactions, such as crying, sadness, anxiety, depression, yearning, and searching for the deceased (Jordan, Baker, Matteis, Rosenthal & Ware, 2005; Prigerson et al., 1995). Some instruments also measure behavioural characteristics when the bereaved are confronted with loss and grief, such as coming to terms with the loss and making readjustments to life (Jordan et al., 2005; Faschingbauer, 1981).

Some commonly used instruments to measure loss and grief amongst the adult population are included in this literature review to help identify different ways in which loss and grief might be assessed. Measurements included and outlined below are: the Texas Revised Inventory of Grief (TRIG) (Faschingbauer, 1981); Grief Evaluation Measure (GEM) (Jordan et al., 2005); the Inventory of Complicated Grief-Revised (ICG-R) (Prigerson et al., 1995); and the Core Bereavement Items (CBI) (Burnett et al., 1997).

Texas Revised Inventory of Grief (TRIG)

The Texas Revised Inventory of Grief, TRIG (Faschingbauer, 1981) is commonly used amongst health professionals. The TRIG is a 26 item scale rated on a five- point Likert-type questionnaire with responses ranging from completely true to false. It is administered via pen and paper and divided into two parts. It measures 'past behaviour' (immediately or shortly after the loss or death) and progress through the stages of loss and grief, and it measures 'present feelings' (time of data collection) and the ability to maintain day to day activities and tasks. Furthermore, there are several questions in TRIG to help identify existing mental roadblocks that may be hindering the bereaved's ability in finding meaning in the loss and making future goals.

There is some evidence of the validity and reliability of the TRIG instrument being used in a group analysis which showed the intensity of responses usually worsening over the first year of grief and then gradually improving (Hansson, Carpenter & Fairchild, 1993). Therefore, the TRIG is a useful instrument in measuring grief over a length of time as every person grieves differently

and symptoms of intensity generally lessen for majority of people. However, in retrospect, the questions relating to memories of past behaviour, the bereaved's response can be potentially altered or influenced by their current state.

Grief Evaluation Measure (GEM)

The Grief Evaluation Measure (GEM) is an instrument designed to measure the intensity and the development of complicated grief in a bereaved adult (Jordan et al., 2005). This instrument is divided into seven parts using quantitative and qualitative questions to screen for risk factors, including risk-taking behaviours, previous losses, physical symptoms, medical history, circumstances surrounding the loss, and coping resources pre and post death.

Studies were conducted to test GEM's reliability and validity using two samples of bereaved adults. The results showed high consistency and reliability in measuring bereavement, trauma, physical and psychiatric symptoms. However, GEM is a very lengthy assessment tool which may weary both the assessor and bereaved (Jordan et al., 2005).

Inventory of Complicated Grief-Revised (ICG-R)

The Inventory of Complicated Grief-Revised (ICG-R) is a 19 item scale that was developed by Prigerson et al. (1995) to help identify emotional and physical grief symptoms relating to the loss of a loved one. Symptoms can range from ruminating about the deceased to unexplained aches and pains, which can lead towards a decline in mental and physical wellbeing if not treated appropriately. The researchers conducted a study on 97 elderly widows and the results showed high scores in reliability, validity and consistency.

Core Bereavement Items (CBI)

The Core Bereavement Item (CBI) is a 17-item questionnaire that assesses the intensity and development of grief experiences among three groups; bereaved spouses, bereaved adult children losing parents, and bereaved parents losing children. The items are rated on a four-point scale divided into three subscales: images and thoughts relating to the deceased, acute separation, and grief. The items were developed from studies and clinical experience in dealing with grief and bereavement. The CBI also scored high in reliability and validity (Burnett et al., 1997).

2.1.7 Māori Perspective on Loss and Grief

In Te Ao Māori (traditional Māori world), plants, animals, objects, including our lands, sea, rivers, mountains, environment, marae, cemeteries, language, iwi (tribe), hapu (sub-tribe), and people possess life and a spirit (Huriwai, 2002). They are all connected and have significant value. Consequently, the traditional tribal structures and processes that helped to preserve and protect Te Ao Māori eroded with the arrival of colonization, urbanization and globalization, resulting in loss of lands, language, identity, spirituality, discrimination, economic and educational disadvantages, poor enculturation, mental health disorders, anti-social behaviours, criminal offending, physical illnesses, relationship difficulties, psychosocial problems, and substance abuse (Huriwai, 2002; Kunitz, 1994; Jackson, 1988; Brady, 1985).

Also, in Te Ao Māori the kin group was the most fundamental unit, and individuals had their defined roles that supported the collective. This was voiced by Paratene Ngata (Department of Health (DOH), 1987), author of *"Death, Dying and Grief, a Maori perspective"*, who asserted that strength is in the kinship ties and every individual member contributing towards the holistic wellbeing of the whānau group. Therefore, any illness, death or loss affecting one whānau member is shared by others, and it has the potential to weaken the whole family network. Hence, the whānau is only as strong as its weakest member; the most vulnerable members, usually the elderly and the young, receive much nurturing and support.

Ngata (DOH, 1987) also expressed that death is an evitable part of life and living. Although death ends the physical link with the deceased, the spiritual connection is eternal, which is often revered and echoed in whaikorero (speeches), karakia (prayers), waiata (chants and songs), carvings, the wailing wall of the marae, legacies (beliefs, values, achievements, land, etc.), and names and roles being passed on to the next generation.

Furthermore, grieving and mourning at a tangi (funeral) which usually last three days, is seen as a process and not as a single event. Customarily the body lies on the marae where all are welcome to offer comfort and pay their respects to the whanau pani (grieving family). Kawa (local protocol) will vary from hapu to hapu, iwi to iwi, and those unfamiliar with the protocol should ask or arrange to be with someone who is local or familiar with the kawa. The traditional practices and rituals of karakia, waiata, koha (gift, for example: food, money, or compassionate services), and te reo (language) is usually seen as an open expression of love and concern from the grieving whanau, hapu or iwi (DOH, 1987).

Ngata (DOH, 1987), provided several formalities surrounding death and Tangihanga (customary services relating to the deceased), as outlined below:

Karakia (Prayers)

Karakia acknowledges and reaffirms the spiritual connection between human kind and the divine creator, and is an essential part of any illness, dying, and grieving process. Karakia can be from the heart, recited, and chanted. It can be used to express gratitude, and to ask for sustenance, protection, strength, forgiveness, peace, guidance, comfort, and healing. Water and certain foods can also be used with karakia as part of a process for cleansing, healing or lifting tapu (sanctity).

Waiata (Songs)

Waiata can be used to endorse karakia, speeches and special ceremonies. It can also aid in expressing sorrow, compassion, gratitude, joy, sorrow, and strengthen family ties.

Karanga (The call of welcome)

The karanga generally performed by the women of the marae is the call of welcome to the deceased, whanau pani, and manuhiri (visitors). The karanga also acknowledges tupuna (ancestors) and their connection to the deceased. It can also be used to farewell the deceased. The karanga supports the spiritual handover process from those who are living to those who have passed on.

Members representing the manuhiri group also respond to the karanga with expression of sadness, sorrow and pain at the loss of the family, hapu or iwi member.

Te Tangi (The expression of grief and sorrow)

Te tangi is the open expression of tears, crying, wailing and emotional pain shared by all those who come to mourn the loss of their loved one. The whanau pani is also comforted by the shared tears and warm embraces of the arriving relatives and friends.

Te Whaikorero (The speeches)

The local kaumatua (tribal elders) or leaders on the paepae (the speakers' platform) begins the forum for speeches, and every speech is supported by a special waiata. The visiting kaumatua usually sitting on the front seats on the opposite side is given the opportunity to respond, and if they are from a different tribe a koha (monetary gift to assist the whanau pani and marae with the catering and funeral expenses) is generally offered. Ngata asserts that reciprocity is of paramount importance to Māori, as there will always be an opportunity to return the support in times of grief and mourning.

The whaikorero addresses the deceased usually in symbolic language and encourages the spirit of the deceased to continue on their journey back to the world of spirits to join with the rest of their whanau who have passed on. Whaikorero also acknowledges and strengthens genealogical kinship connections.

Te Hongi (The pressing of noses)

Once the whaikorero has ended, the manuhiri first move towards the main speakers on the paepae, and then to the tangata whenua (local people of the marae); to hongi (press noses), ruru (shake hands) and tangi (share tears).

The hongi is the pressing of noses and foreheads between manuhiri and tangata whenua. It symbolically represents the sharing of personal mana (strength), mauri (spiritual essence) and tapu. Once this process is completed the tapu is removed and manuhiri and tangata whenua are united as one and made common. However, the whanau pani remain tapu until after the burial of the deceased.

Whakakotahi whakaaro (Unity of support)

When the tangata whenua and manuhiri have become one, they can work together in completing specific duties and roles. The ringa wera (kitchen hands) are responsible for preparing the food for the arriving manuhiri, the tu marae or kaimahi (workers) help to prepare the marae and keep it tidy, and the women elected to do the karanga and assist with the waiata. The younger members of the collective are assigned to different areas of duty to assist, observe, and learn the kawa (protocols), and gain skills. This process helps to ensure the continuity and preservation of kawa, local knowledge and skills.

The whanau pani stays in the whare hui (meeting house) and never leaves the deceased unattended. If the grieving family needs to leave for kai (food/meal) or to attend to personal needs, then arrangements are made with other women kinfolk to sit with the deceased until they return. After everyone has had their evening meal they gather into the whare hui for karakia, sharing of stories, waiata, re-kindling old friendships and strengthening kinship bonds. The women are allowed to speak in this forum. The whanau pani, local people, and manuhiri, stay overnight with the deceased.

Some hapu and iwi have 'po whakamutunga' (the last night before burial). Here the grieving whanau become aware that this will be their last night with their loved one, and a combination of waiata, sharing stories, entertainment and expression of gratitude to the deceased, kaumatua and kaimahi helps prepare them for the events of the morrow.

Te Ra Nehu or Te Ra Tapuke (Day of burial)

The grave is usually dug very early in the morning of the funeral service and its location was already selected by the grieving family, kaumatua and hapu. After the morning karakia, the tangata whenua prepare for the funeral service and hakari (main feast after the burial). The grieving whanau proceed to hongi and kiss their beloved one for the last time. And, it is usual for their crying and wailing to climax before the casket is closed.

After the casket is closed the funeral service begins. The format of the funeral service is given in two parts and it can be one or multi-denominational according to the wishes of the grieving family and kaumatua. The first part is delivered at the marae or church and the second at the urupa (cemetery). After the services are over, mourners wash their hands upon leaving the urupa. The group all return and are welcomed back on to the marae. In some areas the group gather to embrace the whanau pani to remove the tapu before partaking in the hakari. The hakari can be used to provide entertainment, light-hearted speeches and waiata to help the grieving whanau reduce their grief and sorrow.

Te Hurahanga Pohatu (Unveiling of the memorial stone)

The final event of the tangihanga process is the unveiling of the memorial stone. This usually takes place between one to five years later or when convenient for the whanau pani. The

attendance at the unveiling is usually smaller consisting mainly of the immediate whanau, kaumatua and few local people. The formalities, protocols, services and hakari are usually all completed on the day of the unveiling.

Te Ao Hurihuri (The changing world)

Ngata had further expressed the traditional grieving and mourning practices of Maori was affected by the changes in population and family structure, modern living, and socio-economic circumstances where the people evolved from a strong land-based whanau network support system to a predominantly young, landless, and urban population (DOH, 1987). Consequently, many of the rising generation pursuing a more modern lifestyle, and not knowing their native language, cultural practices or protocols, having weak connections with their kin, iwi, hapū, and marae, generally become lost and vulnerable when confronted with grief, terminal illness and death.

Furthermore, Ngata (DOH, 1987) articulated that the changing world had introduced new practices and protocols for Māori, along with some challenges surrounding grief and mourning. For example, many families now choose to bury their dead in the cemeteries of the country, city or town where they currently reside, because it is too costly to bring their tupapaku (deceased) back to their marae and urupa, and their local cemetery is closer for them to visit. This caused a vast ripple effect on the tangihanga process. Tangihanga ceremonies are now either carried out in their homes, urban marae, local churches or the undertaker's chapel. Although convenient, these alternatives presented some challenges, namely: the home or chapels are too small for the continual flow of manuhiri arriving; consideration for the neighbours around car parking; lack of accommodation, provisions and catering facilities; selected speakers in some urban areas lacking te reo (language), cultural knowledge, hapū protocols; and having no prior relationship or kinship ties to the deceased and the bereaved whanau. And as a result, the open expression of grief becomes restrained and restricted. However, to ensure the survival of many other Māori beliefs, customs, protocols, and practices, compromises will continue to be made in adapting to the ever changing socio-economic circumstances.

One of the other main barriers in allowing Māori to express grief and sorrow has been on the part of some people, employers, and contemporary institutions that lack the cultural compassion, knowledge, understanding, and sensitivity. Therefore, to ensure effective engagement and interventions with Māori, AOD counsellors, health, justice and social professionals, including

managers will need to increase their understanding of Māori health concepts and values. They also need to be aware of the importance of providing the appropriate processes for meeting, greeting, and working with tangata whaiora (client/patient), their whanau or supports. Furthermore, they need to ensure the pathway in accessing and consulting with specialised cultural expertise is clear, and for cultural experts be permitted to determine what best approaches and processes should be used in a particular situation (Todd, 2010).

Additionally, a practitioner may need to consider helping tangata whaiora reconnect with their kinship ties especially for those who have been disconnected from their cultural and whanau links (Matua Raki & Te Pou, 2010). This can include whangai (fostered), friends, or anyone the tangata whaiora sees as their strong supports. Incorporating Māori models of health, such as Te Wheke (Pere, 1991), Te Powhiri Poutama (Huata, 2011), and Te Whare Tapa Wha (Durie, 1985), can help broaden the grieving tangata whaiora understanding, search for meaning behind the losses, identify strengths and resources, explore areas of abuse or neglect, and increase self-efficacy and resiliency. An outline of the Te Whare Tapa Wha model (Durie, 1985) is provided in chapter 2, section 2.6. Other cultural interventions to consider for traditional healing are: mirimiri (massage), rongoa (natural remedies), use of karakia, waiata and te reo. However, practitioners will need to assess the tangata whaiora state of readiness, before introducing cultural models and approaches.

2.1.8 Personal transformational journey with loss and grief

Whilst searching through numerous literatures on grief, theorist and their approaches I became very much aware of how much I did not know, and the sheer thought of contemplating this dissertation felt overwhelming. Furthermore, reading about other people's losses had actually reignited memories of my own grief issues resulting in an outpouring of emotions and tears. In addition, the writer actively works with clients who present at the clinic and hospital with multiple losses, and returning home to study more about loss and grief was both startling and draining. I had also restricted contacts with my social and family supports in order to meet the demands of work and study commitments. There was no time for pleasant activities or self-care, resulting in increased anxieties, low moods, poor concentration, bronchitis and emotional fatigue. Whilst studying this topic I was initially oblivious that I was experiencing the impacts of my own loss and grief. I had actually underestimated the magnitude of my dissertation topic. I have since come to recognize and accept these experiences as normal part of life. The personal experiences I had endured, the selection of research findings, supervision, family and spiritual supports, all contributed in making my life's journey with loss and grief more meaningful, valuable and profound.

2.2 Addictions:

The purpose of this section is to provide an introduction of addiction-related definitions, theories, models and measurements that are commonly referred to in Aotearoa New Zealand. Whilst searching through the literature I found other terms such as; alcohol and other drugs, substance abuse, substance misuse, substance use disorder, problem gambling and addiction disorder were all used interchangeably. Therefore, the term 'addiction' is a generic term used throughout this literature review in relation to alcohol and other drug use, including tobacco and gambling (Matua Raki, 2014).

