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RESEARCH ARTICLE

Never ready: Addictions counselors dealing with client death

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Abstract
This study explored the experiences of addictions counselors who have undergone client death and the immediate and long-lasting impacts of client death on addictions counselors through the consensual qualitative research (CQR) method. We conducted semistructured interviews with 10 participants exploring their lived, in-depth, experiences in working with clients with addictive disorders with focus given to the death of clients and how they responded to the experience. Results from a data analysis process using the CQR method indicate eight domains: (a) professional ethics, (b) coping skills, (c) client care, (d) preparation for profession, (e) experience of addiction, (f) agency impact, (g) exploring the death experience, (h) recommendations, and 28 categories embedded in each of these domains. Implications for counselor education, training, and practice are discussed.

KEYWORDS
addictions counselors, client death, client care, consensual qualitative research, grief and loss

NEVER READY: ADDICTIONS COUNSELORS DEALING WITH CLIENT DEATH

Estimates suggest that there are approximately 140,000 deaths related to substance misuse on an annual basis in the United States. (Murthy, 2017). In 2019, the U.S. experienced its deadliest year for overdose deaths, claiming the lives of 70,630 individuals (National Institute on Drug Abuse [NIDA], 2021). Considering the national public health epidemic of the unprecedented levels of drug overdose deaths in the nation, Doyle (2021) argued that counselors are in a unique position to respond to this crisis with “a clinical necessity and an ethical imperative regardless of specialty area” (p. 112).

Due to the complex nature of substance use disorders (SUDs), treatment of such conditions can also be multifaceted. Ramifications of drug and alcohol use, including death, not only affect the individual with the addiction, but also those who have a relationship with the individual (Mcauley & Forsyth, 2011). Valentine et al. (2016) noted the death of an individual due to substance use may be “traumatic” for survivors (i.e., individuals who have a relationship with the deceased; p. 284). There is an emphasis on the client–counselor relationship in addictions counseling, therefore one individual who could be significantly impacted is the counselor.

Urmanche (2020) suggested that client death places an unbearable toll on addictions counselors regardless of the nature of the death. Given the high rate of death in the addictions field, it is worth exploring how addictions counselors are impacted by the experience. Furthermore, during the instances in which a counselor grieves the loss of their client due to an unexpected event, it is important to conceptualize grief as an idiosyncratic experience that varies among counselors (Crunk et al., 2017).

THE NATURE AND CIRCUMSTANCES OF SUD-RELATED DEATH

Although many individuals who bereave respond to bereavement adaptively, it is imperative to identify risk factors for those who might develop bereavement-related negative consequences such as mental health conditions (Crunk et al., 2017). In order to promote such efforts, it is critical to

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better understand how the process (e.g., a course of time) and magnitude of bereavement (e.g., intensity of emotional response) are explicated in the bereavement literature or through bereavement theories such as the Attend, React, Explain, Adapt (AREA) model (Wilson & Gilbert, 2008) that will be described in detail later in this section of the article.

Society tends to categorize deaths into "good" or "bad" with bad deaths being socially and morally condemned by others (Seale & van deer Geest, 2004, p. 883). Deaths related to SUDs are often implicated to be bad as they are assumed to be related to a deviant and immoral lifestyle (Feigelman et al., 2012; Valentine et al., 2016). Considering the stigmatization placed on both SUD-related deaths and individuals with SUDs, counselors who have experienced the death of someone with a SUD may experience disenfranchised grief, as emphasized in Doka's conceptualization, social context is an influential factor shaping who is socially sanctioned to grieve, under what circumstances is the one sanctioned to grieve, and how the one grieves (Doka, 2002). Relevantly, research has suggested that grief among healthcare professionals such as homecare workers was disenfranchised; their losses were wrongly perceived as insufficient losses while their professional intimate relationships to the descendent were also incorrectly perceived as insufficient relationships in order for both to justify grief and validate support (Tsui et al., 2019).

In the context of SUD-related deaths, blame is often placed on the individual with a SUD, regardless of whether their death is directly linked to substance use, which could prevent the survivor from openly processing their grief (Valentine & Walter, 2015). Stigma associated with SUDs can impact survivors' grieving processes and discourage them from confiding in social supports (Feigelman et al., 2012; Valentine et al., 2016). Particularly, these interrupted grieving processes can be deleterious to the bereaved counselor, positioning them at a potential risk for a maladaptive emotional state (e.g., prolonged grief). They may also prevent the counselor from understanding the nature and contextual circumstances of the client's death, potentially leading to interrupted adaptation to an emotional response associated with the experience.

The AREA model (Wilson & Gilbert, 2008) is a framework designed to better understand bereavement responses. The model can be instrumental in explaining an emotional adaptation to stressful life events such as a client's death among counselors. Over time, an individual may adapt to the circumstance, diminishing its impact and alleviating the person's emotional response. In alignment with this model, when exploring how addictions counselors experience client death and their reactions to the experience, one must consider how the nature of these deaths and contextual circumstances—death classification type such as internal disease causes (e.g., dementia) or external injury-related causes characterized as accidental or unintentional, self-inflicted (e.g., suicide), caused by another person, or undetermined—are understood (Veilleux, 2011).

Additionally, the AREA model suggests that "the key to coping with grief is understanding the nature and circumstances of the event" (Veilleux, 2011, p. 225). Two components known to influence a therapist's response to a client death are the difficulty in constructing meaning of the circumstances surrounding the client death itself and the therapist's understanding of the loss relating to themselves (Veilleux, 2011). Creating meaning out of an individual's death helps the bereaved individual reconstruct their identity, regain a sense of control, and reconceptualize their relationship with the deceased (Braun & Berg, 1994). If the meaning-making process is interrupted or inhibited due to stigma or the nature of trauma associated with the death (Neimeyer & Sands, 2011), this could have a detrimental impact on the therapist's grieving processes and their ability to reconstruct their professional and personal identities. Memorialization and upholding the deceased's legacy is an important part of the grieving process. Censorship of reminiscence due to stigma regarding the death can complicate and add complexity to grief, potentially resulting in social isolation for the individual dealing with the loss (Simone, 2010; Valentine et al., 2016).

COUNSELORS' EXPERIENCES WITH CLIENT DEATH

Researchers have previously explored the impact of client death on healthcare professionals, such as rehabilitation counselors (Allen & Miller, 1988; Hunt & Rosenthal, 2000), homecare workers (Tsui et al., 2019), psychologists (Veilleux, 2011), social workers (Rubel, 2004), and mental health professionals in general (Urmanche, 2020). For example, Urmanche (2020) investigated the impact of client suicide, accidental death, and overdose-related deaths on mental health professionals, including counselors. Similarly, it is well documented that mental health professionals are left with "a residue of grief with no formalized connection to the mourning process" when their client dies during professional care (Rubel, 2004, p.1). Depending on the contextual circumstances, such as suddenness of an accidental death, the experience with client death may intensify feelings of shock and sadness due to spontaneity and unpredictability (da Silva et al., 2007; Mcauley & Forsyth, 2011). Moreover, Veilleux (2011) recounted her own experience of undergoing a client's death and revealed that she experienced a multitude of emotions including disbelief, shock, anger, and sadness. One factor that complicates the experience when a client has a nonsuicidal and/or accidental death is the uncertainty of the intent, which can complicate the meaning-making process for the therapist.

