Integrating the Transtheoretical Model and Stages of Grief to the Co-Occurring Population

A Literature Review

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By

Maria Roche

Chair: Jill Hubble, MSEd, LPCC, LADC
Reader: Rashida Fisher, MS, LPCC, LADC

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Co-occurring disorders are the co-existence of a mental health disorder and substance use disorder. Often times, individuals with co-occurring disorders are dealing with grief and loss. Unresolved grief is one reason individuals return to substance use. Because of the diverse of application, Adlerian theory can be applied to theoretical concepts regarding grief and loss. The Transtheoretical Model has been used in treatment for health behaviors including, substance use disorders and mental health disorders, as a model for improved wellness. Bowlby’s attachment theory explores the relationship between attachment and grief. Grief happens after a loss of attachment relationship. In this paper, Kübler-Ross’s stages of grief are applied to better understand the feelings of grieving individuals, and conceptualize in conjunction with other theories to better understand grief and loss as change within an individual’s life. It is argued that utilizing Adlerian perceptive, Bowlby’s attachment theory, integrating the transtheoretical model with the stages of grief can help individuals with co-occurring disorder cope with the grief and loss problems more effectively. Effectively treating grief in co-occurring individuals can decrease the risk of relapse.

*Keywords:* co-occurring disorders, grief and loss, mental health disorder, substance use disorder, Transtheoretical Model, attachment theory, stages of grief, stages of change, processes of change, effects of the brain, Adlerian theory, complicated grief
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Integrating the Transtheoretical Model and Stages of Grief to the Co-Occurring Population

According to Hartshorne (2003), grief can be seen as separating from attachment and is a significant change in individual’s life. In individuals with co-occurring disorders (COD), losses can be overwhelming. Furthermore, research suggests the connection between grief, attachment, and addiction in the brain, which will be discussed to help better understand these processes (Burkett & Young, 2012; Hurlermann & Scheele, 2016). Through an Adlerian perspective, integrating the Kübler-Ross’s stages of grief with the transtheoretical model (TTM) could provide counselors with more insight on how to help the COD population cope with the changes after experiencing losses in their lives, while the work of John Bowlby helps counselors better conceptualize the role of attachment through the grieving process.

Alfred Adler collaborated with Sigmund Freud until 1911. In 1912 Adler founded the Society for Individual Psychology (Oberst & Stewart, 2003). Moving away from Freud’s point of view of biology and determination, Adler believed individuals began to interpret the world in the first six years of life, and that individuals interpretation of these early events in life continue to affect the individuals’ behavior in their present (Corey, 2013). Adler also postulated that individuals have a creative force, which allows them to make their own decisions and opinions regarding life events and experiences (Oberst & Stewart, 2003). Ansbacher and Ansbacher (1956) stated Adler called this concept the “creative self”, where the individual is both the picture and the artist.

**Adlerian Individual Psychology**

Adler’s holistic perspective of human nature included his argument that personality worked as whole to create movement towards a life goal. Each part of individual works in relationship with each other in effort to achieve this goal (Corey, 2013). Corey (2013) also
stated that Adler stressed individuals are social-embedded, and the family, culture, school and work have an effect on the individual’s decision-making. Therefore, according to Adler, all behavior has a purpose, and its purpose is to move towards the accomplishments in the individual’s life goal of seeking connection with others.

Since individuals are goal-oriented, understanding the goal can help make sense of the behavior (Hartshorne, 2003). Behaviors are guided by fictions that help individuals cope with the reality of life (Oberst & Stewart, 2003). Adler used the idea of fictions from Hans Vaihinger, who defined fictions as ideas, including the unconscious notions, to enable individuals to deal with the realities of life (Ansbacher & Ansbacher, 1956), and argued individuals will act as if the fictions were true.

Adlerian therapy suggest individuals have a set of guiding fictions that help create their own way of thinking, ideas, and conclusions that help develop and comprise the individuals’ private logic (Oberst & Stewart, 2003). Corey (2013) stated individuals’ problems start when the private logic does not conform to the requirements for social living. According to Stoltz and Kern (2007), part of therapy is to help individuals become aware of their private logic, goals, and purpose of their behaviors, so as to produce movement towards the individual’s goal.

Adlerian therapy argues that life is all about movement, and moving from a felt minus (perceived lower position) to a perceived plus (perceived better position) (Corey, 2013). The argument can be made that individuals are trying to move upwards in life and are striving to make better changes. Individuals are working on compensating or overcompensating for the inferiority feelings; however, when attempts to compensate and overcompensate are unsuccessful, then individuals start to develop neurosis (Oberst & Stewart, 2003). Weber (2003) found as a result of inferiority feelings, an individual develops safeguarding behaviors, such as
substance use, anger, and other unhealthy behaviors, as a way to protect the individual’s self-esteem, or self-worth.