2.2.1 Definition of Terms:

Addiction:

Addiction mostly used interchangeably with dependence, is a result from consuming hazardous amounts of substances over a prolonged period in which an individual is determined to pursue their drug of choice regardless of any negative consequences to themselves, family or community. In the initial stages, addiction usually produces a state of euphoria, or quick relief from distress, or relief from emotional or physical pain. Sustained use provokes changes in the central nervous system which leads towards tolerance, dependence, craving, lapse and relapse (Cami & Farre, 2003). Matua Raki (2011) uses the term addictions to generally include the wide-range of problems relating to the misuse of alcohol and other drugs, tobacco and gambling.

The term "drug" can be defined as any chemical substance that is used non-medically for its positive psychoactive effect, and the usual route of administration is drinking, eating, smoking, inhaling, sniffing, snorting, or injecting (Matua Raki, 2014). The psychoactive effect sought by substance users varies according to the different classes of drugs. The four most common groups of drugs are: Central Nervous System (CNS) depressants, CNS stimulants, hallucinogens and cannabinoids.

Central Nervous System Depressants

People generally use depressants to induce feelings of euphoria, calmness and relaxation. However, higher doses can cause drowsiness, respiratory problems, impaired motor control, disinhibition and depression. And overdosing on CNS depressants can cause key body functions, such as breathing to shut down, resulting in coma and death (Matua Raki, 2014).

The most commonly used CNS depressant, and the most abused drug in New Zealand is alcohol (MOH, 2013c). It is also the third largest global disease burden and risk factor, resulting in 2.5 million deaths each year (World Health Organization (WHO), 2011). Other drugs used recreationally within this class include benzodiazepines (e.g. diazepam/valium), barbiturates, opioids (e.g. methadone, heroin, opium, codeine, morphine, and oxycodone), gamma hydroxy-butyrate (GBH), and volatile solvents (e.g. aerosol sprays, air freshener, degreasers, glue, petrol, and paint).

Central Nervous System Stimulants

The most commonly abused CNS stimulant in New Zealand is nicotine at 18 per cent (MOH, 2012). A Ministry of Health survey (2010), showed that 3.9% of the adults in New Zealand also take other stimulants, namely; amphetamines (e.g. methamphetamine, P, Pure or speed), ecstasy, cocaine, methylphenidate (Ritalin), mephedrone (bath salts), and benzylpiperazine (BZP).

A CNS stimulant increases feelings of pleasure, energy, euphoria, sexuality, wellbeing, alertness, and reduces levels of anxiety where the individual feels more confident, sociable, enthusiastic and productive. The individual often feels motivated to use more in order to replicate the pleasant and rewarding experience. Higher dosage of this drug can lead the user experiencing symptoms of grandiosity, decreased need for sleep and food, impulsiveness, irritability, agitation, increased feelings of sexuality, impaired judgement, hyperactivity, and hypervigilance. Individuals who continue to abuse high amount of CNS stimulants like amphetamines and cocaine, risk developing anxiety and paranoia disorders, with some becoming psychotic. And overdosing can cause convulsions and death through a brain haemorrhage or heart attack (Matua Raki, 2014).

Hallucinogens

The most commonly used hallucinogen used in New Zealand is lysergic acid diethylamide (LSD). Other forms of hallucinogens include magic mushrooms, datura (thornapple and angels trumpet), and cactus (MOH, 2010).

The effects of hallucinogens can include euphoria, alterations in mood and sensory perception, auditory, tactile or visual hallucinations, distortion of time and space, heightened sensual awareness and emotional experiences. Risk taking behaviours and the exacerbation of some mental illnesses, namely psychosis, are some of the harms associated with this drug (Matua Raki, 2014).

Cannabinoids

Natural cannabinoids are derived from cannabis sativa and indica plants, and contain more than 60 cannabinoid chemicals (Matua Raki, 2014). The two main active ingredients of this drug are delta-9-tetrahydrocannabinol (THC) and cannabidiol (CBD). This drug has been placed in a category of its own as they can produce a combination of complex effects similar to CNS depressants, CNS stimulants and hallucinogens.

Apart from alcohol, nicotine, and caffeine; cannabis is the most popular recreational drug in New Zealand, with approximately 14.6% adults report using on a regular basis (MOH, 2010). Cannabis can be used in several ways, such as marijuana (dried leaves and flowers); hashish (dried resin from the plant); and hash oil (purified and concentrated oil taken from the flowers and leaves).

The desired effects of cannabinoids can include feelings of euphoria, confidence, grandiosity, calmness, relaxation, increased sense of meaningfulness, and wellbeing. When used socially, the euphoria is often allied by infectious laughter, increased confidence and talkativeness. Excessive use can result in the user experiencing anxiety, paranoia, frightening hallucinations, depression, symptoms of schizophrenia, and other mental health problems (Matua Raki, 2014). It has also been linked to chronic bronchitis, impaired respiratory function, respiratory cancers, and cardiovascular diseases (Hall, 2009).

Substance Abuse:

The DSM-5 defines substance abuse as a person who within one year meets two or more of the following 11 criteria:

1. The substance is consumed in large amounts over an extended period than was planned.
2. There is a continual wish or failed attempts to reduce or control substance use.
3. A large amount of time and effort spent in seeking and using the substance, or recovering from its effects.
4. Experiencing strong urges or cravings to use the substance.
5. Failure to meet family, educational or employment responsibilities due to recurring substance use.
6. Continuous use of substance even when experiencing recurring interpersonal or social problems caused or aggravated by the effects of substance use.
7. Significant interests, hobbies, work, or social activities are abandoned or slowed down because of recurring substance use.
8. Chooses to continue using substance even when in a hazardous situation
9. Continuous substance use even with the knowledge that recurring mental or physical health problems was caused or induced by the substance.
10. Tolerance defined by any of the criteria below:
    a) A distinct need to increase the amounts of substance use in order to achieve the desired effect or level of intoxication.
    b) A noticeably reduced effect with the same amount of continued substance use.
11. Withdrawal defined by any of the criteria below:
    a) The traits of withdrawal syndrome experienced for the substance.
    b) The substance (or a comparable substance) is consumed to reduce or prevent withdrawal symptoms.

A substance use disorder is best shown on a continuum of use starting from abstinence (no use) through different degrees of use illustrated later in the 'Stage and Process Models' part of this section, and also briefly outlined below :

- **Mild:** when 2-3 of the 11 criteria or symptoms mentioned above are met.
- **Substantial:** when 4-5 of the 11 criteria or symptoms mentioned above are met.
- **Severe:** when 6 or more of the 11 criteria or symptoms mentioned above are met.

(American Psychiatric Association, 2013, *as cited in Matua Raki, 2014*).

Cravings

A craving is a compelling desire or urge for a drug (Sayette, Shiffman, Tiffany, Niaura, Martin & Shadel, 2000). According to Matua Raki, the National Addiction Workforce Development and author of *'A Guide to the Addiction Treatment Sector in Aotearoa New Zealand'* (2014) further explained that cravings, mild or strong can stimulate people to continue using substances even when it has become problematic and harmful. Also, cravings come and go like waves and managing them can be very challenging, especially for people who have abused substances for longer periods of time. Failure to maintain abstinence or keeping changes around substance use can increase the likelihood of someone relapsing.

Although cravings generally occur during the early stages of reduced use, withdrawal and abstinence, some people may also experience those years later (Cami & Farre, 2003). Cravings are usually ignited by internal or external triggers. Some examples of internal triggers are: thoughts, positive or negative feelings, physical sensations and memories. External triggers can be certain places, events, people, situations, and objects like paraphernalia used to prepare or use drugs. The usual way some people choose to cope with their problems is to use their drug of choice (Matua Raki, 2014).

Lapse and Relapse

Addiction has been described as a 'chronic relapsing condition' frequently requiring several attempts to abstain or reduce use in order to achieve a controlled or sober lifestyle (Matua Raki, 2014; Swanson & Cooper, 1998).

The term lapse is when a person has temporarily slipped up on their change goal of abstinence, sensible limit or social use. The term relapse is when a person goes back to their old alcohol and drug use behaviour (Marsh, Dale, O'Toole, 2013).

Majority of people go through lapse or relapse. For example, studies show that relapse rates ranged from 80-95% twelve months after alcohol or tobacco cessation. These relapse results were also comparable for various classes of substance use (Brandon, Vidrine & Litvin, 2007 as cited in Hendershot, Witkiewitz, George & Marlatt, 2011). Though lapse or relapse can be disappointing

and discouraging, it is important to see them as a normal part of change and as learning opportunities (Marsh, Dale, O'Toole, 2013). Addiction counsellors can assist their clients to identify their triggers, develop coping strategies, enhance self-efficacy, and build supports. Long term abstinence or controlled use at sensible limit or social use level can be very challenging but achievable (Matua Raki, 2014).

Gambling

According to the Ministry of Health (2012b), 52 per cent of adults in Aotearoa New Zealand have gambled in the past 12 months. Also, approximately 0.3 per cent of adults have been diagnosed with a gambling disorder with 2.5 per cent (89,000) negatively affected by someone's gambling.

With gambling there is a euphoria and a compulsive fixation on winning. People who become addicted to gambling or other behavioural addictions, such as; shopping, eating, sex, exercise, internet and electronic entertainment reinforces their 'feeling good' or reward pathways which stimulates the desire to repeat the addictive behaviour resulting in lifestyle imbalance and problems (Matua Raki, 2014).

The negative effects of problem gambling can include financial stressors, job losses, legal issues, relationship breakups, child abuse or neglect, mental health concerns, alcohol and drug abuse (Academy of Medical Sciences, 2008).

Similarly to alcohol and drug addiction, problem gamblers can also experience cravings, withdrawal, lapse and relapses (Matua Raki, 2014).

Recovery

Traditionally, recovery was only accomplished when abstinence from alcohol, drugs and gambling use was maintained. Since then, recovery has taken on a broader perspective to also include emotional, psychological and spiritual wellbeing. The Substance Abuse and Mental Health Services Administration (SAMHSA, 2012) defined recovery as: *"A process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential,"* and the Peer Workforce Competency Framework (Te Pou, 2014) provided

their definition as *"…creating a meaningful self-directed life, regardless of challenges faced, (and) includes resilience and aspirations and the achievement of these"* (as cited in Matua Raki, 2014).

2.2.2 Addiction Theories:

The purpose of this section is to present some theories that have been used to help explain alcohol and drug addiction and the interventions specified.

Initially, individuals with alcohol and other drug use or gambling addiction was viewed as people with low morals who wilfully choose to abuse substances and behave inappropriately to their families, community or society. Therefore, the religious parties and criminal justice system were viewed as the most fitting agencies in restoring moral control, punishing anti-social behaviours and providing treatment (Matua Raki, 2014).

However, individuals with "good moral" standards are just as likely to experiment or use alcohol and other drugs, or gamble. Consequently, the moral model was considered insufficient as it ignored other critical factors such as biological, physiological and sociological backgrounds of addicts. Eventually the moral model lost its influence and the disease model was adopted, with doctors and physicians taking over as the best experts on human behaviours and treatment (Wilbanks, 1989).

The 20th century introduced the concept that 'alcoholism' and 'drug addiction' was a physical disease to help explain the loss of willpower and control amongst people who abused substances. It was also asserted that alcoholism has a genetic disposition (Hirschman, 1995).

The Alcoholics Anonymous (AA) programme began in 1935, initiated by Bill Wilson and Doctor Robert (Bob) Smith who helped each other to achieve abstinence from alcohol use. Then from the AA group talks the Twelve-Step movement evolved, accepting 'alcoholism' as a disease preferred to base their programme on the bio-psycho-social-spiritual disease model. Gamblers Anonymous (GA) and Narcotics Anonymous (NA) also adopted the Twelve-Step model (Matua Raki, 2014).

The disease model claims there is no cure for addiction and therefore the only way to treat it is to supress the urge to use. People who are addicted are firstly encouraged to acknowledge they have a sickness which they cannot treat on their own, and they need professional help from counsellors

or therapists. Critics of this model (Schaler, 1991; Wilbanks, 1989), argues that this perspective characterizes addicts as victims, removing any responsibility away from them, thus creating a sense of learned helplessness. Furthermore, if addicts come to believe that there is no cure for addiction they may conclude it is pointless making an effort to achieve sobriety, and use this as an excuse to continue with their substance use (Wilbanks, 1989).

The causes of addiction are multifaceted and changeable. Currently there is no one model that integrates all theories. However, it is generally accepted among health professionals that addiction has its roots within the bio-psycho-social domains and interventions that are comprehensive and holistic is therefore recommended. The main core theories that help to explain addiction will be briefly outlined below (Matua Raki, 2014).

Biological theories

According to the Academy of Medical Sciences (AMS, 2008), there is a common reward pathway within the human brain that releases certain chemicals (e.g. dopamine), which creates feelings of relaxation and wellbeing when activated. This neural reward pathway reinforces behaviours that are essential for survival, for example; eating when hungry and this stimulates people to continue using this behavioural process. Neurobiologists have found that psychoactive substances can also activate the neural reward pathway where their continued use is reinforced.

It is not yet known why some people become more strongly addicted to substances than others. Nevertheless, substance abuse appears to have a greater influence on people with fewer receptors for dopamine (AMS, 2008). Also, there are some suggestions that points to genetics as a factor which may be due to a history of substance abuse related issues within the family (Berglund, Balldin, Berggren, Gerdner & Fahlke, 2013).

Research studies in gambling addiction behaviour have discovered the same neural reward pathway is also activated even though there are no chemicals going directly into the brain (AMS, 2008). This phenomenon highlights the important interaction between medical and psychological processes.

Psychological theories

There are several approaches derived from the psychological theories that help to explain causes of addiction, such as learning, personality and psychoanalytic theories. The biology of addiction steered towards how other psychological processes were also affected, like problem solving, memory, motivation, learning, decision-making and impulse control (AMS, 2008).

These theories see addiction as a conditioned and learned response in order to escape from problems or a painful reality, and cope with stress. From this perspective individuals generally resort to abusing alcohol and other drugs to help bring immediate relief to their emotional, physical or psychological pain. The concepts of association and reinforcement explain how cravings can be triggered by the senses or emotions being aroused, attending special events and seasonal celebrations, and being with certain people or places. Thus this approach regards addiction as a habit rather than a sickness (Schaler, 1991).

Social theories

The sociological theories direct our attention to look at the immediate and wider social factors that may explain why people start and continue abusing substances or gamble, like colonisation, marginalisation, discrimination, unemployment and poverty (Matua Raki, 2008).

Harm Minimisation

Harm Minimisation views addiction as a personal choice and its aim is to prevent and reduce the harms for the addict, their family and wider community. It focuses on two main treatment approaches, harm reduction and abstinence (Matua Raki, 2008).

The harm reduction approach has a holistic view with the goal of helping to decrease health and social problems connected to substance abuse among individuals, families and communities. Abstinence is not a condition in harm minimisation, but it is generally offered as an option. Alcohol, other drugs and gambling provides pleasure in many ways and most individuals do not want to give it up entirely or they may have mixed feelings about it. On the other hand, some people should not be drinking or using drugs temporarily or permanently, like during pregnancy, on medications, or diagnosed with an illness or substance dependency. Harm reduction believes an individual has the right to choose treatment when they are ready and forcing clients to make positive changes to their substance use will be ineffective. Therefore, the counsellor assists the

client to determine their own goals with specific plans of how to achieve positive lifestyle change (Matua Raki, 2008).