Upon the extant literature review, one area of exploration that is relevant to client death and its impact on counselors is the topic that pertains to client suicide. The research on the impact of client suicide on counselors and their organizations has recently generated increased attention (Darden & Rutter, 2011; Draper et al., 2014; Fairman et al., 2014; Wagner et al., 2020). Client suicide appears to affect counselors on a personal and professional scope (Wagner et al., 2020) and could

be traumatic for the counselor (Grad & Michel, 2004). After losing a client to suicide, researchers suggest that counselors experience a range of emotions including anger, denial, powerlessness, shock, self-doubt, betrayal, sadness, self-blame, regret, fear, grief, and shame (Campbell & Fahy, 2002; Draper et al., 2014; Ting et al., 2006; Veilleux, 2011; Wagner et al., 2020). They may also experience somatic symptoms such as sleep inconsistencies, diminished appetite, and difficulties with maintaining concentration (Linke et al., 2002). Additionally, counselors may believe that they neglected their responsibility in preventing the client's death and consequently lose their professional confidence (Christianson & Everall, 2009; Draper et al., 2014). They may also become more hypervigilant toward documentation, detecting any living client's future suicidal ideation, and pursuing consultation with peers and supervisors (Draper et al., 2014; Fairman et al., 2014; Veilleux, 2011; Wagner et al., 2020).

However, Veilleux (2011) found that there is minimal literature about how a nonsuicidal and/or accidental client death impacts the therapist. One assumption is that therapist responses to suicide or self-inflicted death may be more significant (Coverdale et al., 2007). While some research has focused on intentional death such as client suicide, little is known about the effects of nonsuicidal or accidental client death (e.g., overdose of substance) on addictions counselors beyond specific case studies (Rubel, 2004; Veilleux, 2011). Moreover, much of the research has examined the impact of client death on therapists in general, as opposed to explicitly focusing on counselors. Thus, there is a gap in the research that pertains to the impact of client death specifically on addictions counselors in the counseling literature. Given the high prevalence of client relapse and death in the addictions sector, addictions counselors are exposed to the experience of client death with a high occurrence (Gutierrez et al., 2019). Urmanche (2020) explored the potential impact of overdose-related deaths on addictions counselors. Their research did not explore how circumstances surrounding a death (e.g., nonsubstance-related deaths such as deaths caused by other chronic issues or nonsubstance-related accidents) can impact addictions counselors. Urmanche (2020) primarily focused on opioid-related deaths and acknowledged that deaths caused by other substances remain underrepresented in the literature.

RATIONALE

Considering the implications of the death of an individual with a SUD on surrounding supports, it is important to explore how the death of a client can impact their counselor (Mcauley & Forsyth, 2011). While some research has explored the impact of client death such as suicide and/or accidental death on counselors (Darden & Rutter, 2011; Draper et al., 2014; Fairman et al., 2014; Wagner et al., 2020; Veilleux, 2011) and how personal bereavement affects counselor functionality (Broadbent, 2013), to our best knowledge, no researchers have explored how counselors working in the addictions field experience client death and how they cope with the experience that could accompany substantial distress. We acknowledge that not every death that occurs while the client is in treatment is caused by substance misuse. Nonetheless, addictions counselors are heavily impacted by disproportionate rates of client death in the field (Urmanche, 2020).

In consideration of the identified dearth in the counseling literature with focus given to the addictions sector, the purpose of the identified study is to develop an understanding of how counselors working in the addictions field experience client death. The primary research team discussed and arrived at consensus on research questions to guide the study (Hill et al., 1997). We posed the following research questions: (1) How do addictions counselors experience the death of their client?, (2) What are the short- and long-term effects of addictions counselors who have experienced client death?, (3) What strategies did the participants use to help them cope with stressors associated with the experience?, and (4) What recommendations would participants make for other counselors who might experience client death in the future?

METHODOLOGY

The consensual qualitative research (CQR) method guides this study. CQR is a robust, intentional, constructivist research method (Hill et al., 2005). Exploring, finding, and reaching consensus is a vital component of the CQR method (Hill, 2015; Hill et al., 2005). CQR was selected as the method to guide this study for its ability to gather robust, trustworthy data from an individual's lived experience and its use of an objective panel of experts. The two lead researchers of this study have significant experience in the field of addictions counseling. Thus, a panel of knowledgeable and objective experts serve to bracket and reduce bias in study creation, data collection, and analysis of results. Panel composition is discussed further in the Researchers as Instrument section.

Sampling procedure

Participants were recruited for the study following approval from the institution's human subject review board. Individuals were considered eligible for participation if they: (a) were 18-years old or older, (b) previously earned a master's degree in counseling or related field, (c) currently working in the substance misuse/addiction field, and (d) previously experienced the death of a client while the client was on the therapist's caseload. Participant solicitation notices were sent via social media (e.g., Facebook), Counselor Education and Supervision NETwork (CESNET) listserv, and the American Mental Health Counselors Association (AMHCA) listserv. Those who were willing to share their experience with the researchers were informed of participation expectations: (a)

participate in a 1-hour interview, (b) agree to participate in follow-up interviews if needed, and (c) review transcriptions for accuracy. The lead researcher facilitated the identification, qualification, and communication with participants.

Participants

CQR data collection should continue until stability of findings are reached or when researchers are confident that saturation has occurred (Williams & Hill, 2012). CQR methodologists suggest a sample size of 8–15 participants (Hill, 2015; Hill et al., 2005). Stability of findings were reached at ten participants. Sample participants included six females and four males. Participant cultural identities included White ($n = 9$), and Asian American ($n = 1$). Addictions treatment professional experience was balanced with four early-career (5 or less years), three mid-career (6–15 years), and three seasoned professionals (16+ years of practice). Nine participants were licensed by their state of practice as professional counselors ($n = 7$), marriage and family therapist ($n = 1$), or addictions treatment professional ($n = 1$). One participant was a certified substance abuse counselor seeking supervision for licensure. Participants were located in the Southeastern ($n = 5$), Midwest ($n = 3$), or Northeast ($n = 2$) geographic regions of the United States. Participant names were changed to pseudonyms to protect confidentiality.

Interview protocol

Based upon a review of current literature and our research questions, an interview protocol was constructed by the primary research team to elicit rich content from participants (Hill et al., 1997). The primary research team has considerable clinical and research experience related to addictions counseling. This expertise assisted in the crafting of questions. The protocol was then reviewed by a member of our secondary research team who has extensive experience in qualitative research. Feedback from this reviewer led to the refinement of several questions for conciseness. The final interview protocol can be found in Figure 1. Questions broadly focused on professional experience, the death experience, and implications for the profession. Participants also completed a brief demographic questionnaire. Interviews were conducted via Zoom by the two lead researchers with the most sophisticated understanding of the topic (Hill et al., 2005). All interviews were semistructured in nature and transcribed verbatim. Filler words were excluded from the final transcriptions. To ensure accuracy and promote trustworthiness, each participant was provided a copy of the verbatim transcript to confirm it accurately embodied the participant's experience (Hays & Wood, 2011; Hunt, 2011). All participants confirmed accuracy of transcripts prior to data analysis.