Adler believed the movement from a felt minus to a perceived plus resulted in the development of a life goal, which unified personality and core beliefs, he called this the lifestyle (Corey, 2013). Lifestyle is developed by childhood experiences and how the child interpreted these experiences (Oberst & Stewart, 2003). According to Peluso, Peluso, White, and Kern (2004), Adler believed people created their own reality at an early age from interactions within the family unit, and as a result people developed private logic, or attitudes or reactions to life, how the world works, and their place in the world thus creating their lifestyle. This influenced the individual’s creative self and lifestyle.

Understanding an individual’s lifestyle can give insight regarding the individual’s private logic and mistaken beliefs (Oberst & Stewart, 2003). Corey (2013) stated mistaken beliefs are personal mythology created in the lifestyle where individuals will act as if the myths are true. The mistaken beliefs will guide the behavior of the individual. Therefore, a central part of therapy is uncovering the mistaken beliefs, which contribute unhealthy lifestyle.

**Social Interest and Community**

Two of Adler’s most significant concepts are social interest and community feeling. Community feeling, as developed by Adlerian therapy, is the feeling of being connected to all of humanity and wanting to make the world a better place (Corey, 2013). Social interest is defined as, individuals creating their sense of belonging and purpose within the community (Peluso et al., 2004). A central belief in Individual Psychology is that happiness and success relate largely to social connectedness (Corey, 2013). Oberst and Stewart (2003) state Adlerian therapy supports
the idea that social interest begins in childhood as the child begins to develop a sense of belonging.

Oberst and Stewart (2003) described Adlerian tasks that each individual needs to master that are referred to as the tasks of life. Hartshorne (2003) stated social interest is often expressed through the tasks of life. Corey (2013) describes the first three tasks as building friendships through the social tasks, establishing intimacy through the love task, and contributing to society through the work task. Oberst and Stewart (2003) added that two Adlerian contributors, Rudolf Dreikurs and Harold Mosak, proposed two more tasks of life:

(a) spiritual task is about developing meaning to life

(b) self task is about developing a sense of self.

Adlerian theory has different point of view from other theories regarding mental disorders and goals of therapy. Adlerians believe that individuals are “discouraged” rather than “mentally ill.” Adlerians consider this could be the result of lack of social interest, and emotional problems can stem from problems in the tasks of life (Oberst & Stewart, 2003).

According to Corey (2013), the goals of therapy would be to move people towards to social interest, move more effectively through the tasks of life, modify the lifestyle, and build a sense of encouragement.

According to Stoltz and Kern (2007), Dreikurs addressed four phases of psychotherapy to help with the change process. Corey (2013) defined these phases as:

(a) establish a collaborative therapeutic relationship with individual,

(b) assess the individual’s lifestyle and exploring the individual’s psychological dynamics.
(c) interpret the findings from the lifestyle assessment, and promoting insight and self-understanding.

(d) help the individual develop new ways of thinking and living through reorientation and reeducation.

**Grief and Loss**

Grief and loss are part of the human experience; yet the way individuals experience and express grief and loss varies (Howarth, 2011). For individuals living with COD, their experiences with grief and loss can be more complicated, for a variety of reasons which will be discussed throughout this paper (Furr, Johnson, & Goodall, 2015). As such, helping professionals working with the COD population need to be trained effectively to treat grief and loss.

Adler postulated concepts that can be applied in the treatment of individuals with COD, who are also struggling with grief. Although Adler did not write extensively about grief or mourning, he briefly mentioned grief as one of the heightened effects that will often become a feeling of inferiority that ends in superiority complex (Hartshorne, 2003). This paper will integrate Adlerian concepts into existing theories regarding grief and loss, as well as discuss the theoretical applications in the treatment of COD where grief is problematic.

When considering grief and loss one must first examine why individuals experience grief, specifically this paper will focus on the role attachment plays in the recovery process when an individual has a co-occurring disorder that this further complicated by grief. John Bowlby developed the theory on attachment, which will be utilized throughout this paper. Bowlby noted that grief could be viewed as loss of attachment relationship (Hartshorne, 2003). Bowlby (1980) explored attachment and the relationship between loss and attachment throughout his work and
theoretical development. Understanding attachment theory, as developed by Bowlby may also help us develop a more expanded view of how individuals move through grief process as it relates to Adlerian theoretical principles.

Elisabeth Kübler-Ross (1969) created the stages after observing how her patients were coping with grief. The framework of the stages has been used to understand how individuals learn to live with loss and to identify the feelings of loss (Kübler-Ross & Kessler, 2005). Using the stages of grief can help individuals become more aware of their feelings of grief; therefore, integration of this model, and exploration of the Adlerian concept within it, is beneficial to understanding not only how to treat those with COD and grief concerns, but also to deepen the understanding of how these concepts can be viewed together in the conceptualization of the client’s lifestyle.