2.2.3 Stage & Process Models of Addiction:

(A) The Transtheoretical Stages of Change Model:

The transtheoretical stages of change model were developed in the 1980's by two American researchers, Prochaska and DiClemente (Blume, 2005). This is a useful model for understanding the process by which an individual can change their substance use or lifestyle behaviour. The transtheoretical model proposes that clients tend to move through six stages on the road to recovery as outlined below.

Stage 1: Pre-contemplation

The journey begins at the pre-contemplation stage where an individual is usually more focused on the positive benefits of their substance use or gambling, or have no awareness of their addiction, or appear less concerned about their drug use despite the signs of related problems (e.g. financial, legal, employment, health and relationships issues), and may show resistance when talking to them about their alcohol and drug use (Blume, 2005). Some useful tools to help motivate and shift clients from this stage are: Motivational Interviewing Therapy (MIT), data results from the screens and assessment interview with brief educational advice.

Stage 2: Contemplation

Clients who arrive at this stage appear to have some awareness that they may have a substance abuse or gambling problem, but appear ambivalent about it (Blume, 2005). Assisting them to weigh up the "good things" and "less good things" about their addiction issues and providing information about possible risks of continued misuse can be helpful in assisting clients to move towards cutting down or abstaining from their drug of choice.

Stage 3: Preparation/Determination

Clients in this stage are ready for change and committed in taking action or seeking help (Blume, 2005). They may talk to others about their intensions and start making small changes to their substance or gambling abuse. This is an ideal time for professionals or counsellors to provide advice or guidance on what strategies to use to help meet their desired goals for behaviour change.

Stage 4: Action

Clients in this stage are actively doing something about their substance use or gambling behaviour, for example: cutting down, abstaining, avoid contact with drug or gambling associates and places, or participating in healthier alternatives. It is important for counsellors or professionals at this stage to explore and evaluate with the client on how well their strategies for change is working, and to offer other tools (e.g. managing high risk situations and triggers, assertiveness skills, and rewarding success), resources, supports and other services that may be helpful (Blume, 2005).

Stage 5: Maintenance

Clients at this stage have successfully sustained positive changes to their substance use or gambling over a long period of time and enjoying the benefits of living a new lifestyle. It is important for counsellors and professionals to work together with the client in acknowledging and affirming their own achievements, strengths and supports. Like the action stage, clients may also benefit in having their strategies for high risk situations reviewed and learn further relapse prevention skills (Blume, 2005).

Stage 6: Lapse/Relapse

At this stage a client may lapse (temporary slip up on their change goals), or relapse (going back to old behaviours relating to their substance or gambling abuse). Lapse and relapse is a very common phenomenon and should be viewed as a natural part of the change cycle and a learning opportunity rather than a failure (Blume, 2005). It is important for clients not to give up hope, to stay calm and reflect on the reasons for the lapse/relapse, look for strategies and strengthen supports to be better prepared for the next high risk situation that may occur. There are other helpful supports such as: General Practitioners (GP), Detox Services, Alcoholic Anonymous

(AA), Narcotics Anonymous (NA), Gambling Problem Helpline New Zealand, Alcohol and Drug Helpline, Connect Services and residential rehabilitation programmes.

In conclusion, it is entirely normal for clients to journey through some or all stages of the transtheoretical model of change. It can be applied to other behaviours requiring change like food addictions, and it is common for clients to travel around this model of change more than once before significant progress is achieved and maintained (Blume, 2005).

(B) The Relapse Process Model:

Relapse, or return to problematic use following a period of abstinence or sensible use, is a natural part of change and it does not suddenly happen without any reason (Blume, 2005). The relapse process model was developed in 1985 by Marlatt and Gordon, which identifies several factors for why relapse occurs (Larimer, Palmer & Marlatt, 1999). The relapse model is briefly outlined below:

Lifestyle Imbalance

Lifestyle imbalance appears when an individual spends too much time in one area of their life, for example; long hours at work with little or no time for pleasant activities, self or family (Blume, 2005). Stress and boredom can also contribute towards lifestyle imbalance and lead a client into making 'seemingly irrelevant decisions' (SID's) about their substance use or gambling, develop a yearning to participate in a 'high risk situations' (HRS), or give in to the 'problem of instant gratification' (PIG), despite the negative consequences. Assisting clients to develop problem solving skills to reduce stress and boredom, and coping skills to best manage current and future high risk situations.

Seemingly Irrelevant Situation (SID's)

Clients can also make irrelevant decisions regarding their substance use or gambling that can lead them straight into a high risk situation. Individuals are usually unaware of the potential risks that may occur from their decisions. For example, a client goes shopping at a local supermarket and eventually finds they're travelling down the liquor aisle peering at their favourite wines. To an

alcoholic the trip into the supermarket was innocent, but it can eventually tempt a person into a high risk situation. Generally, many clients may not be able to link how they ended up into a high risk situation, so it is important for counsellors and professionals to assist clients in identifying and managing this part of the process (Blume, 2005).

High Risk Situation (HRS)

High risk situations are triggers that can lead an individual to return to their old addiction behaviour (Larimer, Palmer & Marlatt, 1999). HRS can arise when clients are experiencing strong or negative feelings, such as anger, anxiety, stress, frustration, boredom, loneliness and depression; or when attending social events; or being exposed to social pressure to use; or become involved in an interpersonal conflict with their partners, family, employer or others. Positive feelings can also be a trigger, for example; celebrating achievements and seasonal events. Clients' self-efficacy and confidence levels to control their addiction may begin to weaken if HRS is not managed effectively (Blume, 2005). It is therefore important for counsellors and professionals to empower clients by applying appropriate coping skills to their identified triggers, acknowledge their strengths, and assist them to strengthen their own internal and external supports.

Problem of Instant Gratification (PIG)

The 'problem of instant gratification' (PIG) usually occurs when an individual is wanting a change or an effect immediately and knowing by experience that alcohol and drugs will help them achieve this, for example; to calm down, relax, relieve pain (emotional or physical), gain confidence or feel secure. There may also be times when a client feels they should be rewarded for their hard work or strong efforts in overcoming their addictive behaviour, thus becoming intensely tempted to indulge in substances or gambling again. Other times that clients may become vulnerable to 'PIG' is when they are experiencing cravings, being triggered by other drug associates or environment they live in, or lifestyle imbalance, which may influence them to make 'seemingly irrelevant decisions' or being placed in 'high-risk situations'. Therefore, counsellors and professionals will need to work together with clients in developing their lifestyle balance plans, coping strategies, address any unhealthy core beliefs about their addictions, identify and enhance their values and supports, to seek out pleasurable activities, hobbies or interests as a practical substitute to substances or gambling (Blume, 2005). Other interventions or supports to consider for clients struggling with the PIG can include: medication (e.g., Benzodiazepines, Naltrexone,

Disulfiram, and Antabuse), residential rehabilitation programmes, AA, NA, Gambling Problem Helpline, Alcohol & Drug Helpline, Connect Peer Support Services, and involving supportive family or friends (Matua Raki, 2014).

Lapse

Lapses occur when a client temporarily slipped up on their goal to maintain abstinence or moderate use of their drug or gambling behaviour. The difference between a lapse and a relapse is that a lapse does not necessary mean returning to old drug use behaviour but tends to be more of a transitory phase. Clients experiencing a lapse, may often feel disappointment, guilt, shame, or other negative emotions, and may frequently blame themselves for the slip. The experience of negative emotions related to a lapse is referred to as an 'abstinence violation', or 'goal violation effect (GVE)' which will be briefly defined below (Blume, 2005).

It is important for counsellors and professionals to help clients understand that lapses are a natural part of change and it does not mean they have failed. Counsellors can encourage clients to use lapses as a learning opportunity in developing coping strategies for their identified triggers (e.g., The 3 D's: 'delay' the decision to use, 'distract' themselves by participating in pleasurable activities or interests, and consciously 'decide' not to give into a thought or feeling to use by focusing on their reasons for desiring change); explore any fears of change and possible losses that might go with that, set small achievable goals to increase their self-efficacy, and strengthen internal and external supports (Matua Raki, 2010).

Goal Violation Effect (GVE)

There seems to be a natural tendency for clients to become intensely discouraged when experiencing a 'goal violation effect' (GVE). This discouragement can lead towards negative thinking, such as black-and-white thinking (e.g., "Stuff it! I've really blown it this time, there's no point trying to change things now"), the client may then return to a more regular pattern of substance abuse, commonly known as relapse. It is therefore essential for counsellors and professionals to orientate clients about GVEs much earlier in the treatment process and through to post-care (Blume, 2005).

Cognitive restructuring is useful in helping clients reframe lapse to the situation rather to the self. If the lapse or relapse was attributed to the self then the client is viewed as the problem. Changing the attribution of lapse or relapse from the client to the situation can make the drug behavioural problem less difficult to solve. Therefore, the client needs to understand that the situation is the trigger and not them (Blume, 2005).

Relapse

As defined earlier, a relapse is when a client returns to their old drug routine and behaviour. Relapse should not be viewed as a failure but as a great learning opportunity to strengthen the client's recovery plan and supports. A relapse recovery plan should contain instructions to the client not to panic after a lapse or relapse, and to contact their counsellor or professional soon after it occurs. This plan may also include advice to seek help from a community support group, general practitioner, social or respite detoxification services, residential rehabilitation programmes, learn behavioural modification skills, or distract self with pleasant activities or interests (Blume, 2005).

Counsellors and professionals can also help clients develop their own relapse roadmaps. A relapse roadmap is a useful tool in examining past relapse behaviours, and it can help the client develop a plan to avoid future seemingly irrelevant decisions, high-risk situations, lapse and GVE. The different intersections or links along the relapse highway provides an opportunity for the client to detour or engage in an intervention (Blume, 2005).

2.2.4 Measurements for screening substance abuse and problem gambling:

The purpose of screening tools is to identify clients who may have a substance use and/or gambling problem from those who may not (Matua Raki, 2011). Screening is a vital step in prevention and reduction of substance use and gambling related problems. Screening tools provide quick information about an individual's substance use behaviour. There are mainly two forms of screening devices, biomarkers (laboratory tests) and questionnaires.

Breath alcohol testing equipment is one form of biomarker. It can be reliable, portable, and simple to administer with immediate results. However, this device has difficulty in distinguishing

between severe and prolonged alcohol use, as it can only recognise recent use of alcohol (Matua Raki, 2011). Another biomarker is a urine drug test which can detect the absence or presence of specific substances in the urine. The urine drug test can help the toxicologist determine approximately the time, dose and extent of the drug use. As a general rule, the higher the dosage and frequency of the substance used the more likely it will be detected (Dawe, Loxton, Hides, Kavanagh & Mattick, 2002).

The questionnaires are usually brief and can help health professions determine the level of severity of substance use and consider the appropriate treatment and supports (Matua Raki, 2008). A brief outline of some of the common questionnaire tools used for substance use and gambling are listed below.

Alcohol Use Disorders Identification Test (AUDIT)

The AUDIT screening tool is a ten-item self-report questionnaire created by the World Health Organisation (WHO) in 1993, used to detect alcohol problems at hazardous, harmful or dependency levels (Saunders, Aasland, Babor, De La Fuente & Grant, 1993).

The AUDIT is scored by adding all ten items up, and a score of 8 or more would indicate the client is experiencing some form of alcohol related problem (Matua Raki, 2011). Listed below are the recommended interventions for the AUDIT scores.

0 – 7	Alcohol education
8 – 15	Brief advice on alcohol misuse
16 – 19	Comprehensive advice on alcohol abuse, counselling with on-going support
20 – 40	Referral to specialist for diagnosis, assessment and treatment

Clinical judgement should be applied where a client's score conflicts with other evidence, or if the person has a prior history of alcohol dependence (Matua Raki, 2011).

Heaviness of Smoking Index (HSI)

The HSI is commonly used internationally but not yet validated in New Zealand. It is a very simple and brief screening tool used to assess the severity of nicotine dependence amongst adults (Heatherton, Kozlowski, Frecker, Rickert & Robinson, 1989). It can assist health practitioners to predict patterns of craving once an individual has stopped, and decide on what treatment (including nicotine replacement therapy: gum, lozenges, patches, mouth spray, inhaler, and medication) would be the best to apply (Matua Raki, 2011).

The HSI is a two-item self-report regarding time between waking and first cigarette used, and amounts of cigarettes used on daily basis. This tool is simply scored by adding up points allotted to the answers. The total score highlights the level of dependence (Matua Raki, 2011). Listed below are the recommended interventions for the HSI scores.

5-6 points: High nicotine dependence

2-4 points: Moderate nicotine dependence

0-1 points: Low nicotine dependence

Cannabis Use Disorder Test – Revised (CUDIT-R)

The CUDIT-R is a New Zealand self-report screening tool to assess for problematic cannabis use amongst adolescents and adults. This tool was originally designed in 2003 and later revised to highlight the specific areas of cannabis consumption, abuse, dependence, and psychological features (Adamson, Kay-Lambkin, Baker, Lewin, Thornton, Kelly & Sellman, 2010).

The CUDIT-R is scored by adding each of the 8 items as explained below:

Item 1-7 are scored on a 0-4 scale

Item 8 is scored 0, 2 and 4.

Scores of 8 or more indicate problematic cannabis use, whilst scores of 12 or more indicate a possible cannabis dependency disorder where further intervention may be more effective (Matua Raki, 2011).

Alcohol, Smoking & substance Involvement Screening Test (ASSIST)

The ASSIST is an eight-domain screening tool developed by an international group of substance abuse researchers for the World Health Organisation (Humeniuk, 2006). This tool is used to help identify problematic or dependency related issues for individuals consuming alcohol, tobacco, cannabis, amphetamine type stimulants, cocaine, hallucinogens, inhalants, opioids, sedatives, and other drugs). ASSIST has not yet been validated in New Zealand (Matua Raki, 2011).

The ASSIST screening tool is administered by an interviewer which takes approximately 7-10 minutes to complete. The results are recorded on the ASSIST Feedback Report card and provided as feedback to the clients about the level of their substance use. When hazardous, problematic or dependency risks are detected then the linked Brief Intervention questionnaire is administered by the interviewer which takes a further 10-15 minutes to complete (Matua Raki, 2011).

Early Intervention Gambling Health Test (EIGHT)

The EIGHT is a New Zealand self-report screening tool designed to help identify if gambling has become a problem and to ascertain if further intervention is required for related issues such as, depression, anxiety, and risks (Sullivan, 2007). This tool was originally designed for primary health services but can now be used in various health and social service agencies (Matua Raki, 2011).

The EIGHT screening tool is eight-item self-report questionnaire, or it can be administered by an interviewer if literacy or language is a barrier. All questions are responded with either "Yes" or "No". The guidelines for the scores are provided below (Matua Raki, 2011):

0 controlled gambling

1-2 low harm

3 low harm but risk for moderate harm

4-5 harm occurring from gambling

6-8 serious harm occurring from gambling (to assess for Pathological Gambling Disorder)

2.2.5 Maori perspective on addictions

Historically, Māori had no psychoactive substance use before the colonizers arrived to Aotearoa, New Zealand. It was Captain James Cook and his men that first brought alcohol here in 1773, and only isolated alcohol-related problems recorded for Māori were documented around mid to late 19th century (Mancall, Robertson & Huriwai, 2000; Hutt, 1999).

Nowadays, according to the latest "Te Rau Hinengaro, The New Zealand Mental Health Survey" (Oakley Browne, Wells & Scott, 2006), Māori have higher rates of substance misuse disorders (mainly alcohol, tobacco and cannabis) compared to non-Māori. For instance, there are 76% Māori aged 18 years and over who identify themselves as regular drinkers, and 36% as binge-drinkers (Raggett, Palmer, Fryer & Kalafatelis, 2009); 43% of Māori reported consuming alcohol when 14 years or younger compared to 32% of the total population in New Zealand (MOH, 2009a), and Māori are four times likely to die of alcohol related illnesses than non-Māori (Conner, et al, 2005).