Researchers as instrument

CQR requires researchers to recognize the potential and presence of bias throughout the research process (Hill et al., 2005). Collection of data in CQR is through active conversational space facilitated by the researcher. Analysis of data through dynamic researcher engagement leads to meaning. It is important to recognize the intimate and integral relationship researchers have with data collection and analysis (Hunt, 2011; Pezalla et al., 2012). Primary and secondary research teams were identified based upon individual researcher expertise (Hill et al., 1997; Williams & Hill, 2012).

The primary research team consisted of two counselor educators and one international faculty/counselor educator (first three authors). The first author and primary researcher, a White female, is a counselor educator, researcher, and licensed professional counselor with considerable experience in substance abuse and addictions counseling. The second author, a White male, is a counselor educator, researcher, and licensed professional counselor with experience in addictions counseling and grief and loss. The third author and final member of the primary research team, an Asian female of Korean descent living and working in the United States, is a counselor educator, researcher, and licensed professional counselor with experience in trauma, grief, and loss such as disenfranchised grief and nondeath losses manifested as chronic stress in family caregivers, and multiculturalism. The primary research team's interest in the burnout of professional counselors, its attributes, and relevant coping, and their experience in qualitative research informed and strengthened this study. The secondary team included two female counselor educators who identify as Latinx and a person of color (fourth and fifth authors) and they served as external auditors, given their experiences in qualitative methods, clinical acumen, and knowledge of addictions counseling. This team had sufficient distance to recognize assumptions and promote rigor in data analysis.

Continued routine reflection on the potential impact of bias was infused within all aspects of this process (Hill et al., 2005; Pezalla et al., 2012). An audit trail cataloging the reflective process and the strategies undertaken to reach consensus was maintained throughout the study. During the conceptualization, interview protocol creation, and predata collection, the primary research team met and discussed in synchronous and asynchronous formats their assumptions. The primary team members have direct addictions counseling experience. As a research team, we acknowledged the lethality and addictive nature of substances. Opioid addiction specifically has high rates of overdose, which can lead to death (Doyle, 2021) The research team held the belief that processing the death of another is a personal experience and participant approaches to client death would be varied in nature. We recognized that for some, this may lead to desensitization and for others, confirmation that the work they are doing is vital. We recognized the potential for the experience of client death to lead to work-related stress that can be manifested as counselor burnout,

Interview Protocol

1) What does it mean to you to be an addictions counselor or substance abuse treatment professional?
2) During your career as an addictions counselor, what have been some impactful experiences you've had?
3) Could you please describe your experience with client overdose or death due to substance use?
4) How did experiencing a client's death due to substance use impact you?
5) How did you go about making sense of or processing the client's death?
6) How did you process this experience with colleagues?
7) How did you process this experience with clinical supervisors?
8) How did you process or share this experience with your partner, family, friends, or other loved ones?
9) What did the conversation about this client's death look like at your agency? With other clients?
10) How were you prepared to process/handle the experience of a client's untimely death?
11) What could have helped you to be prepared in processing this experience?
12) What could help you process this experience in the future?
13) How did this experience impact your view of addictions counseling or the profession?
14) What influence has a client's death had upon your professional practice?
15) How might you help prepare an entry-level addiction counselor who has limited experience with this population for the potential overdose/death of one of their clients?
16) After having this experience, what recommendations would you make to the field or for counselor training programs?
17) What else should we know about your experience with a client's death?

Examples of Exploratory Questions:

1) Can you expand more on that?
2) Can you clarify or explain what you mean by that?
3) Do you have any specific examples that speak to what you just described?

FIGURE 1 Interview protocol

vicarious traumatization, and compassion fatigue reviewed in the human service field literature, which impact persistence in the profession.

The researchers continued to openly discuss beliefs and assumptions throughout the data analysis process to ensure that each individual was sufficiently bracketing held beliefs. For instance, when analyzing participant discussions of supervision, the researchers discussed their own experiences with supervision both as supervisors and supervisees. For those with less than ideal experiences with agency supervisors, this discussion and dialog ensured sufficient bracketing was occurring. Such dialogs occurred at various times throughout the data analysis and ensured trustworthy analysis.

Data analysis

Data were analyzed according to CQR methodology outlined by Hill and colleagues (1997, 2005) and Hill (2012, 2015). The primary research team was active in data gathering and analysis, while the second team served as auditors to provide feedback, which promoted trustworthiness (Hill & Knox, 2021). Following the process outlined by Hill (2012), the primary research team collectively evaluated the first transcript, proposing and discussing potential domains. Once a tentative domain list was created, a second transcript was collectively evaluated while domains were refined, removed, or altered as needed. Transcripts three and four were evaluated collectively by the primary team with further revisions to the domain list made. The remaining transcripts were reviewed jointly by two rotating members of the primary research team with routine conversations with the entire team to ensure consensus (Hill, 2012). A final review by the primary research team determined the domains had reached stabilization (Hill and Knox, 2021).

The process of reaching consensus on domains was intentional and purposeful. As the primary team was composed of individuals with professional experience as addictions counselors, we routinely explored our personal assumptions. This led to discussions surrounding cultural considerations, ways of knowing, professional ethics, boundary violations, and professional experiences. Each of these discussions ensured that we were sufficiently bracketing our assumptions during analysis. The researchers distanced themselves from the phenomena for 3 weeks, allowing them to visit the next phase of

data analysis with fresh eyes and insight, a method of promoting rigor in analysis (Vaismoradi et al., 2016).

Returning to the data, the primary research team comprehensively reviewed the domains to ensure coherence and definition. Next, the primary team reviewed each case ensuring the raw data included in each domain was accurate and created a consensus version of the data (Hill & Knox, 2021). From the consensus version, the primary research team began capturing the essence of the participant's statements in clear, concise, language or what Hill (2012) refers to as core ideas. The entire team participated in building consensus around all participant's core ideas. Once core ideas were agreed upon, they were moved to the consensus version (Hill & Knox, 2021). In this manner, content from each manuscript helped to capture the essence or focus of a domain (Hill et al., 1997).

Lastly, the researchers embarked upon cross-analysis, a process of identifying the underlying themes present within each domain across cases (Hill, 2012). These common themes across cases are termed categories. The primary research team collaboratively identified categories, beginning with the smallest and working our way to the largest as suggested by Hill and Knox (2021). With tentative categories developed for each domain, the primary research team began discussing which core ideas should be placed in relevant categories (Hill & Knox, 2021). As with all prior endeavors, the primary research team openly discussed thoughts to reach a consensus and ensure bracketing of any personal bias in data analysis.

The primary research team, having reached consensus on domains, categories, and core ideas, sought an external audit from the secondary research team. Data were sent simultaneously to both auditors allowing for difference in feedback and thus a more robust consideration of the data (Hill & Knox, 2021). The external auditors first reviewed the initial extracted domains and core ideas, providing feedback to the primary research group on the first two steps of analysis. Second, the auditors reviewed the refined domains, categories, and core ideas for veracity and precision. Feedback from the auditors focused on the naming of categories and domains and cohesiveness of core ideas. Feedback was discussed by the primary team and was used to further refine data. Collaborative dialog between the primary and secondary team continued until final consensus on domains and categories were reached.

Trustworthiness

To promote trustworthiness in the CQR process the researchers maintained an audit trail of all decisions, meetings, and processes within the study. The researchers valued reflexivity, open dialog, and frequent discussion of thoughts, feelings, ideas, opinions, and concerns. The researchers regarded each other as equals and thus dialog was free flowing and open within and between research groups. This atmosphere fostered dialog which ensured sufficient dialog to reach consensus. We adhered to trustworthiness principles outlined by Hill (2012, 2015) and Hill and Knox (2021) including ensuring stability in data analysis, use of external auditors to assess and verify veracity of findings, and a purposeful, consistent, interview process for data collection.

RESULTS

We identified a total of eight domains and 28 categories (Table 1) from the data analysis process. The domains include: (a) professional ethics, (b) client care, (c) preparation for profession, (d) experience of addiction, (e) coping skills, (f) agency impact, (g) exploring the death experience, and (h) recommendations. Four of the domains captured the experiences related to providing care to the client before they died (professional ethics, client care, preparation for profession, and experience of addiction) while the other four revealed participants' immediate reactions and potentially prolonged responses to the death itself (coping skills, agency impact, exploring the death experience, recommendations). Following recommendations by Hill and Knox (2021), we extracted categories that were embedded in each of the domains and identified the frequency in which each category was present. From there, we identified 11 categories that were general (80–100%), 12 categories that were typical (50–79%), and five categories that were variant (below 50%).

Domain 1: Professional ethics

Each of the participants broached the topic of ethical practice when experiencing a client's death as an addictions counselor. While the experience of client death can be overwhelmingly devastating, participants did not lose sight of their responsibilities as counselors. Participants' narratives were consistent with components outlined in the *2014 ACA Code of Ethics*. Two specific sections in the *2014 ACA Code of Ethics*, Professional Responsibility and Counseling Relationship, had particular relevance to participants' experiences. Therefore, we labeled the categories as professional responsibility and counseling relationship, which both had general occurrences in the data.

Professional responsibility

Participants spoke to the gravity of the professional responsibility that addictions counselors harbor given the severity of the complications that can arise when working with clients. Participants shared that working in the field requires a specific level of competency due to the nature of issues that develop when working with the population. Participants highlighted the importance of having a particular "educational background to be able to walk the walk and not just do the talk" and understand the "relevant issues that [the addictions population] shows up with" in therapy. Joey commented that his role when working in the addictions field encompasses a

TABLE 1 Domains, categories, and frequencies of findings

Domains and categories	Frequency
Professional ethics	
Professional responsibility	General
Counseling relationship	General
Client care	
Treatment philosophies	General
Psychospiritual factors	Typical
Confront[ing] stigma	Typical
Preparation for profession	
Lack of preparation	Typical
Experiential learning	Typical
Serendipitous introduction to profession	Typical
Experience of addiction	
Complexity of addiction	General
Process of change	Typical
Community closeness	Typical
Coping Skills	
Self-care	General
Professional peer support	General
Supervisory support	General
Personal supports	General
Acceptance of death inevitability	General
Compartmentalization	Variant
Agency impact	
Lack of agency support	Typical
Agency support	Variant
Business-centered vs. Person-centered	Variant
Exploring the death experience	
Client autonomy vs. counselor responsibility	General
Individual processing	General
Unanswered questions	Typical
Nature of the death	Typical
Stress responses	Variant
Collective processing	Variant
Recommendations	
Training recommendations	Typical
Professional recommendations	Typical

level of flexibility and is "multifaceted" due to the multiple responsibilities he assumes on a regular day.

Counseling relationship

Participants shared that the counseling relationship is at the forefront of client care and is intertwined with the death experience. Considering the closeness of the counseling relationship, participants were negatively impacted when the client died. During the interview, participants reflected on how their connection with their client altered the experience. In describing his relationship with his deceased client, Joey shared, "I would say [our relationship] was very much a big brother/little brother type of relationship. It was one that I think the countertransference was very much like a little brother." Some participants acknowledged that they maintained a level of emotional distance between themselves and their clients due to the regularity of client death. Greg stated that he has to "maintain a pretty stoic mindset about the work because people tend to die a lot."

Domain 2: Client care

Participants acknowledged that the ways in which they provided client care impacted the death experience. This domain consisted of the following categories: treatment philosophies, psychospiritual factors, and confront[ing] stigma. Treatment philosophies had general occurrences throughout the data while psychospiritual factors and confront[ing] stigma were variant.

Treatment philosophies

Multiple participants explained the various treatment philosophies that they incorporated in their work with clients to conceptualize and explain addiction. Lucy shared that part of her role as an addictions counselor is "understanding the true disease model of addiction and understanding how it hijacks a person's brain." Michelle acknowledged her understanding of addiction as a "deadly disease" and compared it to "Russian Roulette." Kate also shared similar sentiments regarding the disease model of addiction:

> I am much more comfortable with the disease model because it's what I truly believe. I stand behind it and it's easier for me to talk about it and teach it because to me, that makes so much more sense. I don't want to help somebody on the road to disaster. Sometimes I have a difficult time working with agencies that don't necessarily have that model because I don't know if we're really on the same page.

Through the incorporation of the disease model in their conceptualization of addiction, participants were able to refrain from placing blame on the client for their own death. They recognized that SUDs are a consequence of a culmination of factors including neurobiology, sociology, trauma, and psychological wellness.

Psychospiritual factors

Participants discussed the importance of utilizing psychospiritual factors, especially hope, in their work with clients. In attempting to reassure living clients who are grieving the loss of their peer, Greg acknowledged the importance of "convinc[ing] [surviving clients] that everything's going to be OK, just like you would if you were a parent, and you don't want your kid to know that you are going through some really bad financial times." Lucy shared that an integral part of her work is "providing hope for people who are at their rock bottom." Through the use of hope, participants were able to develop the momentum to move forward and provide continued therapeutic care to other clients. Participants used their hope to inspire clients to persevere through the challenges they faced while battling addiction.

Confront[ing] stigma

Several participants mentioned the importance of confront[ing] stigma since it can have an influence on the experience. This stigma often discouraged participants from confiding in personal supports, such as family members or friends outside the profession, due to a perceived lack of understanding. Madison explained that her family members "aren't really educated about addictions" and that they have misconceptions about addictions, which discourages her from reaching out to them for support. Kate shared her hesitation in reaching out to others who may not understand addiction by stating, "I want to stay away from processing it with anybody that doesn't understand this disease."

Domain 3: Preparation for profession

Preparation for profession described how participants felt equipped to enter the profession and effectively respond to a client's death. The categories within this domain are lack of preparation, experiential learning, and serendipitous introduction to the profession. All three categories emerged as typical.

Lack of preparation

Participants acknowledged the lack of preparation they felt when confronted with their client's death. Megan shared that she did not anticipate her client's death and shared that the news was the "last thing that [she] expected to hear on the phone that day." Participants believed they were "not prepared professionally or personally" and noted that, "in terms of feeling prepared for it, [there's not anything] you can prepare for until it's on you."