In regards to cannabis use in New Zealand, Māori have the highest rate of consumption than the total population, with one in four Māori use cannabis compared to the national average of one in seven (MOH, 2010a). Like unto alcohol, the starting ages for consuming cannabis recorded for Māori were 14 years or younger compared to non-Māori were ages 15 to 17 years. Cannabis use has also been linked to truancy, poor academic performance, behavioural and relationship problems, poly-substance use, unemployment, criminal offending, physical and mental health problems from adolescence to adulthood (Government of New Zealand (GNZ), 2003).

What is also concerning is the significant amounts of tobacco being smoked by Māori on a daily basis at 36.1%, compared to Pacific 22.1%, European/other 13.4% and Asian at 8.6%. Approximately 5,000 people die each year in New Zealand because of smoking or exposure to second-hand smoking. This equates to 13 people a day (MOH, 2013b).

It was also further reported that up to 95% of people receiving treatment for substance abuse, in community alcohol and other drug (AOD) services, have co-existing mental health problems (Todd, 2010).

The 2006/07 New Zealand Health Survey indicated that 1.7% of the total adult population were identified as moderate-risk or problematic gamblers (MOH, 2009b). Also, that Māori were approximately four times likely to be problematic gamblers than the rest of the adult population.

This survey also reported that Māori problem gamblers were four times more likely to be active smokers, five times more likely to have careless drinking behaviours and higher rates of anxiety and depression.

It is important to note that raising the issue of substance abuse and gambling with any Māori client can present some challenges for some counsellors or professionals. Such as, lack of cultural awareness, fluency, responsiveness, safety and sensitivity. In 1995, a study was conducted to investigate the importance of cultural identity, factors and values in an alcohol and other drug (AOD) treatment services (Huriwai, Sellman, Sullivan & Potiki, 2000). This research comprised of 111 Māori with substance abuse related issues aged between 17 and 55 years, attending AOD treatment at two dedicated Māori services and four non-dedicated Māori services. The results showed that the importance of cultural factors in AOD treatment, irrespective of their age, gender, cultural connectedness, level of dependence, mood, previous admissions, or whether they were treated in a Māori dedicated program or not, was highly validated. It is therefore essential to use culturally appropriate processes when engaging and working with Māori, and to involve their whanau (family) and key supports. Furthermore, there were a significant number who believed that being identified as a Māori, belonging to an Iwi (tribe), and having pride in being Māori was crucial in the recovery/healing process.

2.2.6 Māori Model of Health – Te Whare Tapa Wha:

There are a range of Māori models relating to wellbeing, including Nga Pou Mana (Henare, 1988), Te Wheke (Pere, 1991), and Te Powhiri Poutama (Huata, 2011). Mason Durie (1985) also presented a model 'Te Whare Tapa Wha', the four walls of holistic wellbeing for Māori. Te Whare Tapa Wha can be part of the assessment process and used in developing a comprehensive treatment recovery plan. A brief outline is provided below.

Te taha wairua

Te taha wairua is spiritual wellbeing (Durie, 1998). Te taha wairua acknowledges the spiritual connection and respect to Matua i te Rangi (Father of the heavens and universe), Papatuanuku (Mother Earth including forest, land, air and sea), Tupuna (ancestors), whanau, all peoples and all creatures. Durie also added that te taha wairua is the capacity for faith, values, self-respect, beliefs around karakia (incantation), tangihanga (funeral and bereavement), taonga (treasure), tapu

(sacred), noa (safe), mate Māori (Māori illness), makutu (Māori curse), rongoa (Māori medicine), and waiata (songs). Te taha wairua links Māori with the past, present and future, and helps to provide their life with a sense of purpose and meaning. Therefore, without taha wairua the intervention would not be considered holistic or complete.

Te taha whānau

Te taha whānau is the wellbeing of family which includes relationships with partners, parents/guardians, kuia and kaumatua (elders), siblings – teina (younger sibling) and tuakana (older sibling), immediate and extended whānau, hapū and iwi (Durie, 1998). Te taha whānau can also be referred to the individual's wider support network such as; church, sport clubs, alcohol/drug associates, peers, gangs, professionals who may also be involved such as; social workers, general practitioners, psychologists, psychiatrists, cultural workers, counsellors and therapists. In collaboration with the individual 'te taha whānau' has got the potential to help build self-efficacy and further enhance the intervention and recovery plan.

Te taha hinengaro

Te taha hinengaro is mental wellbeing, the capacity to think, feel and communicate (Durie, 1998). It also includes thought processes, managing emotions, decision making, problem solving, cognitive abilities, learning development, and intuition. However, negative thinking styles, substance abuse, poor diet, lack of exercise and insomnia can all contribute towards a client becoming mentally unstable and unwell, and thus unable to fulfil their respective roles and responsibilities adequately within the whanau and community.

Te taha tinana

Te taha tinana is physical wellbeing, the capacity for physical growth and development (Durie, 1998). It includes the concepts of tapu (sacred) and noa (not sacred) especially when applying traditional tikanga practices around safety, hygiene and health. The body is viewed as tapu for it houses the 'wairua' and a vehicle for accomplishing physical tasks, achieving goals and serving the whanau and community. Poor diet, lack of regular exercise, insomnia, and substance abuse erodes the client's capacity to think, feel, work, play, rest and serve. Therefore, as part of the

intervention it is vital that counsellors and professionals assist the individual in identifying concerns, develop their health and fitness/activity plan, establish key supports, evaluate and review progress. Te taha tinana can also include the physical surroundings such as; house, work, school, parks or places of daily activities. It also includes your turangawaewae (home roots/place of identity). The taha tinana highlights the strong connection with taha wairua, taha whanau and taha hinengaro.

2.2.7 Measurements for screening addictions with Māori

When working with Māori clients it is important to screen for substance and gambling abuse early in the treatment. When conducting screen test with Māori, genuine cultural respect, empathy, openness, welcoming atmosphere, and a non-judgemental attitude can help reduce discomfort and establish relationships trust for both the client and counsellor. The screening tools outlined in Section 2.2.4 to identify problems with alcohol use (AUDIT) (Saunders et al, 1993); tobacco use (HSI) (Heatherton et al, 1989); cannabis use (CUDIT-R) (Adamson et al, 2010); and problem gambling (EIGHT) (Sullivan, 2007); was also recommended by the Ministry of Health and Best Practice Journal as suitable tools to use with Māori (MOH: 2010b).

The fundamental feature of Te Whare Tapa Wha is that it takes a holistic view of wellbeing, and in order for this to be achieve, all its dimensions needs to have a healthy balance. Durie (1998) also noted that a common gap in many contemporary health services was including the taha whanau and taha wairua dimension.

Therefore, in order to provide a service that is culturally responsive to Māori, counsellors and professionals will need to have sufficient amount of cultural competence, including whanau, wairua and other cultural values into their interventions and practice. Which also has implications for how treatment services are designed, how staff are recruited and trained, and the effectiveness of their treatment to Māori (Huriwai et al., 2000).

2.3 Synthesizing grief and addictions

When people go through changes in life, there is always an element of loss related to that change. For some individuals loss becomes too difficult to deal with and alcohol and drug use become an immediate relief from fully experiencing the loss, and grief then becomes suspended and complicated. Furthermore, some people really struggle to cut down on their drug of choice or give it up, and those going through treatment recovery can be grieving for the loss of their addictive lifestyle. This type of loss also impacts on their coping mechanisms for further losses and social supports, including family and friends who also use substances (Martin & Privette, 1989).

Addiction runs a chronic course of relapse in bereaved individuals with fewer resiliencies and supports especially when experiencing further losses. When under the influence of substances, the bereaved individual may ignore the negative consequences of their alcohol and drug use on their partners, children, employment and holistic wellbeing. Therefore, future research is recommended to examine effective interventions to assist bereaved individuals stuck in the denial stages of grief and addictions. Recovering from grief and substance abuse can be difficult and challenging but with the appropriate supports the journey can become more meaningful and life changing.

Chapter 3

3.0 A structured review of loss, grief and addictions

3.1 Introduction

The purpose of this structured literature review was to identify interventions that would be pertinent in assisting the bereaved in progressing through their grief experiences and recovery from substance abuse.

As the writer is of Māori decent, and a high number of clients presenting at CADS, hospitals, social and justice services are Māori, a Māori perspective was therefore included throughout this research.

The writer reviewed qualitative and quantitative research studies that related to the dissertation topic, which were obtained from a variety of sources including journal articles, literature reviews, and systematic reviews.

3.2 Structured literature review methodology

Systematic reviews have been proposed as a rigorous approach to find relevant research in relation to a specific area. Dickson (1999, p.42), describes such reviews as a means to, "locate, appraise and synthesise evidence from scientific studies in order to provide informative, empirical answers to scientific research questions". The key components of a systematic literature review include a distinct research question, a well-defined inclusion and exclusions criteria, clear route in accessing relevant literature and studies, and a synthesis of the data (Dickson, 1999). A common methodology adopted for systematic reviews is the Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) approach which offers standards to provide a transparent and complete reporting of systematic reviews and meta-analysis (Moher, Liberati, Tetzlaff & Altman, 2009).

The methodology used in this dissertation is more that of a structured literature review, where the above approaches described by Dickson are undertaken, but without the strict rigour of the PRISMA methodology including the adoption and develop of criteria that appraises the quality of the various studies extracted by the search criteria.

3.3. Databases

A number of databases were considered to help cover the diverse range of professional fields relevant to this research as identified in 3.3.2 below. This resulted in six databases being selected and all extracted from the University of Auckland Database website: CINAHL Plus (1937 – Oct 2014), PsychINFO (1806 – Oct 2014), Scopus (1994 – Oct 2014), Medline (1946 – Oct 2014), DRUG (1987 – Oct 2014), and Social Work Abstracts Plus (1968 – Oct 2014). All of these databases are commonly used within the Health Science, Medical, Education, Humanities and Social Science faculties. Table 1 provides an outline and brief summary of each database used in this research. Tables 2 and 3 provide the search results that surfaced from each database.

3.3.1 Search strategy and keyword search

To maximise the success rate of identifying all relevant work that has been conducted on grief and addiction recovery a combination of search terms was developed and assistance from the University of Auckland librarian was gained. The search terms were grouped into three main search categories: 'Grief', 'Substance Abuse' and 'Interventions'. These search categories were then linked together to find literature that contained at least one of the terms from each category. The Boolean Operators (and, or) were used to help link the search terms. 'Or' was used to link the search terms within each search category, whilst 'And' was used to help link search categories together. Table 2 provides a brief outline of the range of terms consistently used with each data base.

3.3.2 Inclusion criteria

The criteria used to include material for this review consist of studies that included: (i) interventions for loss, grief and addictions and (ii) measurements used for screening grief and or addictions were retrieved. In addition, all literature published in English or Māori, written only in full text between the starting date of each database and the month the search was actually conducted in (October 2014), was included to help emphasize the uniqueness of the grief and substance abuse concepts over time from specific professional fields i.e. medical, mental health, social services, counselling, and alcohol and drug services. Qualitative and quantitative findings were assessed to help answer the research question *"Are issues relating to loss and grief being addressed in clients attending treatment/rehabilitation for substance abuse?"*. Tables 4 and 5

provide a brief outline of the inclusion process. Table 6 provides the final result of the articles selected for this review.

3.3.3 Exclusion criteria:

As the writer is Māori and primarily working with Māori and non-Māori adults in the alcohol and drugs field, studies that were (i) more child and adolescent focused (ii) not relevant to the research topic (iii) provided no discussion or measurement on loss, grief and substance abuse (iv) published books, government and non-government reports or theses/dissertations (v) not published in English or Māori and (vi) not available in full text were excluded. Both titles and abstracts were examined to determine whether selection criteria were met. If an article was unable to meet all of the criteria, the reference was excluded and the full text article was not retrieved. Tables 4 and 5 provide a brief outline of the exclusion process.

Table 1. Summary of databases used in this research extracted from University of Auckland

Database	**Range in years** (Starting date to time of research)	**Description**
1. CINAHL Plus	1937 – Oct 2014	The expanded version of the *CINAHL* index, *CINAHL Plus* is the expanded version of CINAHL index and it provides an even wider scope of nursing and allied health journals which includes social services in health care, and rehabilitation. It has more than 3.8 million records and indexing more than 4,900 journals. The literature and records date back to 1937. CINAHL Plus is an American database that comes with an easy-to-use advanced search tool.
2. PsycINFO	1806 – Oct 2014	PsycINFO is a major international database which provides access to over 1 million references from the international literature of psychology and the behavioural sciences. Relevant material from the related disciplines of anthropology, linguistics, law, physiology, education, medicine, business, sociology and psychiatry is also included. PsycINFO indexes and abstracts more than 2,497 journals from over 50 countries, as well as English-language books and book chapters, technical reports and dissertations published worldwide. PsycINFO is produced in the United States by the American Psychological Association.
3. Scopus	1994 – Oct 2014	Scopus is a bibliographic database owned by Elsevier, an international academic publishing company based in Amsterdam and has operations in United Kingdom, United States, Mexico, Brazil, Spain and other countries. It covers approximately 21,000 titles from over 5,000 international publishers, of which 20,000 are peer-reviewed journals in the scientific, technical, medical, social sciences including arts and humanities.
4. Medline	1946 – Oct 2014	Medline is a bibliographic database formed by the United States National Library of Medicine (NLM) and is freely available and searchable on the internet via PubMed and NLM. The database contains more than 21.6 million records from 5,639 selected publications covering medicine, pharmacy, nursing, dentistry, veterinary and health care from 1946 to the present.
5. DRUG	1987 – Oct 2014	The DRUG database was formed in 1987 by the Alcohol and other Drugs Council of Australia (ADCA) in Canberra. DRUG is a bibliographic database that indexes articles from published and unpublished material on the psychosocial and treatment aspects of substance abuse.
6. Social Work Abstracts Plus	1968 – Oct 2014	Social Work Abstracts Plus was produced by the National Association of Social Workers and published by EBSCO. It provides indexing and abstracts backdated to 1968 to date dealing with social work, education, human services, addictions, child and family welfare, mental health and more.

Table 2: Keyword Search Strategy

(**Question:** "Are issues relating to loss and grief being addressed in clients attending treatment/rehabilitation for substance abuse?")

Database	Search limits	Search no.	Search terms	citations
1. CINAHL Plus	**1937 – Oct 2014**	1	grief OR "personal loss" OR bereavement OR mourning	10,404
		2	"substance abuse" OR "alcohol abuse" OR "substance dependence" OR "substance abuse, intravenous"	34,961
		3	Intervention OR Recovery OR "Substance Use Rehabilitation Programs"	140,315
		4	#1 AND #2 AND #3	**8**
2. **PsycINFO**	**1806 – Oct 2014**	1	grief OR "personal loss" OR bereavement OR mourning	13,461
		2	"substance abuse" OR "alcohol abuse" OR "drug abuse" OR "substance dependence"	101,113
		3	treatment OR rehabilitation OR intervention OR recovery	665,813
		4	#1 AND #2 AND # 3	**65**
3. Scopus	**1977 – Oct 2014**	1	grief OR "personal loss" OR bereavement OR mourning	22,653
		2	"substance abuse" OR "alcohol abuse" OR "drug abuse" OR "substance dependence"	137,152
		3	treatment OR rehabilitation OR intervention OR recovery	6,739,067
		4	#1 AND #2 AND # 3	**154**
4. Medline	**1860 – Oct 2014**	1	Grief OR "personal loss" OR bereavement OR mourning	11,573
		2	"substance abuse" OR "alcohol abuse" OR "drug abuse" OR "substance dependence"	66,159
		3	treatment OR rehabilitation OR intervention OR recovery	3,949,182
		4	#1 AND #2 AND # 3	**26**

Database	Search limits	Search no.	Search terms	citations
5. DRUG	**1987 – Oct 2014**	1	grief OR "personal loss" OR bereavement OR mourning	42
		2	"substance abuse" OR "alcohol abuse" OR "drug abuse" OR "substance dependence"	16,184
		3	treatment OR rehabilitation OR intervention OR recovery	37,148
		4	#1 AND #2 AND # 3	**6**
6. Social Work Abstracts Plus	**1968 – Oct 2014**	1	grief OR "personal loss" OR bereavement OR mourning	706
		2	"substance abuse" OR "alcohol abuse" OR "drug abuse" OR "substance dependence"	2,598
		3	treatment OR rehabilitation OR intervention OR recovery	14,887
		4	#1 AND #2 AND # 3	**2**

Table 3. Total Number of searches identified through database search.