Experiential learning

Participants discussed the importance of experiential learning when confronted with client death. Participants acknowledged the value of experiential learning and remarked that "experience is the best teacher" to become better equipped to cope with future deaths. In terms of experiential learning, Megan found it helpful to hear other professionals' stories about the realities of client loss to understand "what it actually is like." Max stated that having experienced a client's death in the past helps him feel "better prepared for what to expect the next time that it does happen."

Serendipitous introduction to the profession

Five participants shared they had a serendipitous introduction to the profession. These participants did not expect to work in the addictions field, which impacted their level of preparation for client death. Multiple participants worked with a different population at the beginning of their careers and were even reserved about working with SUDs. Due to the pervasiveness of addictions in their respective communities, they eventually transitioned into working in the addictions sector and became passionate about the specialty.

Domain 4: Experience of addiction

Each of the participants discussed how their client's experience of addiction influenced the treatment process and eventual death. This domain consisted of the following categories: complexity of addiction, process of change, and community closeness. Complexity of addiction had general occurrences throughout the data while process of change and community closeness were typical.

Complexity of addiction

The complexity of addiction placed extraneous stressors on participants leading up to the client's death due to the notion that working with the population often means "dealing with two themes of disorders" leading up to the client's death. In other words, participants were not just working with the addiction itself, but they also had to consider co-occurring disorders that were impacting or "trigger[ing] the move into addictions." The complexity of addiction created a vacillation between recovery and active addiction, which left participants feeling overwhelmed and disenchanted with the process. Kate referred to addiction as a "losing game" at times due to the reality that many "patients don't get better."

Process of change

Participants observed the process of change among clients while in treatment. Joey experiences a "rewarding feeling" when clients begin to make progress in recovery and get a "part time or full-time job" or when "their family starts to want to have contact with [the client]" due to "bridges being mended." However, he noted that change is not always positive and that "peoples' lives can either change drastically for the better, or for the worse" such as in instances of client death.

Community closeness

Participants observed a level of community closeness that was impacted by the death experience. Joey reflected on how the "small-knit" nature of the community inspired surviving clients' willingness to "talk very openly about their relationship with the [deceased client]." This community closeness also served as a mechanism for how counselors found out that former clients had died. Greg mentioned,

> You know, it's a small community so you're involved with everybody. You're going to meet everybody or work with everybody in some way, shape or form. So, there were times when I ran the anger management track, there were times when I ran the grief counseling track and I'd find out that somebody in one of my tracks had died.

Josh shared that when a client dies, it not only impacts him but also the surviving clients especially during the group therapy process. He shared, "it was the other group members who had some grieving around [the fact] that this was a member of our group and this person is no longer a member of our group because he passed away."

Domain 5: Coping skills

As participants reflected on the death experience, many of them broached the importance of actively implementing appropriate coping skills to manage their reactions and effectively process the experience. This domain consisted of the following categories: self-care, professional peer support, supervisory support, personal supports, acceptance of death inevitability, and compartmentalization. Self-care, professional peer support, supervisory support, personal supports, and acceptance of death inevitability had general occurrences throughout the data. The frequency for compartmentalization was variant.

Self-care

While they processed the experience, participants spoke regarding the importance of self-care. Multiple participants including Max, Joey, and Greg mentioned specific strategies they used, including personal therapy. While she knew about the importance of self-care, Lucy admitted that it is difficult to actively pursue this practice and relies on colleagues to hold her accountable. She shared, "[helpers] are notorious for not doing well at self-care. Anybody in this field, we're the worst [at self-care]. Usually someone has to slow me down and say, 'you need some time off.'" While the term, "self-care" is commonly used in graduate programs, participants admitted that they were unclear on tangible strategies they could pursue to promote this practice. Lucy shared,

> [Self-care] is not discussed enough in school. When I graduated from my graduate program, if I heard the term self-care one more time, it wasn't going to be pretty. Because it was like, oh yeah, self-care, self-care. What is that? What does that look like? What do you mean by that? It is not discussed enough in this field.

Professional peer support

All 10 participants spoke to the importance of seeking out professional peer support when confronted with a client's death. Participants recounted specific instances when they grieved alongside their peers. Madison reflected on one specific instance: "I just remember my officemate and I were both sitting there crying and then we kind of did a debrief with the group together. I didn't have to do it by myself." For Lucy, "talking with [peers]" was an important part of processing the experience.

Supervisory support

Along with professional peer support, participants also discussed how the presence or absence of supervisory support impacted their experience. Participants experienced various reactions and levels of support from their supervisor. Joey shared that upon hearing of the client's death, his clinical supervisors were proactive in ensuring that he "had the tools necessary in order to heal." Megan shared that her supervisor gave her the opportunity to go home if she needed a break from work to recover from the event. In contrast, other participants expressed frustration that they did not receive the supervisory support they needed. Michelle shared that there was a significant discrepancy between how her site and off-site supervisors responded to the event. She explained,

> With my work clinical supervisor, it was a blanket statement of something like, 'oh, we just received word late last night that John Doe overdosed.' And that was it. There was no talk or say if anybody needs to process this further, you know where to reach us or anything like that. So, there was no processing. With my outside clinical supervisor, I do remember having a little bit more space to be able to process some of my own emotions.

Madison shared that she felt pressure from her supervisor to immediately "get that paperwork done" following the incident, which interfered in her own processing.

Personal supports

In addition to professional peer support and supervisory support, participants also shared that personal support including friends, family, and other loved ones were relatively important. However, many participants disclosed that there was a disconnect between them and loved ones due to a lack of shared experience. Carrie shared,

> Substance use in general kind of makes [my mom] a little uncomfortable and so she's not really one that I would give all those heavy emotions to. That's not really her style…it's hard to explain a client relationship and it's hard to feel valid in feeling sad because you know so much about this person but then nothing about this person.

Ethical and legal guidelines require confidentiality. This impacted the level of disclosure participants could engage in with family members and friends outside the profession. Lucy shared that she simply informed her husband that she "had a bad day" and refrained from "talk[ing] in a lot of detail to [her] husband about it."

Acceptance of death inevitability

Several participants spoke to the acceptance of death inevitability as a coping mechanism. Megan stated, "when you're going through your internship, you get the message that [death] will happen." Michelle acknowledged the unique nature of the addictions field given the "increased propensity for clients to [die] for various and multiple reasons when compared to some other mental health diagnoses." Greg recognized that while it was challenging to prepare for the death to occur, he "knew that this would be a risk of working in substance abuse."

Compartmentalization

Some participants utilized compartmentalization to cope with the event. Participants recognized that while it was tragic to lose a client, they still had to carry on with work-related responsibilities. Participants did not experience a break between undergoing a client death and tending to living clients. For some, the opportunity to focus on other tasks provided an avenue for participants to shift their attention. Carrie shared, "it was very go, go, go. It was kind of distracting. I would just distract myself with more work." Joey disclosed that despite the death, he recognized that he still had to complete his responsibilities to his other clients. He shared, "[I] just had to put [the death] on the bench while [I] was dealing with all this other stuff that was going on with the job and 34 other cases that had very unique needs."

Domain 6: Agency impact

During the interview, participants reflected on the role of the agency before and after the client's death. This domain consisted of the following categories: lack of agency support, agency support, and business-centered versus person-centered. Lack of agency support had typical occurrences in the data. Agency support and business-centered versus person-centered emerged as variant.

Lack of agency support

Lack of agency support produced negative consequences for participants. In one instance, a participant ultimately decided to terminate his employment:

> The circumstances of the death had been a contributing factor in me leaving the agency too because I feel as though the agency didn't do enough to help support the patient or their family and it was very clear that the actions of the agency didn't have the best interests of helping the patient in a very clear time of need.

Michelle also recalled that she was "wanting acknowledgement and support but [did not] receive it" from the agency. She shared that not having "a space to talk and process" the event was detrimental to her experience.

Agency support

On the other hand, some participants experienced varying levels of agency support. When client deaths were at a high rate due to overdose, Lucy recalled that her agency was supportive in providing employee assistant program (EAP) services for the employees which were beneficial in helping

employees process the tragedy. Megan shared that her agency allotted her the opportunity to "go home and take care of [her]self" immediately after finding out that her client was deceased. This opportunity of going home allowed Megan to briefly detach from her work before being expected to return.

Business-centered versus person-centered

Several participants discussed the delineation between business-centered and person-centered foundational frameworks of their respective agencies. Michelle disliked that her agency was "more business-oriented than client-oriented," which limited the amount of support she received. Michelle explained how agencies that require their employees to serve "8 to 10 clients a day or [maintain] caseloads of 80–90 clients" leave little time for self-care. Lucy disclosed that her agency had the expectation that she would "pick [herself] up and move on" immediately after a client's death.

Domain 7: Exploring the death experience

Participants talked about their immediate and long-term reactions to the death experience. Exploring the death experience encompassed the following categories: client autonomy versus counselor responsibility, individual processing, unanswered questions, nature of the death, stress responses, and collective processing. Client autonomy versus counselor responsibility and individual processing were general occurrences throughout the data. Unanswered questions and nature of the death were typical while stress responses and collective processing were variant.

Client autonomy versus counselor responsibility

Participants explained how a large part of the death experience involved needing to resolve uncertainty between client autonomy and counselor responsibility. Participants were reflective about their role in the counselor/client relationship and were launched into an exploration of the limitations in their responsibilities to the client prior to the death. Some participants questioned if they were to blame for the event and experienced a level of guilt related to this self-blame. Greg shared, "whenever someone died, I would reflect on their story and think, is there something I should have been looking for?" Lucy also said,

> "it's very questioning of yourself [when a client dies]. Did you do the right thing? Did you say something wrong? What could you have said different? What did you need to say different? Am I in the right field? Am I making a difference?"

Michelle also engaged in self-questioning, "[I] question[ed] my own competence as a counselor. Did I do something wrong? What could I have done differently? There was a lot of inward self-reflection and some of it was negative."

Individual processing

Each participant had their own experience with individual processing in the aftermath of the client's death. Megan elected to go home so that she could have time to "really sit and think and process it and figure out" what occurred. Megan shared that she would use therapeutic interventions on herself in order to assist with processing. She explained, "I used CBT on myself. Just recognizing that my automatic reaction wasn't necessarily the truth [was helpful]." Kate also talked about the importance of letting herself grieve the event:

> It's a process of letting myself grieve for that person and talking about it and allowing myself to have hopes and dreams that I wish would have happened for that person but ultimately coming to a place of acceptance that's not the plan for that person.

Unanswered questions

Several participants noted that there were multiple unanswered questions following the client's death. Participants struggled with their uncertainty regarding whether the death was intentional or accidental. Megan shared, "to this day, I don't know if it was intentional or not. And there's just those little things that kind of bug you that you don't know." Other participants had questions regarding the conditions that the client experienced in their final moments. Lucy shared,

> That was a hard one. I don't know if she was alone. I don't know if she was with somebody, don't know if she wasn't alone, why didn't they try to do something? You get angry, mad, confused. You experience all emotions at one time. You don't know who to get angry at, there's nobody to get angry at.

Nature of the death

Participants also spoke to how the nature of the death impacted the experience. They admitted that not every death is attributed to drug misuse and reflected on the variability of causes of death. Kate shared that she had clients die from a variety of causes including murder, intentional overdose, and accidents. Madison stated that "not all of [the deaths] have been overdoses." Josh's client had a slower, lingering death due to being hospitalized after having a heart attack. In fact, Josh experienced a level of hopefulness that his client

would survive and was ultimately saddened when the client succumbed to health complications related to the heart attack. He explained, “there was a lot of prayer and hope that recovery [from the heart attack] might occur and it didn’t happen.”

Stress responses

Participants reflected on stress responses they experienced following the client’s death, including nightmares and flashbacks. Other participants experienced a kind of “dissociated state” after finding out that the client was dead.

Collective processing

Participants explained that they engaged in collective processing with others after the death. They not only processed with professional colleagues but with clients as well since it tended to be a shared grieving process. Greg believed it was his responsibility to support the surviving clients in their grieving process following their peer’s death. He discussed the importance of modeling grieving behaviors through transparency, “We were transparent with [the surviving clients] because we wanted them to understand we were fully human and that we were hurting too.” Lucy indicated the importance of bringing the EAP into staff meetings to facilitate collective processing among the clinicians. Josh shared, “we all grieved together. I think there were a lot of fond memories, but we grieved the loss of the member of the group who was a reliable person who sat in the same chair.”

Domain 8: Recommendations

During the interviews, participants offered multiple recommendations for counselors/counselor trainees, supervisors, counselor educators, and agencies, to consider in the future should they experience a client death. This domain consisted of the following categories: training recommendations and professional recommendations. Both categories were typical.

Training recommendations

Participants encouraged supervisors and educators to consider incorporating specific training recommendations. Greg advised that the accrediting organization for counselor education, Council for Accreditation of Counseling and Related Educational Programs (CACREP), should consider adding “grief counseling” as part of its required standards. He said,

> You know in CACREP, it doesn’t mandate anything for grief counseling. Death is one thing we all do, and we don’t have any discussion or education or professional planning in it as part of the CACREP standards. Folks have all kinds of problems and issues, but what they all have in common is that they’re going to die and they’re going to know others who die because everyone dies.

Josh discussed the value of intentionally broaching the topic of client death in the classroom, despite students’ discomfort. He acknowledged that students may feel reserved when discussing these topics, but it is the educator’s responsibility to initiate these conversations. He said,

> What I say [to the students] is if we don’t raise these issues with you in your training, you’re going to look back and say, ‘Why didn’t they talk about this when I was in grad school?’ We owe [the students]. [They’re] paying us so sometimes we’re going to have to make [them] feel uncomfortable talking about something that’s not pleasant or not socially easy to talk about. It’s important to find ways in the training process.

Max advocated for “support systems to be in place” for the trainee to prepare for the eventual experience of client death. He shared,

> Now I’m much more vigilant about making sure that when it happens because it’s going to happen. It’s not *if* it’s going to happen. It’s *when* this is going to happen. You’re sort of prepared in advance of what you’re going to do.