Database	Number of references sighted	Number of references identified
1. CINAHL Plus	185,680	8
2. PsycINFO	780,387	65
3. Scopus	6,898,872	154
4. Medline	4,026,914	26
5. DRUG	53,374	6
6. Social Work Abstracts Plus	18,191	2
Total number	**11,963,418**	**261**

Table 4. Selection process for exclusion and inclusion of literature

Database	Number of literature identified	Number of records after duplicates removed	Child or Adolescent focused	Not relevant to research	Book	Non-English Non-Māori	Not available In full text	Total number Excluded	Total number Included
CINAHL Plus	8	0	0	7	0	0	0	**7**	**1**
PsycINFO	65	8	11	36	0	0	6	**61**	**4**
Scopus	154	5	20	124	0	0	1	**150**	**4**
Medline	26	22	0	4	0	0	0	**26**	**0**
DRUG	6	0	0	1	0	0	0	**1**	**5**
Social Work Abstracts Plus	2	0	0	2	0	0	0	**2**	**0**
Total Number	**261**	**35**	**31**	**174**	**0**	**0**	**7**	**247**	**14**

Table 5. An adapted PRISMA flow diagram of the selection process for inclusion of literature:

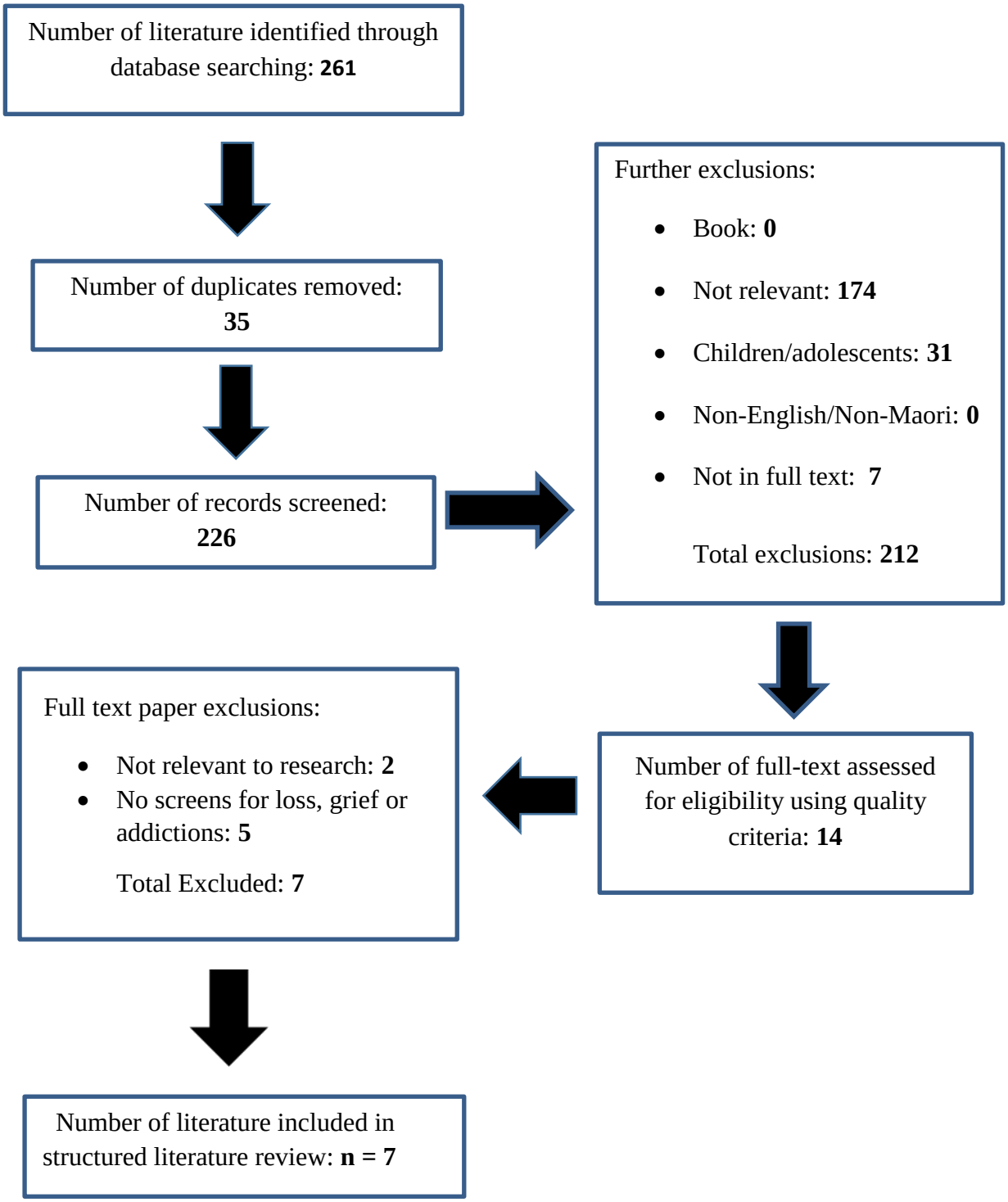

Table 6. Summary of references included in the systematic review in descending year of publication

Author/Year/Title/Database	Location & Setting	Participants	Aims of Study / Type of research	Measurement	Findings
1. Pilling, J., Thege, B.K., Demetrovics, Z. & Kopp, M.S. (2012). *Alcohol use in the first three years of bereavement: a national representative survey.* Substance Abuse Treatment, and Policy, 7:3. Database: DRUG	Hungary, 12,668 subjects was drawn from National Population Register and consented to being part of a national representative survey	Hungarian population. 4,457 Male and Female adults (18-75 years) completed survey	To analyse the relationship between bereavement and alcohol consumption accounting for time and gender differences. Quantitative	National representative survey and AUDIT used to measure the harmful consequences of alcohol use in the first 3 years of bereavement	Results indicate higher levels of alcohol consumption and alcohol related problems amongst men who bereaved for 1 year 18.4%, and for 2 years 29.8%. Women no difference was found with respect to alcohol use compared to non-bereaved.
2. Streifel, C. & Servaty-Seib, H.L. (2009). *Recovering from Alcohol and Other Drug Dependency: Loss and Spirituality in a 12-Step Context.* Alcoholism Treatment Quarterly, 27:2, 184-198. Database: CINAHL Plus	Medium size community in Midwestern state, United States of America (USA). 12-Step Programs: Alcoholic Anonymous (AA), and Narcotics Anonymous (NA) meetings.	128 recovering alcoholics and drug addicts. Female 59%, Male 41% (20-77 years with mean age of 47.6 years). Caucasian 89%. Other ethnicities – not reported.	To examine the extent to which the participation in AA/NA involvement is mediated by reactions to the losses associated with recovery, and what extent is a reaction to loss mediated by spirituality. Qualitative	Obsessive-Compulsive Drinking/drug Use Scale-Revised (OCDS-R) to measure recovery. Alcoholic Anonymous Involvement Scale (AAI) to measure AA/NA involvement. Miller Measure of Spirituality (MMS) to measure spirituality. Hogan Grief Reaction checklist (HGRC) to measure painful grief reactions and personal growth.	Results indicate a link between involvement in AA and NA and reactions to recovery- related losses and suggest that spirituality may play a central role in transforming losses into personal growth, enhancing changes of lasting recovery.

Author/Year/Title/Database	Location & Setting	Participants	Aims of Study / Type of research	Measurement	Findings
3. Smith, C.S. (2009). *Substance Abuse, Chronic Sorrow, and Mothering Loss: Relapse Triggers Among Female Victims of Child Abuse*. Journal of Pediatric Nursing, 24:5. Database: Scopus	Arkansas Cares for Addictions Research, Education & Services (ArCARES), USA. ArCARES is a licensed substance abuse treatment centre, mental health provider and child care centre.	12 women participated, ages 26 to 41 years. Caucasian 7, African-American 5. All reported being single parents. All were victims of domestic violence, and 10 suffered childhood abuse. All in treatment for substance abuse relapse and using substances to block feelings.	To explore relapse triggers among female victims of child abuse seeking treatment for substance abuse. Qualitative	The Burke Chronic Sorrow Interview Guide, a semi-structured interview guide with open-ended questions to allow participants to discuss their experiences of loss and relapse.	Each participant had varied life experiences of abuse and relapse. Three common themes emerged and were interwoven in their stories. Themes included mothering loss, blocking feelings, and relapse triggers. Relapse triggers identified: loneliness, sadness, anger, and frustration. To enhance treatment success among women who survived abuse, insight into losses and chronic sorrow is also included as potential relapse triggers.
4. Zuckoff, A., Shear, K., Frank, E., Daley, D.C., Seligman, K. & Silowash, R. (2006). *Treating complicated grief and substance use disorders: A pilot study*. Journal of Substance Abuse Treatment, 30: 205-211. Database: DRUG	University based clinic, University of Pittsburgh, USA.	16 adults, 9 women and 7 men. Age range = 24-57 years. 8 African-American, 7 Caucasian and 1 Native American. 1 married, 6 never married, 9 widowed, separated or divorced. 7 grieving over violent deaths, and 9 grieving over nonviolent deaths. All entered treatment with substance abuse issues.	To conduct a treatment development project by adapting Complicated Grief Treatment (CGT) for persons presenting with complicated grief and substance abuse/dependence issues. Qualitative & Quantitative	Inventory of Complicated Grief (ICG) to assess grief symptoms. Beck Depression Inventory (BDI) to measure symptoms of depression. Timeline Followback (TLFB) a semi-structured interview for quantifying alcohol and drug use. Likert-scale questions to assess the frequency of substance use and craving intensity levels. Breathalyser test for alcohol before each treatment session.	8 participants completed treatment (5 men and 3 women). 1 declined to continue with grief-focused procedures. 3 dropped out – reasons unknown. 2 were withdrawn for medical reasons. 1 withdrawn - failed to attend treatment sessions. 1 withdrawn for substance use and depression increased after 9 sessions. 10 participants on antidepressants – 6 completed and 4 did not. 6 participants not on antidepressants – 2 completed and 4 did not. Study showed reductions in grief, depression and cravings. Study was limited by small number of participants, further research is recommended.

Author/Year/Title/Database	Location & Setting	Participants	Aims of Study / Type of research	Measurement	Findings
5. McComish, J.F., Greenberg, R., Kent-Bryant, J., Chruscial, H.L., Ager, J., Hines, F. & Ransom, S.B. (1999). *Evaluation of a Grief Group for Women in Residential Substance abuse Treatment.* Substance Abuse, 20:1. Database: DRUG	Flint Odyssey House (FOH), a women's residential substance abuse treatment program, Michigan, USA.	24 women participated in grief group, with a comparison group of 31 women. Both groups were mostly African-American (85.5%), single (98.2%). Primary drug use reported – crack cocaine (90.6%). Mean age was 29.8 years. 81.8% reported history of abuse.	To examine the effectiveness of a therapy group addressing loss and grief among women enrolled in a gender-specific residential substance abuse treatment program. Qualitative & Quantitative	Quantitative: t-test and chi-square, ANOVA and MANOVA to compare variables of both groups over time. Qualitative: Hudson Self-Esteem Index (ISE), Center for Epidemiology Studies-Depression Scale (CES-D), Profile of Mood States (POMS) and Adult-Adolescent Parenting Index (AAPI).	Women who participated in grief group had longer length of stay and higher self-esteem than women who did not attend group.
6. Martin, S. & Privette, G. (1989). *Process model of grief therapy in an alcohol treatment program.* The Journal for Specialist in Group Work, 14:1, 46-52. Database: PsycINFO	28-day residential alcohol and drug abuse treatment program at Alachua County Crisis Center, Gainesville, Florida, USA.	6 participants, 5 men and 1 woman. All 6 treated for alcohol and other drug addiction. Age range form 19-57 years. All had previous group therapy experience. Losses identified were divorce, and death of significant family members or spouse. Ethnicity not provided.	To explore the relationship between grieving and addiction and to assist clients in identifying loss, recognizing reactions, exploring coping mechanisms, and mourning losses. To also present a model for group therapy. Qualitative	The Beck Depression Inventory (1978). Therapy tools used: Models of grief from Worden (1982) and Kubler-loss (1969). Brief Psychodrama facilitated.	After completing a 1-week long group therapy, group members expressed feeling more relaxed and in control. The group also reported an increase of confidence in understanding loss and their ability to complete the grief process successfully.

Author/Year/Title/Database	Location & Setting	Participants	Aims of Study / Type of research	Measurement	Findings
7. McGovern, T.F. (1986). *Loss Identification in the Treatment of alcoholism.* Alcohol, 3: 95-96. Database: PsycINFO	Pilot study conducted on 28-day treatment program located in general hospital setting. USA.	50 participants, males – 24, females – 16, all diagnosed with alcoholism and voluntarily attended treatment. Median age – 41.5 years. 84% completed high school education, 36% married, 44% divorced, 12% widowed, and 8% single. Most group in high employment status (84%) with ability to pay for treatment.	To explore patient ability in identifying alcoholism related losses. Qualitative and Quantitative	Loss Identification Measure (LIM). Michigan Alcoholism Screening Test (MAST).	The study demonstrated that alcoholic patients had the ability to identify losses associated with their alcohol use within the first of week of treatment and awareness increased significantly at completion of program.

Chapter 4

4.0 Summary of selected articles:

The search strategy identified seven relevant references and the findings for this review are presented in descending year of publication below. More detailed information is available in Table 6 summary of references included in the structured review, or in the original literature. All seven references included in this review are journal articles.

Article 1: Alcohol use in the first three years of bereavement: a national representative survey.
Pilling, J., Thege, B.K., Demetrovics, Z. & Kopp, M.S. (2012).

This study undertaken by Pilling, Thege, Demetrovics & Kopp (2012) in Hungary explored the relationship between bereavement and alcohol consumption, with 4,4576 female and male adults aged 18 to 75 years. The harmful consequences of alcohol use in the first 3 years of bereavement were measured using the Alcohol Use Disorders Identification Test (AUDIT). The results showed that men who were bereaved for one year scored high on two dimensions of AUDIT (alcohol dependence and harmful alcohol use), while men who were bereaved for two years scored higher on three dimensions (alcohol dependence, harmful alcohol use and hazardous alcohol use). The rate of non-bereaved men clinically at risk of problematic alcohol use was 12.9%, and 18.4% among men who bereaved for one year compared to 29.8% among men who bereaved for two years. However, among men who bereaved for three years, no significant differences regarding alcohol consumption were found, when compared to non-bereaved men. Among women we have not found significant differences regarding any aspects of alcohol consumption in the first three years of bereavement. The AUDIT also tested the possible interaction between gender and bereavement status. The results of the study confirm gender differences can only be identified among adults bereaved for two years. Furthermore, the results also draw attention to the high morbidity and mortality rates among bereaved men, and that early and effective intervention may contribute to reducing alcohol related health problems. Limitations of this study include its cross-sectional design as it cannot substantiate casual relationships, and the application of self-rating report rather than an interview-based assessment as individuals may under estimate their alcohol consumption and minimise alcohol related problems.