Professional recommendations

In addition to training recommendations, participants offered professional recommendations for counselor trainees and professional counselors. Michelle cautioned against supervisors and agencies placing too large of a burden on counselors in terms of caseload and questioned the ethicality of these actions. She said,

> I feel it is very unethical for supervisors to demand that counselors see seven, eight clients back-to-back. I find that to be a very unhealthy model. I find that to be unsustainable in relation to the self-care of the clinician.

Megan encouraged supervisors to speak about death “in a concrete way” and to “provide concrete examples” of what counselors can do if they experience client death. Joey encouraged professionals to have an “outlet” such as personal therapy and for supervisors to initiate conversations about the event with their employees. As he reflected on his experience, he said

> Honestly just having an outlet whether it's my therapist at the time or if the opportunity presents attempting like some sort of ceremony or physical-like ritual to help process it. I think my clinical supervisor asking me how I can be better supported or if they needed to have a series of conversations with me following the loss–I think these are all ways to hopefully make the event, if it does happen again, a bit better.

DISCUSSION

Our findings suggest that client death has a profound impact on addictions counselors. These results provide a variety of avenues that promote meaningful preparation for counselor education and training, societally and professionally sanctioned grief and loss related to client death, and clinical practice and service delivery at varying levels. Four of the domains pertained to the timeline prior to the death (e.g., professional ethics, client care, preparation for profession, experience of addiction) while the other four were relevant to processes subsequent to the death (e.g., coping skills, agency impact, exploring the death experience, recommendations).

To answer our first research question (How do addictions counselors experience the death of their client?), we learned that the experience of client death in the addictions field has a significant impact on the counselor given the inherently intimate and meaningful connection between counselor and client. Findings from the current study suggest that participants were reflective about their role in the counselor–client relationship and considered the limitations of their responsibilities to the client prior to the death. Consistent with prior research (Rubel, 2004; Tsui et al., 2019), participants wondered if they were somehow responsible for the death, which resulted in self-questioning, self-blame, and internalized guilt. Additionally, the participants relied on other counselors actively working in the field to assist with the collective grief experience. The participants shared that colleagues as opposed to personal loved ones, were instrumental in helping them process through their grief given a greater understanding of what it is like to lose a client. The lack of understanding from loved ones produced a sense of disconnection, which created obstacles and barriers for the participants as they attempted to navigate through the experience. The importance of connecting with others to process the experience and reduce feelings of isolation has been previously supported throughout the literature (Valentine et al., 2016) Moreover, participants were concerned about potential breaches of confidentiality if they processed with personal loved ones. Considering the ethicality of case consultation with fellow colleagues and co-workers, participants experienced a level of safety to talk openly with those who had a professional connection with the client. Many participants also relied on solitary or individual processing to make sense of the event.

In response to our second research question (What are the short- and long-term effects of addictions counselors who have experienced client death?), we discovered that the participants experienced both short- and long-term impacts as a direct result of client death. Given the traumatizing and sudden nature of the death, participants experienced a variety of acute stress responses including nightmares, flashbacks, and disassociation. This is consistent with previous research that has explored short- and long-term effects on family members who have experienced the loss of a loved one to a drug-related death (Valentine et al., 2016). Our study suggests the impact from the death of an individual with an addiction transcends personal relationships (e.g., family members, friends) and affects professional counselor–client relationships. This study reinforces Linke et al.'s (2002) findings that counselors experience an array of somatic symptoms including difficulties with maintaining concentration and sleep inconsistencies following a client's death. However, unlike Linke et al. (2002), we investigated how addictions counselors specifically, as opposed to mental health therapists in general, experienced client death to determine if there were differences in types of responses or severity. Participants were often informed of details about the client's death, which created additional stress responses and visualization of what occurred. This coincides with Valentine et al.'s (2016) findings that relaying details to family members about their loved one's death can intensify adverse stress responses. In the aftermath, participants had difficulty maintaining boundaries and effectively separating themselves from their work, which led to blurred lines between their personal and professional worlds. Given the high intensity and case overload in treatment facilities, some participants received minimal agency support, which led them to seek employment elsewhere. In other cases, the limited agency support motivated participants to alter the agency climate and implement supportive practices to prepare for future client deaths. In other words, some participants were inspired by what they did not receive and worked to ensure that other professionals had a more supportive experience in the wake of client death.

To answer our third research question (What strategies did the participants use to help them cope with stressors associated with the experience?), we found that participants used a variety of coping strategies and resources to manage their responses to the experience. Some participants recognized that they had a limited understanding of self-care due to minimal instruction on the topic in their graduate program. Participants were thrust into the position to identify personal means of self-care, which ranged from attending therapy to journaling activities. Participants often turned to professional colleagues and supervisors to engage in collective processing to create meaning out of the experience and reconstruct the narrative around the death. This response is consistent with previous literature that has underscored the importance of meaning-making processes as a coping skill after experiencing a death (Braun & Berg, 1994). Participants' family members and friends outside of the profession offered limited support and comfort due to a lack of understanding and presence of ethical and legal guidelines related to confidentiality. This lack of understanding and perception

that the loss somehow lacked meaning seemingly intensified feelings of isolation and disconnection for the participants, which is consistent with previous literature that explored the resultant isolating effects for those experiencing disenfranchised grief (Tsui et al., 2019). Similar to previous research (Simone, 2010; Valentine et al., 2016) if stigma or misperceptions about addiction ultimately censored participants from processing with family and friends outside the profession, then they experienced intensified grief responses, making the process more complicated. In many cases, the supervisory relationship was instrumental in assisting participants with processing the death. Participants found it imperative to support surviving clients process their peer's death. In contrast, pretending as though the death never occurred and refusing to acknowledge it with other clients was deemed unhelpful.

Finally, regarding our fourth research question (What recommendations would participants make for other counselors who might experience client death in the future?), there were multiple recommendations. First and foremost, participants urged educators to intentionally incorporate the topic of death into their teaching to normalize the phenomenon. Currently, the CACREP (2016) standards do not include a curriculum guideline for death education, which researchers posed as a limitation in previous literature (Harrawood et al., 2011). Harrawood et al. (2011) found that providing death education instruction to counseling students can have positive effects on their attitudes toward death in their work with clients. Providing this instruction would not only help students feel prepared to work with clients who are bereaved, but also support students in identifying helpful ways to cope with the experience if they encounter it personally in their work. Sharing professional experiences validate and help students reconcile with the possibility that they can move forward after a client's death. Considering the universality of death, it is crucial that educators and supervisors remind students that they will most likely experience the phenomenon in their work given the high-risk nature of the population living with SUDs.

The experience of undergoing client death needs continued empirical investigation given an evident dearth in the literature about how a nonsuicidal and/or accidental client death impacts the therapist (Urmanche, 2020; Veilleux, 2011). In relation to this, previous studies suggested that substance-related deaths are traumatic for survivors (Valentine et al., 2016). Counselors who lost clients to substance-related deaths may be hindered from adaptive grief processing due to varying reasons such as societal stigma. As described previously, deaths related to SUDs are often implicated to be bad (Feigelman et al., 2012) and subject to societal and individual stigmatization. Thus, the experience of those who have encountered these types of death may likely be disenfranchised (Doka, 2002; Valentine et al., 2016). This interrupted grief or bereavement may prevent the bereaved particularly as trauma survivors from healthy mourning processes by creating normative meaning-making in their death experience through the reconstructing of their identity, regaining a sense of control, and reconceptualizing their relationship with the deceased (Braun & Berg, 1994). Therefore, such individuals may be vulnerable for prolonged grief-related outcomes such as complicated grief (Crunk et al., 2017).