Article 2: Recovering from Alcohol and Other Drug Dependency: Loss and Spirituality in a 12-Step Context. *Streifel, C. & Servaty-Seib, H.L. (2009).*

Streifel & Servaty-Seib (2009) undertook a study of 128 recovering alcoholics and drug addicts attending Alcoholics Anonymous (AA) and Narcotics Anonymous (NA) 12-step programme in Midwestern state of America, examining to what extent of their participation is mediated by reactions to the losses associated with substance misuse recovery, and to what extent is loss mediated by spirituality. Of the 128 completed surveys, 66 were obtained online and 62 obtained via paper-and-pencil format. The participant's age ranged from 20 to 77 years, with a mean age of 47.6 years. Participants in this study were 59% female, 41% male, and 89% were Caucasian. Several previously validated instruments were used in this study. Recovery from substance misuse was measured using the Obsessive-Compulsive Drinking/Drug Use Scale-Revised (OCDS-R). The scales reliability and validity for the total scores was established by Morgan et al. (2004). The Alcoholics Anonymous Involvement (AAI) scale, adjusted to reflect involvement in AA or NA, was used to measure two subscales: Attendance (e.g., number of meetings attended), and Involvement (e.g., number of steps achieved, working with a sponsor). The subscales reliability and validity for the total scores was established by Morgan et al. (2004). The Miller Measure of Spirituality (MMS; Miller, 2004) was used to measure two domains of spirituality, Prosocial Beliefs (the importance for individuals to be at peace with themselves), and the Importance of a Higher Being (the belief and need to communicate to a Higher Being/Power). The subscales reliability and validity for the total scores was established by Miller (2004). The Hogan Grief Reaction Checklist (HGRC) designed by Hogan, Greenfield, and Schmidt (2001), was used to measure six subscales of the bereavement process: Despair (shattered hopes/dreams), Panic Behaviour (excessive worrying), Blame and Anger (resentfulness), Detachment (inability to cope), Disorganization (inability to concentrate/focus), and Personal Growth (positive view of present and future). The subscales reliability and validity for the total scores was established by Hogan et al. (2001). The results of the study showed that the mediation effect was significant between painful grief reactions and the OCDS-R (b = - .2295 x 7294 = .1674, $p < .01$). The results also confirmed that higher participation in AA/NA was associated with lower scores on the painful grief reactions measure and higher on personal growth (B = -.6407, $p < .01$). Individuals who are more involved in AA/NA exhibit fewer symptoms of despair, anger, resentment, anxiety, and other grief symptoms. These lower painful grief symptoms in turn are associated with a lower obsession-compulsion to drink/use. However, there was an unexpected finding that involvement in AA/NA was not directly related to personal growth (B = .0811, $p > .05$). On the other hand, AA/NA involvement was associated with personal growth via spirituality. Individuals who

attended AA/NA meetings regularly, are involved in sponsorship, read the AA/NA literature, and are involved in prayer and meditation had higher levels of personal growth. This finding enhances our understanding of the importance of spirituality in AA/NA program. In contrast, spirituality (prosocial beliefs and importance of a higher being) was not associated with less anger, despair, anxiety, detachment, and feelings of disorganization (B = .0593, $p > .05$). This finding was also unexpected. An explanation offered for this is that increased spirituality provides individuals with greater awareness of grief, which does not necessarily mean they are spared from experiencing the emotional pain associated to recovery-related losses. However, the results confirmed that the mediated effect of AA/NA involvement on personal growth via spirituality was significantly high ($b = .1070$, $p < .01$). Limitations of this study include its cross-sectional design as it does not allow casual relationships among variables, and majority of the participants were currently deeply involved in AA/NA. A broader sample to test the core hypotheses may have been more useful. Another limitation noted was the grief measure for generic loss was used as a proxy for recovery-related losses. Furthermore, there was no data on other ethnicities and the length of abstinence from alcohol and drug use. However, the overall results validates that individuals who had developed more hope, tolerance, compassion, and held a better view of life, had lower obsession-compulsion to drink or use. This finding highlights to counsellors and professional the importance of the relationship between personal growth, spirituality and positive recovery outcomes which was evident by the involvement in the AA/NA program.

Article 3: Substance Abuse, Chronic Sorrow, and Mothering Loss: Relapse Triggers Among Female Victims of Child Abuse. *Smith, C.S. (2009).*

The research conducted by Smith (2009) at the Arkansas Cares for Addictions Research, Education & Services in America (licensed substance abuse treatment centre, mental health provider and child care centre), explored chronic sorrow as a relapse trigger among twelve women seeking substance abuse treatment for relapse with a self-reported history of child abuse. The ages of the women ranged from 26 to 41 years, 7 were Caucasian and 5 were African American, all were single parents at time of the interviews, all were victims of domestic violence, 10 had suffered childhood abuse, and all were diagnosed with a mental health disorder in concurrence with their substance abuse disorder. The findings showed three common themes had emerged from life experiences of abuse and relapse: mothering loss, blocking feelings, and relapse triggers. The Open-ended questions in conjunction with Burke Chronic Sorrow Interview Guide were used to facilitate discussions with participants in sharing their experiences and feelings relating to the

topic (Hall, 2000). Feelings described by the women for relapse triggers included sadness, anger, loneliness, and frustration. Limitations of this study include the small sample size and setting. As the sample consisted of women in substance abuse treatment, the findings will not apply to other populations. Also the sample on consisted of African American and Caucasian females, and therefore cannot be generalized to other ethnicities. Furthermore, this was the first time the Burke Chronic Sorrow Interview Guide was used with women reporting child abuse and substance abuse. The findings of this study emphasizes early intervention that promotes self-esteem, role model of healthy relationships, and education on developing positive coping strategies to deal with abuse, high risk situations, triggers and relapse.

Article 4: Treating complicated grief and substance use disorders: A pilot study. *Zuckoff, A., Shear, K., Frank, E., Daley, D.C., Seligman, K. & Silowash, R. (2006).*

Zuckoff, Shear, Frank, Daley, Seligman & Silowash (2006) explored the capacity of adapting the Complicated Grief Treatment (CGT) for individuals who are presenting with complicated grief and substance use disorders. The research project was based at the University of Pittsburgh clinic in America, involving a total of 16 participants, 9 women and 7 men, age ranging from 24 to 57 years with the mean age of 42.3 years. Seven participants were Caucasian, 8 were African American and 1 Native American. One of the participants was married, 6 never married, 9 widowed, separated or divorced. Seven of the participants were grieving over violent deaths, and 9 were grieving over non-violent deaths. Most participants had postsecondary education, and were unemployed. All participants also presented with at least one mental health disorder including generalized anxiety disorder, panic disorder, post-traumatic stress disorder, depression, and specific phobia. All participants were provided with 24 individual sessions for complicated grief and substance use (CGSUT) over a 6 months period. The Inventory of Complicated Grief (ICG) was used to assess grief symptoms. The Beck Depression Inventory (BDI) was used to measure symptoms of depression. The timeline Followback (TLFB) was used for quantifying both alcohol and drug use. The Likert-scale questions were used to assess the frequency of substance use and the intensity of craving levels. The Breathalyser test was used to test for alcohol use before each treatment session. The results of this study showed that 8 participants, 5 men and 3 women completed the treatment, with significant reductions found in pre-treatment-to-post-treatment in ICG scores (M = 30.9, SD = 15.4, S = 18, p = .01), and mean reductions scores in the comparable CGT pilot study (Shear, Frank, Foa, Cherry, Reynolds, Vander Bilt & Masters, 2001) were 22.8 (SD = 13.14, z = -3.11, p = .002). The BDI results also showed reductions for

completers (*M* =15.5, *SD* = 5.5, *S* = 18, *p* = .01), with similar reduction in the CGT pilot study scores (*M* = 13.1, *SD* = 10.19, *z* = -2.98, *p* = .003). The TLFB scores showed a significant increase of abstinent days among completers from all substances (*M* = 26.5, *SD* = 29.8, *S* = 15, *p* = .04). The ICG mean reduction scores among completers on antidepressants was 30.8 (*n* = 6), and 31.0 for those not on antidepressants (*n* = 2). There was also a significant decreased in cravings over time, with score at time of treatment initiation being 2.2 and predicted value at termination was 1.6 (*F* (1, 13) = 5.30, *p* = .04, *d* = 1.30). Although this study was limited by its small number of participants with only 50% completing the treatment, the results does highlight that treating both complicated grief and substance use disorders together showed a significant reduction in grief, depression and cravings. The results suggest that grief-focused treatment would be further enhanced with Motivational Interviewing, coping and communication skills to patients with extensive substance use disorders.

Article 5: Evaluation of a Grief Group for Women in Residential Substance abuse Treatment. *McComish, J.F., Greenberg, R., Kent-Bryant, J., Chruscial, H.L., Ager, J., Hines, F. & Ransom, S.B. (1999).*

The research presented by McComish, Greenberg, Kent-Bryant, Chruscial, Anger, Hines & Ransom (1999) investigated the effectives of a therapy group addressing loss and grief among women enrolled in a gender-specific residential substance abuse treatment program. The treatment program was conducted at Flint Odyssey House (FOH) in Michigan, America. The sample involved 55 Women, 24 of the women attended the grief group voluntarily and 31 non-participants voluntarily attended the comparison group. Both groups were mostly African-American (85.5%), and single (98.2%). The mean age overall were 29.8 years, and a majority completing high school (56.4%) and some had post-school education. The primary choice of drug was crack cocaine (90.6%). Majority of the women reported at induction to FOH a history of emotional, physical or sexual abuse. The women had an average of two children living with them at the treatment facility, and most women (83.6%) reported attending a substance abuse treatment at least once before. The qualitative instruments used to measure each of the variables included the Center for Epidemiology Studies-Depression Scale (CES-D), Hudson Self-Esteem Index (ISE), Profile of Mood States (POMS), and Adult-Adolescent Parenting Index (AAPI). The *t*-test and chi-square instruments were used to analyse the quantitative data when comparing the demographic characteristics of the women inducted in the two groups. The ANOVA and MANOVA were used to compare the outcome variables of interest of both groups over time since

induction into the treatment program. The results of the study showed that at induction of treatment program the women who voluntarily participated in the grief group had scored significantly better on the self-esteem compared to the group of non-participants (M = 42.15, SD = .96, vs. M = 51.43, SD = 13.33; $t(df = 32) = 2.16$, p = .038). Also, the grief group had stayed significantly longer compared to the women who did not (M = 293.29 days, SD = 209.85, vs. M = 170.48 days, SD = 179.09; $t(df = 53) = -2.34$, p = .023). Over time the grief group held higher self -esteem compared to the group of non-participants. The results on overall mood (POMS) and depression (CES-D) were comparable at induction and had significantly improved over time for both groups. Women in both groups had improved significantly over time on parenting. There were three major themes that emerged: traumatic loss or death, loss or estrangement from mother, and loss or separation from children. Other losses also reported were loss of childhood, sense of self, drug lifestyle, and loss of other adults. Limitations to the research include not being able to conduct a 6-month follow up after leaving treatment as some of the women were difficult to locate. There were inconsistencies in the collection of data which threatened the validity of the study findings. Another limitation was using progress notes for collecting qualitative data instead of a transcribed tape recording device which would have been more accurate and reliable. Furthermore, the evaluation of loss and grief on both the etiology of substance abuse and intervention outcomes was overlooked.

Article 6: Process model of grief therapy in an alcohol treatment program. *Martin, S. & Privette, G. (1989).*

Martin & Privette (1989) presents a qualitative study that explores the relationship between grieving and addiction and to assist clients in identifying loss, recognizing reactions, exploring coping mechanisms, and mourning losses. The authors also presented a model for group therapy. The research was carried out amongst 6 clients, 5 male and 1 female, age range from 19 to 57 and all participants were accustomed to working together in treatment groups for alcohol or other drug abuse. Losses identified amongst the group participants included divorce, death of significant family member or spouse. The Beck Depression Inventory (Beck, 1978) was used to identify loss and related emotional and physical reactions. Therapy models and tools used in facilitating the group were Worden's (1982) four tasks of grief, Kubler-Ross's (1969) five stages of grief and brief psychodrama therapy. As a result of this intervention the group reported an increase of confidence in understanding loss and their ability to complete the grief process successfully. Limitations to this research includes a small sample of participants, no quantitative data on

ethnicities provided, and no evaluation of substance use in relation to loss and grief treatment outcomes.

Article 7: Loss Identification in the Treatment of alcoholism. *McGovern, T.F. (1986).*

McGovern (1986) conducted a pilot study on 50 participants who voluntarily attended treatment for alcoholism in a treatment unit at a general hospital in America. Of the 50 people that participated, 34 were male and 16 were female, median age of the group was 41.5 years, 84% completed a minimum of high school education, 84% were in relatively high employment status, 36% were married, 44% divorced, 12% widowed and 8% single. The Loss Identification Measure (LIM; McGovern, 1986) was used to examine the effect of treatment on the study group in identifying losses commonly associated with alcoholism, which was classed into three categories: External losses (loss of family, income, employment, marriage), Internal losses (loss of health, ability to drink normally, self-respect, peace of mind and emotional control), and Spiritual losses (loss of God and beliefs, meaning and purpose). The results showed a significant increase in loss identification ($p < .01$). Therefore the findings confirmed the ability of treatment to have a significant impact on loss awareness and identification which can be set apart from the depressive states commonly related with alcoholism.

4.1 Discussion on the findings:

The purpose of this study was to determine if issues relating to loss and grief were being addressed in clients attending treatment/rehabilitation for substance abuse, and to identify specific interventions that would assist AOD clinicians in working with bereaved clients (Māori and non-Māori).

I begin my discussion by integrating my findings from the seven selected journal articles categorized under several emerging themes. Furthermore, I will deliberate how the findings answered my research questions previously conveyed in section 1.3 and also provided below:

1. Is there a relationship between, loss, grief and substance abuse?
2. Does addressing loss and grief in AOD counselling help reduce the harms of substance abuse or relapse?
3. What interventions would assist AOD clinicians in working with bereaved clients?

Finally, I will acknowledge the strengths and limitations of the findings, provide future recommendations for practitioners, research, policy, and conclude with some personal insights.

The findings of this research come from a very small sample of articles that will provide the reader with only a snapshot on the perspectives of loss, grief and substance abuse. Therefore, the results will need to be interpreted cautiously and not generally.

4.2 Themes from the findings:

In appraising the selected seven journal articles on loss, grief and substance abuse, specific themes were discovered that appeared to be helpful in assisting the bereave journey through their losses, grief and addiction recovery. The themes listed below are based on the writer's interpretation of the literature exploring what important ingredients are needed in order to working effectively with bereaved individuals presenting with substance abuse issues.

4.2.1 The nature of loss and its relationship to substance abuse

The first research question asked was *"Is there a relationship between loss, grief, and substance abuse?"* The answer is "Yes". Change is an inevitable part of life and there is always an element of loss associated with that change. When loss becomes too difficult for some bereaved to bear, alcohol and drug use becomes an immediate remedy in 'taking out the edge' from fully experiencing loss and grief, and in doing so, the loss and grief issues continue to be unresolved (Martin & Privette, 1989).

According to the study conducted by McGovern (1986), patients who completed treatment for detoxification were able to identify certain external, internal and spiritual losses connected to their alcohol dependency. This would suggest the presence of a grieving process distinguished from the depressive syndromes seen in different stages of dependent drinking.

On the other hand, Martin and Privette (1989) study group reported that abstaining from alcohol and drug use is also a significant loss to grieve. This type of loss impacted on their coping mechanisms and lifestyle, including family and friends who also use substances.

Pilling, Thege, Demetrovics, and Kopp (2012) indicated their study results showed an increased risk of alcohol related problems among bereaved persons who had lost a parent or spouse within the past three years. Their results also showed that the significant increase of alcohol related problems was mostly found among their male participants compared to women.

However, in another study conducted at a women's residential substance abuse treatment programme three major losses were identified: estrangement from their mothers; death or being separated from their children, and traumatic losses, such as rape, suicide, or murder (McComish, et al., 1999). The majority of these women (90.6%) reported crack cocaine as their main choice of drug, and 83.6% of them had been in a substance abuse treatment at least once before. The gender

differences will be elaborated further in section 4.2.3 under *special populations*. Smith (2009) conducted a similar study with 12 women who all reported being victims of childhood abuse and neglect, using alcohol and drugs to block feelings of hurt, anger, inadequacy and to avoid painful experiences. The average age of their first substance use reported in this study ranged from 8 to 18 years. Hence, the importance of conducting an early assessment when dealing with abused children, adolescents, or adults, and making a referral to the appropriate services.

Thus, it would be important to recognise the uniqueness of different types of losses and its relationship to alcohol and drug use. Ignoring the losses among the bereaved only increases the risk of substance abuse, and grief becoming pro-longed and more complicated. The findings regarding the nature of loss and grief on alcohol and drug use is still green and developing. Therefore, further research in this area is desired.

4.2.2. Socio-demographic factors of the bereaved

All participants included in the seven studies reported loss and grief as their primary concern besides their substance abuse. Two studies chose to address loss and grief in general terms including loss from substance use recovery (Streifel & Servaty-Seib, 2009; McGovern, 1986). Three researchers preferred to focus their study on participants grieving over the death of a close relative or partner (Pilling et al., 2012; Zuckoff et al., 2006; Martin & Privette, 1989), and two studies concentrated on women who experienced childhood abuse, neglect, violent trauma, and loss custody of their child/ren (Smith, 2009; McComish et al., 1999).

There were different perspectives relating to the socio-demographic factors of grief and substance abuse. Some researchers indicated that the severity of each loss and substance misuse varies according to age, education, mental health, self-esteem, marital status, and availability of parental or family support of the bereaved individual (Smith, 2009; Zuckoff, shear, Frank, Daley, Seligman & Silowash, 2006; McComish, Greenberg, Kent-Bryant, Chruscial, Ager, Hines & Ransom, 1999). From the seven articles that met the inclusion criteria, 6 studies were based in America and 1 in Hungary.

The recruitment of participants in all 6 American studies were clients already engaged within a specific AOD treatment service. The participants were mostly Caucasian and African-American, with 1 Native American. The sample size was 50% small ranging from 6 to 16, and the other three studies reported a sample range of 50 to 128. Three studies were conducted at an AOD

inpatient treatment facility, 2 of the inpatient treatment facilities included both male and female participants, and 1 inpatient program was specifically for women. Researchers also voiced that bereaved individuals who had experienced abuse, neglect, violence or trauma in their childhood and adolescent years were at risk of developing complicated grief and substance abuse related issues later in their adult years (Smith, 2009; McComish et al., 1999; Martin & Privette, 1989). Some of these participants also presented with mental health issues (anxiety, depression, PTSD, or MDD). Majority of the participants were unemployed, had low educational qualifications, single, divorced or separated, and all reported using alcohol or drugs to help cope with loss and grief. On the other hand, there was one study where majority of the participants were middle class, 84% had completed a minimum of high school education and 84% had relatively high employment status, and therefore could possibly afford to pay for their treatment. However, the cost of treatment and ethnicity of the participants in this study was not reported (McGovern, 1986).

Conversely, the one study conducted in Hungary, all 12,668 participants were drawn from their National Population Register and the analyses was based on the cross-sectional data from the Hungarostudy Epidemiological Panel Survey (HEP, 2006), resulting in 4,457 adult individuals completing the survey questionnaire. From this survey 466 people who reported experiencing loss of a close relative (partner, mother or father) within the past three years were included in this study. The cost of treatment and ethnicity of the participants in this study was also not reported (Pilling, Thege, Demetrovics & Kopp, 2012).

Lastly, the participants in all 7 studies had volunteered to take part in the research, none were coerced by the Department of Courts, Department of Community Corrections, Mental Health Services, Social Services, AOD treatment providers, general practitioners, counsellors, employers, partners or family members.

4.2.3 The use of assessment and screening instruments

Screening and assessment instruments were used in all 7 studies in an effort to measure grief responses and the effect it had on substance abuse recovery. Four studies were qualitative whilst 3 were both qualitative and quantitative. Some studies also included additional screens for measuring the impact grief had on cravings, relapse, bereaved parents, mental illness, participating in treatment, self-esteem, spirituality and identifying losses. The types of measurements varied from study to study, and ranged in length with some being simple and brief (Pilling, Thege,

Demetrovics & Kopp, 2012; McGovern (1986). On the other hand, Smith (2009) preferred to use a semi-structured interview consisting of open-ended questions in conjunction with the Burke Chronic Sorrow Interview Guide to allow participants to discuss their significant losses in depth, and to explore triggers that lead towards continued use of substances or relapse. Other researchers used several instruments to cover a broader bereaved population (Streifel & Servaty-Seib, 2009; Zuckoff, Shear, Frank, Daley, Seligman & Silowash, 2006). One study (Pilling et al., 2012), chose to modify the Alcohol Use Disorder Identification Test (AUDIT) in order to collect specific information relating to risks attached to the different types of alcohol consumed (e.g. beer, wine, or spirits). On the other hand, researcher, McGovern (1986) developed his own instrument, Loss Identification Measure (LIM), which was administered to patients after completing detoxification and was asked to identify losses commonly associated with alcoholism.

The second question *"Does addressing loss and grief in AOD counselling help reduce the harms of substance abuse or relapse?* The answer again is "Yes".

Streifel & Servaty-Seib (2009) conducted a study of 128 recovering alcohol and drug addicts attending Alcoholics Anonymous (AA) and Narcotics Anonymous (NA) 12-step programme. There were several validated instruments used in this study, namely; the Obsessive-Compulsive Drinking/Drug Use Scale-Revised (OCDS-R) was used to help measure recovery from substance abuse; the Hogan Grief Reaction Checklist (HGRC, 2001) was used to measure the bereavement process: Despair (shattered hopes/dreams), Panic Behaviour (excessive worrying), Blame and Anger (resentfulness), Detachment (inability to cope), Disorganization (inability to concentrate/focus), and Personal Growth (positive view of present and future); the Alcoholics Anonymous Involvement (AAI) scale to measure attendance and involvement in AA/NA; and the Miller Measure of Spirituality (MMS; Miller, 2004) used to measure two domains of spirituality, prosocial beliefs (the importance for individuals to be at peace with themselves) and the importance of believing and communicating to a Higher Being. The findings of this study showed that higher attendance and involvement in AA/NA 12-step programme resulted in an increase in personal growth, lower painful grief symptoms and lower obsession-compulsion to drink/use.

In addition, Zuckoff et al. (2006) conducted a study on 16 participants all presenting with complicated grief, mental health and substance abuse disorders. Several validated instruments were also used in this study, namely; the Beck Depression Inventory (BDI) used to measure symptoms of depression. The timeline Followback (TLFB) used for quantifying both alcohol and drug use. The Likert-scale questions used to assess the frequency of substance use and the

intensity of craving levels. The Breathalyser test used to test for alcohol use before each treatment session. All participants were provided with 24 individual sessions for complicated grief and substance use (CGSUT) over a 6 months period. The Inventory of Complicated Grief (ICG) was used to assess grief symptoms. The findings of this study revealed that 8 participants who had completed treatment, including those on antidepressants, showed significant reductions in their cravings over time, ICG and BDI scores. Although only 50% of the participants had completed treatment, the evidence is clear that treating both complicated grief and substance use disorders together showed a significant reduction in grief, depression and cravings.

Overall, the measurements used in all 7 studies that was developed and tested to measure grief responses and recovery from substance abuse had demonstrated good estimates of reliability and validity.

4.2.4 Grief Interventions:

In this section, the review identified two studies that investigated the effectiveness of applying grief group therapy at an AOD residential treatment facility based at separate locations in America. In answering the third research question: *"What interventions would assist AOD clinicians in working with bereaved clients?"* the individual and group inventions outlined in the studies below and other sections of this review will help provide AOD clinicians with some useful models, tools and processes.

Individual therapy

A pilot study by Zuckoff and colleagues (2006), assessed the effectiveness of applying complicated grief treatment (CGT) for bereaved individuals who abuse or are dependent on substances by providing 24 individual manual-guided treatment sessions over 6 months, which included motivational interviewing, emotion coping and communication skills. The study included 16 adults, 7 men and 9 women, grieving over the deaths (violent or nonviolent) of their significant other. Symptoms of grief was measured by the Inventory of Complicated Grief (ICG), the Beck Depression Inventory (BDI) measured the depression, and the Timeline Followback (TLFB), and to measure substance use and cravings the Likert-scale self-report questions and a breathalyser test was delivered to all participants. The results of this study are promising, with half of the participants who completed treatment showed significant pretreatment-to-posttreatment

reductions in ICG, BDI and craving scores, plus achieving and maintaining abstinence from all drugs. However, this study was limited by small sample size and lacked a control group of bereaved individuals who did not receive CGT.

Group Therapy

Another treatment option available for bereaved individuals is group therapy or group counselling. Some of the benefits for bereaved individuals attending grief groups is the support, the ability to share their feelings about their losses and feel validated. Groups can also provide the bereaved with the opportunity to learn about the grief process, find meaning to their losses, have their strengths acknowledged, and gain more coping skills.

McComish et al. (1999) examined the effectiveness of group therapy in addressing loss and grief among 55 women attending a gender-specific AOD residential treatment programme in America. The grief therapy intervention group consisted of 24 bereaved women compared to a control group of 31. The reported losses disclosed by the women in the individual clinical sessions prior to forming groups were: death of children, loss of children to foster care, rape or incest, or witnessing violence including shootings. The grief group was open-ended, consisting of 90-minute weekly sessions over a 2 year period. The group format included traditional psychotherapy and information on the stages of loss and grief. The therapist assisted the women in linking their feelings to the losses experienced, substance use relapse, relationship issues with their mothers for being absent or nonresponsive, and the parenting of their own children. When the grief group was drawing to an end, anniversary reactions and ways to commemorate losses was discussed. The women wrote letters, poems or created art work which was shared to the rest of the group with lit candles to commemorate the end of the group. The women also had the option of engaging in other individual interventions specific to their losses, for example; writing letters to their birth mothers, or trip to the grave site of their child. In the final session the therapist also shared her views on how the women had grown. Many of the women sought for continued grief work in individual counselling sessions following the closure of this group. The results also showed that the women who participated in the grief group stayed longer in the programme compared to the women in the control group. Furthermore, the grief group showed significant improvements in their self-esteem, overall mood and depression scores. However, both groups made significant improvements in parenting. One area neglected was not evaluating the influence loss and grief

had on substance abuse and treatment outcomes. Another limitation was not using transcribed tape recording instruments for collecting qualitative data which would have been more reliable.

An exploratory study by Martin and Privette (1989) used the Process Model of Grief Therapy in addressing loss and grief with 6 clients, five men and 1 woman, also based in an AOD residential treatment programme. The types of losses identified by the group participants were: divorce, death of a spouse, recent death of a parent in their elderly years, or by suicide when the client was a child. This grief group was led by a female primary therapist, with a male facilitator who was also a staff member of the residential treatment centre, and the grief group was delivered over 5 consecutive days, 2 hours daily Monday to Friday. The clients was also attending individual and group therapy, family therapy, after care programmes and therefore was already familiar working together. The authors used the Beck Depression Inventory (Beck, 1978) to help identify losses relating to psychological and physical reactions, including substance abuse. In addition, therapy models and tools such as Worden's (1982) four tasks of grief, Kubler-Ross's (1969) five stages of grief, brief psychodrama, relaxation exercises, identifying strengths and resources for resolving further losses were all utilized in facilitating this grief group. The findings showed that the grief therapy model helped the bereaved participants identify and validate their feelings attached to their losses. However, the loss concept of severing ties with their substance abuse lifestyle appeared difficult for the participants to grasp. The authors hoped that the skills learnt in the grief group helped to equip the participants to face and resolve this significant loss and any further losses after discharge from the residential program. There were several limitations to this research which included a small sample of participants over a very brief period of 5 consecutive days, with no data on ethnicity and other demographic information. Also, there was no evaluation of substance use in relation to loss and grief outcomes, and no tape-recording or videotaped sessions for later analysis, no control group, and no follow up evaluation data. Furthermore, the group was led by a female therapist where all except for 1 participant were all male, and also placing a male residential staff member as a group facilitator had the potential for participants to be cautious with their responses including experiencing other possible losses within the treatment facility such as; institutional discrimination, marginalization, or relapse.

Finally, future research would benefit from following up with participants discharged after completing grief group intervention in residential care especially where poverty limits employment and housing options and controls over their personal environment. Therefore, it is recommended that AOD treatment providers also consider assisting bereaved individuals to improve their chances in finding employment, and a permanent safe and supportive place to live.

4.2.5 The nature of specific populations:

Gender differences

From the seven studies selected, 5 were conducted on both male and female adult participants, whilst 2 studies were women specific. The findings from some of these studies reported differences in the way men and women reacted to loss. Researchers appear to agree on the influence of gender in the way loss and grief is voiced. For example, Pilling and colleagues (2012) research indicated that men had significantly greater alcohol related problems during the bereavement period compared to women. The limitation to this study was in the application of the self-rating report, which means the responses from both genders may not be altogether objective or accurate. However, the general assumption is that women are most likely to express their emotional reactions more openly than men. These differences are not surprising, considering how many children are raised in our society. Girls generally learn at a young age that it is appropriate for them to express their emotions. Then later women usually take on the role of caretaker, nurturer and mother. On the other hand, boys learn at a young age that it is not acceptable to openly express their emotions. When they become men they usually take the role as protector and provider for their family. However, these generalized roles do not apply to all men and women, hence the individual differences within and between gender groups should also be considered.

The findings from Zuckoff and colleagues (2006) revealed that only 50% of the participants completed treatment for complicated grief and substance abuse, and majority of non-completers were women. There was no explanation provided for this in their report. However, in another study at an AOD residential treatment program for women, who experienced traumatic losses showed that women who attended grief therapy group and those who attended the control group both made improvements over time on mood, depression and parenting. Furthermore, those who attended the grief group remained in treatment longer and had higher self-esteem levels. Although, the results from these two pilot studies were encouraging, there is much that is still unknown about the influences of mixed and specific gender groups on treatment outcomes for grief and substance abuse problems which could be investigated in future research.

Co-existing disorders (mental illness and substance abuse)

Two of the studies included in this review, both located in America, addressed bereaved individuals in populations with mental health and substance use disorders.