Implications for clinical practice and counselor training

Findings from this study suggest many addictions counselors are negatively impacted by client death and require support from clinical supervisors, administrators, and peers. Participants experienced a wide range of short-term and long-term reactions and responses to the experience, including guilt and self-questioning, which was consistent with earlier research (McAuley & Forsyth, 2011). It is important for clinical supervisors and administrators to provide avenues for counselors to grieve, including opportunities for counselors to engage in peer support groups or individual processing. The findings provide multiple implications for counselors, supervisors, and agency administrators to consider.

Our findings underscore the importance of creating tangible strategies for counselors to engage in self-care. Based on what participants shared, training programs, supervisors, and agencies tend to talk about self-care in abstract terms, leaving counselors feeling unprepared to effectively engage in self-care. It could be helpful to provide concrete solutions for self-care so that counselors can effectively employ these methods when experiencing significant stress after losing a client. Counselors and counselor trainees are encouraged to engage in individualized modalities to promote wellness and maintain appropriate boundaries to effectively address uninterrupted grief. It is important to recognize that experiencing a death of this nature may result in disenfranchised grief given its suddenness, ambiguity, and unpredictability. Thus, counselors and counselor trainees are encouraged to take proactive and preventative steps to identify ways (e.g., healthy mourning) to process the experience. For instance, activities such as personal hobbies, social connection, journaling and setting consistent boundaries can be beneficial in helping the counselor/counselor trainee manage their responses to the event (Kramen-Kahn & Hansen, 1998). Our findings also suggest that the loss can feel traumatic for some counselors, which may require therapy for traumatic stress-related symptoms and to normalize these responses. Agency administrators may want to consider enlisting EAPs to provide improved access to therapeutic support for their employees.

Death is a universal process that impacts all living beings. It is imperative to self-evaluate one's own perceptions, beliefs, and biases about its occurrence from a cultural context (Doughty Horn et al., 2013). Furthermore, death is a seemingly frequent event in the addictions field given the nature of the work, requiring counselors to be diligent in reflecting on how they are professionally and personally impacted by the experience to maintain their own wellness (Gutierrez et al., 2019; Urmanche, 2020). Multiple participants subscribed to the disease model of addiction and recognized that SUDs are outside the person's control, despite broader society's viewpoint that it is self-inflicted and

attributed to a moral failing (Feigelman et al., 2011; Valentine & Walter, 2015). However, according to participants, attitudes regarding how and why an addiction develops played a role in how counselors responded to the experience. Based on our findings, we recommend that addictions counselors explore their personalized conceptualization of addiction and assess whether they have attitudinal biases regarding addiction and its potential consequences that are impacting their responses to the client's death.

Counselor educators may want to incorporate instruction related to grief and loss. Previous research highlights that grief and loss are not required subjects in counselor education programs, creating difficulties in standardizing training practices in regard to these topics (Breen, 2010). As several participants shared, it would be beneficial to intentionally broach this topic during supervision and counselor training programs to prepare counselor trainees for the inevitability of client death given the nature of the profession. Specifically, due to the high propensity of client death in the addictions field, educators may want to regularly incorporate this topic into their addictions training. Ideally, counselor educators and supervisors may invite professionals who have undergone the experience to speak with current students for normalization purposes.

Supervisors and administrators are encouraged to be mindful of the societal stigma regarding death occurrences among clients with SUDs, which can negatively impact memorialization processes (Valentine et al., 2016). Counselor educators and supervisors may be intentional about providing timely opportunities for their trainees to engage in these memorialization practices in a nonjudgmental and safe environment. Providing opportunities for counselors to process the client's death with peers and coworkers can create avenues for counselors to effectively process the meaning of the experience (Feigelman et al., 2012; Yule & Levin, 2019). From an agency standpoint, it may be beneficial to reconsider overburdening counselors with high caseloads, which could be ethically problematic. The American Counseling Association (ACA)'s *Code of Ethics* (2014) mandates that "counselors monitor themselves for signs of impairment from their own physical, mental, or emotional problems and refrain from offering or providing professional services when impaired" (p. 9). Therefore, it is the counselor's responsibility to ensure that they are not impaired when providing therapy to clients. If a tragic event such as a client's death occurs, it is the counselor's responsibility to engage in appropriate interventions, so their responses do not interfere in their work. However, it would behoove agencies to provide their counselors with avenues to engage in self-monitoring and appropriate interventions in the event that they do become impaired as a result of the event.

Limitations and future research

The implications of the current study may be considered in light of several limitations. The primary research team included individuals who have a training background in addictions counseling and clinical experience in client death. While their expertise was chosen as a strength to the study given its applicability and relevance, their personal experience and bias is a potential limitation as well. Transferability of findings is a limitation as well. Although the goal of qualitative methodology is not generalizability, the lack of a heterogeneous sample may limit how transferable the findings are to other addictions counselors who do not have the same cultural and racial identity. While participants varied in experience and gender, most participants identified as White. Additionally, we did not have any individuals from countries outside the United States in our sample, further limiting representation. One of the cited components of an individual's experience with death is how they construct meaning surrounding death. How death is conceptualized is influenced by culture (Gire, 2014), thus, transferability of the findings of this study may be limited to White counselors living in the United States.

This study utilized online platforms such as Facebook, CESNET listserv, and the AMHCA listserv to recruit participants. Thus, potential participants were limited to individuals who have access to the identified platforms, limiting the pool of participants eligible to participate. Given the unique experience of a client's death experienced by a counselor in addictions treatment, online recruitment allowed the researchers to reach as many eligible participants as possible (Hays & Singh, 2012).

The participants of this study were diverse in their type of licensure with only one participant specialized in addictions treatment. Given the specific requirements for different licensures, there is an implication that training and preparation for addictions treatment with the intersection of client death was not the same for all participants. A replication of this study with participants who have license in addictions treatment to explore their experience with client death is recommended to better inform the counseling field.

There are potential qualitative studies that can be further explored based on this study's findings. Participants of this study cited supervisor support as one of their coping skills for client death. In the future, exploring the impact of client death on clinical supervisors in addictions treatment could yield fruitful information to develop continuing education training for supervisors to help their supervisees. As noted in the limitations, further exploration of the impact of client death on culturally diverse clients is warranted. How individuals culturally conceptualize death may impact their experience with client death. Increasing awareness of the cultural impact can aid training and preparation with diverse counselors working with this population. Research on the impact of client death on the therapeutic relationship, could lead to practices to bolster stability for remaining clients. Finally, exploring how counselor education programs prepare counselors to manage clients' death could confirm the need for training in grief counseling.

CONFLICT OF INTEREST

The authors declare no conflict of interest.

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