Smith (2009) explored chronic sorrow as a relapse trigger among 12 female victims of child abuse who were all diagnosed with a mental health disorder in concurrence with their substance abuse disorder. Nine women were diagnosed with major depressive disorder (MDD); 3 diagnosed with adjustment disorder and some in conjunction with anxiety or depressed mood; and 7 were diagnosed with an anxiety disorder. Nine of the women had more than one mental health illness with anxiety or PTSD being the most common additional diagnosis. Eight women reported being victims of childhood physical, sexual, and emotional abuse and neglect. Two women reported physical and emotional abuse, and neglect; 1 reported sexual and physical abuse, and 1 declared neglect only. The offenders the women held responsible for the physical abuse, emotional abuse and neglect reported were parental figures (mother, father, stepfather or grandparent). The Women who also reported being sexually abused cited family members as the offender (older brother, uncles, father, or stepfather). All 12 women reported being victims of domestic violence declaring that the perpetrators were either their boyfriends or father of their children. Two of the women reported themselves being abusers of their partners or significant others. The main substances used (1 or more) by the women were: methamphetamine, crack cocaine, alcohol, cannabis, or benzodiazepines. All 12 women were in treatment for substance abuse relapse. All the women were single parents at time of the study, 7 Caucasian and 5 African-American, and all but one reported annual income less than $19,999; seven of them were on an annual income below $9,999. Measures included semi-structured interview with open-ended questions and the Burke Chronic Sorrow Interview Guide. The findings suggest that socially marginalized women were at risk of relapse due to lack of social support and economic resources, especially for those suffering from grief, substance abuse and mental illnesses. The findings also identified common themes among the women which were mothering loss, blocking feelings, and relapse triggers of sadness or depression, anger, and loneliness. Limitations include the small sample and reliance on the Burke Chronic Sorrow Interview Guide which has never been used before on women suffering from childhood abuse, mental illness and substance abuse. Also, it was not known if the nine women had symptoms of chronic sorrow first before being diagnosed with depression, or vice versa. Future research to explore how these factors relate to each other including substance abuse is recommended.

Zuckoff et al. (2006) conducted a study in adapting the Complicated Grief Treatment (CGT) with 16 bereaved individuals, 9 women and 7 men, 8 were African American, 7 Caucasian and 1 Native American, and all were diagnosed with a mental health illness and substance use disorder. Four of the participants had lower than high school qualifications, two were high school graduates, and ten had some form of postsecondary qualifications. However, 12 participants were unemployed. The main choice of drug reported was alcohol, cannabis, opiates and benzodiazepines. Twelve of the participants were diagnosed with MDD, 11 with PSTD, 4 with panic disorder, 4 with generalized anxiety disorder, and 1 with a specific phobia. Eleven of the participants were on psychotropic medication during their participation in this study, which included 10 on antidepressants, 3 on benzodiazepines, 3 on neuroleptics, 2 on mood stabilizers, and 1 on sleep medication (non-benzodiazepine). In addition, 3 of the participants were on methadone treatment programme. Seven of the participants were grieving over violent deaths and nine were grieving over nonviolent deaths. The mean time since the significant death reported was 9.8 years. All of the participants reported that grieving over the deaths of their significant other along with their substance abuse was their primary concern. Overall, the findings did show a significant reduction in grief, depression and substance abuse amongst the 8 bereaved individuals who completed the treatment. However, Zuckoff and colleagues discovered that substance use had worsened amongst some of the participants soon after their first counselling session of telling their story of the significant deaths. The procedure was immediately adjusted to allow for participants to learn coping skills first before telling their stories, resulting in no further decline of substance use or wellbeing. Limitations to this study include its small sample with only 50% completing the study and the open treatment design. Grief-focused treatment, combined with Motivational Interviewing, coping and communication skills was recommended as beneficial for bereaved individuals with histories of extensive substance use and mental illness.

Overall, the findings of these two studies suggest that poverty and other situational factors associated with prolonged and complicated grief also has an impact on the lives of people with mental illness and substance abuse problems. It was also suggested that follow up assessments be conducted to evaluate the durability of implementing complicated grief treatment for this population. Finally, future research would benefit from examining the effectiveness of pharmacotherapy, psychotherapy and psychosocial interventions as it may have the potential to alleviate the suffering in those who are grieving complicated loss, substance abuse and mental health disorders.

Indigenous populations

Although Zuckoff and colleagues (2006) reported one Native American participant participated in treatment for complicated grief and substance use disorder, their research however was not from an indigenous perspective nor did it include a cultural component.

There were no indigenous studies amongst the seven included articles that specifically addressed loss, grief and addictions in Māori or in the entire South Pacific. The exposure of Māori people to a high rate of losses (mental and medical illness, violence, separation, suicides, accidents, unemployment, incarceration, poverty, loss of customary rights, etc.) would suggest that they represent a vulnerable high-risk group for substance abuse. This review highlights the lack of research available for AOD clinicians working with Māori presenting with loss and grief related issues. Therefore, further research is needed to examine culturally effective interventions specifically relating to grief and co-existing disorders among Māori, Pacific Nations, and other indigenous populations seeking help for substance use disorder.

Chapter 5

5.0 Conclusion

After completing this research I later realise that it was very ambitious of me to write a paper that would explain loss, grief and addiction comprehensively within the word count. In hindsight, I can now appreciate why theorists and scholars also struggled to agree on how to best conceptualize and treat both co-existing grief and substance abuse related issues. Grief interventions were useful in helping the bereaved identify their losses and find meaning. Many bereaved individuals held different perspectives of their grief experience depending upon their age, gender, marital and employment status, mental wellbeing, level of self-esteem, spirituality and the nature of the significant loss. The findings showed significant scores in reducing the harms of substance abuse, cravings and relapse when the bereaved participated in individual grief counselling and or grief group therapy sessions. Overall, the results from this study suggest that grief interventions would benefit substance abusers suffering from loss and grief, including mental health disorders (generalised anxiety, MDD and PTSD). Additionally, the findings emphasise the importance for AOD clinicians to screen and assess complicated grief early, especially in bereaved children, adolescents and adults who present less resilient. Conversely, the findings also showed that there were no studies among the selected articles that addressed loss, grief and addictions in Māori or in other indigenous populations. It is hoped that these findings will lead to more research and changes within the field of AOD.

5.1 Strengths and limitations

The first strength of this study was in providing a structured and transparent process for searching, retrieving and collecting literature to be included in this review. Utilizing this method to conduct a review of research helped reduce any bias's, and allows for the review to be replicated or expanded upon (Punch, 2005).

Second, was the enhancement of knowledge and interventions that helped to decrease symptoms of grief, substance abuse and mental health problems as well as increasing self-awareness, self-esteem, spirituality, confidence, and personal growth among bereaved individual's.

Thirdly, was the assortment of qualitative and quantitative research that helped to provide background information on the participants, treatment design and processes, the relationship among the variables including between grief and substance abuse from the participants and authors perspective.

However, there were several limitations apart from those previously mentioned in section 4 of this review. Firstly, the classification of loss and grief varied from one researcher to another (Streifel & Servaty-Seib, 2009; Smith, 2009; Zuckoff et al., 2006).

Secondly, researchers use various measurement tools or screens to assess the bereaved individual's level of grief and or substance abuse. These measurements assessed different aspects of loss, grief and substance use depending upon the researcher's own conceptualization of the loss experience and addiction recovery.

Thirdly, the findings are based primarily upon Caucasian and African-American individuals living in North America with one exception in Hungary. These findings cannot be generalized nor be applied to Māori and non-Māori in Aotearoa, New Zealand.

A fourth limitation of this review is that the findings are taken from a secondary analysis of included articles where the writer solely relies upon the report from each researcher on loss, grief and substance abuse experienced by individuals or groups. The writer would have found it valuable to speak directly to the bereaved individuals or group in gathering more insight around other variables involving substance misuse (e.g. indigenous and cultural losses, inpatient and outpatient treatment, immigrant losses, bereaved families, one significant loss experience compared to several, anticipated loss compared to sudden loss, bereaved young adults compared to

middle aged and older bereaved adults, single parent fathers, bereaved gay and lesbians, bereaved offenders (including those incarcerated) and victims, and bereaved disabled, bereaved practitioners, etc.).

Lastly, another factor that inhibited the progress of research in the realm of loss, grief and substance abuse interventions is the omission of control groups. Among the 7 selected articles selected only one had a comparison group (McComish et al., 1999). Control groups are essential for validating the evaluation of a loss and grief intervention (Punch, 2005); mainly because most pathological grief symptoms diminish within two years of loss as shown in Pilling and colleagues study (2012).

5.2 Recommendations:

Research

The recommendations for future research in loss, grief and substance abuse is provided below:

1. To conduct comparative grief studies that represents the profile of clients that present at AOD services in Aotearoa such as: Māori and non-Māori, mixed and gender specific interventions, individual and group counselling, single parent mothers and single parent fathers, client centred and family inclusive practice, inpatient and outpatient treatment, young adults, middle age and elderly, mandated and self-referred, co-existing disorders, substance abuse and gambling, and client preference for harm minimisation or abstinent based interventions.

2. To examine the short-term and long-term impact of unresolved grief on mental, physical, spiritual and family wellbeing.

3. To examine the specific benefits and risks associated with pharmacotherapy interventions in the context of complicated grief and substance abuse.

4. To assess the grieving experience of clients after discharge from AOD treatment.

5. To investigate the reasons behind social problems including poverty, poor housing, low education and unemployment as significant predictors of treatment outcomes.

6. To explore and develop more culturally appropriate assessment instruments, models, tools, and interventions related to loss, grief and addictions in Māori, Pacific Nations and other populations in Aotearoa New Zealand.

7. To examine the influence of religion and spirituality on loss, grief and substance abuse.

8. To explore the impact of strength based instruments and interventions of resiliency on grief and substance abuse relapse, as the field of psychology and psychiatry tends to be more problem focused, thus neglecting the strengths of the client or group work.

Practice

In light of practice, I hope that the knowledge gained from this study will help AOD counsellors, mental health and social service practitioners anticipate their client's needs when experiencing a loss. Based on the results of this study, the following recommendations are offered:

9. It is recommended that AOD counsellors, health professionals and social work practitioners be provided with specialized training in loss and grief. Training should also be included as part of the under-graduate and post-graduate study.

10. AOD counsellors, health and social work professionals should be proactive in screening people for complicated or traumatic loss as this generally appears to be a predictor for self-harm or suicidal ideation.

11. It is recommended that AOD counsellors be aware of the distinction between complicated grief and the DSM V disorders of generalised anxiety, MDD and PTSD.

12. Future consideration in developing a grief intervention guideline manual for AOD counsellors in Aotearoa. This manual could also offer counselling tools for individual and group work.

13. It is recommended that AOD counsellors consider exploring other types of grief interventions such as: art, music, grief maps, letters, poetry, and psychodrama therapy.

Policy

The following recommendations are suggested:

14. To provide professional training in grief work for all AOD counsellors, clinical supervisors and management which would be beneficial in implementing protocols in case reviews surrounding the death of a client, and in managing practitioner's losses to the client.

15. To apply the loss and grief model when planning and implementing significant changes for staff within the working environment.

In light of these 15 recommendations I am convinced that overlooking loss and grief issues as it sits within the AOD field, will only compound problems for the grieving individual, their family and community. Thus, interventions that focus exclusively on addictions are cosmetic, hinder recovery, and prolong the suffering for the bereaved. For this reason, tailoring research and interventions to address the gaps in knowledge, practice and skills that exists within this field is imperative.

Chapter 6

Draft of a brief article for submission to the Addiction Practitioners' Association Aotearoa-New Zealand – DAPAANZ: Newsletter of the Addiction Treatment Research Interest Group (ATRIG).

What is the nature of Loss and Grief in Addiction Recovery?

Change is an inevitable part of life and there is always an element of loss associated with that change. When loss becomes too difficult for some people to bear, alcohol and drug use may become an immediate remedy in 'taking out the edge' from fully experiencing the significant loss. And consequently, grief becomes suspended and unresolved, and substance use generates a host of problems for the substance user, their family, friends and society.

Abuse of alcohol and other substances is a major health problem among New Zealanders. It has been linked to cancers, emphysema, chronic cardiovascular and liver diseases, acute alcohol and drug toxicity, diabetes, gout, renal failure, arthritis, foetal alcohol syndrome, dementia, anaemia, insomnia, pancreatitis, seizures, Wirnicke-Korsakoff Syndrome, depression, anxiety, paranoia, schizophrenia, other mental health disorders (Ministry of Health, 2013), fatal car accidents, and injuries (Ministry of Transport, 2009; Connor, Broad, Rehm, Hoorn, & Jackson, 2005).

All clients referred to CADS have been struggling to cope with their legal, medical, psychiatric, social, or relationship problems have relied on alcohol and drugs to relieve their emotional pain and suffering. A study that supports this observation was conducted by Bessel van der Kolk (1987) on soldiers who experienced some form of trauma. He discovered that one of the common factors amongst the soldiers was their desire to self-medicate using alcohol or other drugs. I have also observed in my clinical practice that abusing alcohol and drugs during time of loss and grief can lead clients to experiencing further losses.

It is very difficult to be effective in addressing substance abuse first before grief or vice versa as both issues is often linked. Therefore, it is vital for clients to receive therapeutic interventions for both co-occurring issues; unresolved grief and substance abuse.

The majority of people associate grieving as happening only after you lose someone through death. But there are many other non-mortal types of losses apart from death of a loved one. They

may include: loss of mental, physical or sexual capacity; chronic pain or illness; relationship breakup and divorce; losing a job, or licence to drive or one's work; losses associated with discrimination, role redefinition or adjustment to a changing home culture; loss of identity, self-respect, trust, control, dreams, faith, hope, and lifestyle connected to their substance use. Loss is when you lose something or someone of value or significance (Murray, 2003).

The research component of a MHSc degree was a study to examine literature reporting on any relationship between loss and grief and substance abuse. The three research questions were: (1) Is there a relationship between, loss, grief and substance abuse? (2) Does addressing loss and grief in alcohol and drug counselling help reduce substance use and associated harms?, and (3) What interventions are most effective in assisting alcohol and drug clinicians working with bereaved clients?

Additionally, the writer is Māori from Tai Tokerau (Northland) who observed from personal experiences of loss that grief can be very debilitating on individuals, and it can diminish or strengthen whanau (family) relationships. Consequently, the majority of research regarding loss and grief, and addictions originated from Westernized theories and models which are predominately created for and by Non-Māori. Thus, for that reason a Māori perspective was also included in this review.

A structured literature review was conducted, searching CINAHL Plus, PsycINFO, Scopus, Medline, DRUG, and Social Work Abstracts Plus databases', commencing from the start date of each database, and the month the search was conducted in October 2014. The search terms were grouped into three main search categories: 'Grief', 'Substance Abuse' and 'Interventions'. Eligible studies included: (1) interventions for loss, grief and addictions (2) measurement instruments used for examining grief and or addictions and (3) full text articles published in English or Māori.

Searching the 6 databases identified 11,963,418 references, with 261 journal articles requiring more detailed examination, with 7 articles matching the inclusion criteria. In analysing these articles, 5 themes emerged and were explored: (1) the nature of loss and its relationship to substance abuse (2) socio-demographic factors of the bereaved (3) the use of assessment and screening instruments (4) studies that reported grief interventions (individual and group therapy),

and (5) the nature of specific populations (gender differences, mental health and substance abuse disorders, and indigenous populations).

The studies were limited as to data related to demographic differences between studies, lack of control groups, small sample sizes, and based primarily upon Caucasian and African-American individuals living in North America with one exception in Hungary.

Overall, the studies showed grief interventions helped to decrease symptoms of grief, substance abuse and mental health problems, and increased self-esteem, spirituality, confidence, and personal growth among the bereaved.

Despite abundant research on loss and grief, and on substance abuse, there is a paucity of studies being conducted on their co-existent relationship. It is clear from the findings that grief interventions are useful in helping the bereaved identify their losses, and help them find purpose and meaning to their sorrow. Appropriate interventions led to an increase in their self-esteem, and reduced symptoms of grief and substance abuse. A key recommendation of this research is that alcohol and drug clinicians, health professionals and social work practitioners be provided with specialized training in loss and grief to better prepare them for work with their client groups, specifically Māori and other populations in Aotearoa, New Zealand.

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