TTM is a common approach used in behavior change, and can be easily integrated into Adlerian philosophy as well as the grief and loss theories, which may be more useful in conceptualizing effective therapies for clients. Since the development of TTM in the 1970s, TTM has been applied to a wide range of health behaviors and one of the dominant health behavior change models used in the last 20 years (Migneault, Adams, & Read, 2005). The model has been empirically tested and proven useful in therapeutic practice (Calderwood, 2011). As a result, the TTM is well known by professionals in the addiction and mental health field as an effective approach to treating complicated clients. This concept will be explored throughout the paper in an effort to provide clarity for intervention methods and timing to address the multifaceted challenges clients with COD and are experiencing grief and loss.
Co-Occurring Disorder

The Substance Abuse and Mental Health Administration (SAMHSA; 2016) defines co-occurring disorders (COD) as “the co-existence of a mental health disorder and substance abuse disorder” (para. 1). Adler believed substance use disorder (SUD) began as resulted from inferiority feelings such as shyness, a liking for isolation, oversensitivity, impatience, irritability, and neurotic symptoms such as anxiety, depression, and sexual insufficiency (Ansbacher & Ansbacher, 1956). Adlerian theory argues that individuals with SUD had emotional and mental health problems. Substance use is an individual’s creative solution to cope with mental health disorder (MHD) (Ansbacher & Ansbacher, 1956).

Historically, co-occurring was referred to as “dual diagnosis” or “mental illness and chemical dependency” (MICD). It is important to differentiate between these terms to insure that professionals have a similar understanding of the clients who have both MHD and SUD. For many, the term “dual disorders” refers to a treatment approach in which the client has a counselor for alcohol and other drugs (AOD) and a separate counselor for mental health symptoms (Jill Hubble, personal communication, September 20, 2016). The term MICD is an outdated term, in that the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5) has reclassified chemical dependency as Substance use disorders (American Psychiatric Association, 2013). For these reasons the term Co-Occurring Disorders will be used for the purposes of this paper as it more accurately reflects the complex nature of the interplay of SUD with other MHD.

Research by Padwa, Larkins, Crevecocur-MacPhail, and Grella (2013) found that over half of the people in treatment for SUD also suffered from MHD. SAMHSA (2016) cites that there is an estimated 7.9 million people in the United States suffer from COD. Individuals with
serious mental health problems are more likely to develop substance use problems than people without mental illnesses (Green, Yarborough, Polen, Janoff, & Yarborough, 2015). The co-occurrences of the multiple disorders can lead to worse outcomes when these disorders are treated separately due to increased symptom severity (Padwa et al., 2013).

Adlerian holistic approach to case conceptualization and treatment is being implemented into more treatment centers (Corey, 2103). More providers across the United States are beginning to take steps to integrate mental health and substance use treatment to improve quality of treatment (Padwa et al., 2013). COD treatment is viewed as the integrated method of treatment where the client receives services from a professional who has competencies in both the treatment of MHD and SUD (SAMSHA, 2016). Professionals are integrating a variety of different interventions in order to treat individuals with COD holistically (Drake, Mueser, Brunette, & McHugo, 2004). Green et al. (2015) found individuals who took control of SUD were more likely to overcome MHD further demonstrating the need for the Adlerian holistic approach to treating complex individuals with COD.

Grief and Loss and Substance Use Disorders

Furr et al. (2015) noted grief and loss affects all people at some point in their lives; however, the grief and loss process appears to be more complex in those who are struggling with COD. Unresolved grief and addiction have been long recognized by addiction professionals as a complicated factor to successful treatment. Drug use is a way for individuals with SUD to cope with psychic pain. Ansbacher and Ansbacher (1956) stated substance use is way for an individual who is seeking alleviation from a certain situation (i.e. failure in one or more of the tasks of life, inferiority, discouragement, etc.), grief fits a situation many would prefer to avoid.
Grief is often associated with death of loved one; however, the SUD population experiences grief in more ways than the death of loved one (Furr et al., 2015). Beechem, Prewitt, and Scholar (1996) identified three types of losses associated with addiction: losses prior to addiction, losses while in addiction, and losses happening after entering treatment. Haberstroh (2005) noted in addiction individuals have tangible (death or job loss) and intangible losses (identity or meaning of life) in each type of loss, which indicates those with SUD and COD often experience significant losses throughout the cycle of addiction. Beechem et al. (1996) expressed the importance of identifying the losses in order to help individual’s move through their complicated grief.

Losses prior to addiction. SUD populations are grieving losses prior to their addiction. Haberstroh (2005) stated addiction has been associated with the pathological mourning for losses experiences in early life. Furr et al. (2015) found high percentages for the following examples of losses prior to addiction: witness violence, damage to self-esteem, death of someone, loss of romantic relationship, loss of goal or dream, and financial problems. Beechem et al. (1996) losses prior to addiction are associated with guilt and shame, and individuals need to be given permission to grieve without guilt and shame.

Haberstroh (2005) explained unresolved grief prior to addiction is related to loss of trauma and loss childhood innocence, which may be contributing factor to SUD. According to Fletcher, Nutton, and Brend (2015), substance use is an attachment alternative to individuals who suffer from traumatic past as a way to self-repair. The child is unable to cope with excruciating emotional pain associated with loss and will resort substance abuse to lessen the psychological pain (Beechem et al., 1996). In Adlerian terms, the lifestyle of the individual is affected by the
trauma. The creative solution and the purpose behind the substance abuse behavior is to cope with the pain from the losses to move from feeling inferior towards feeling better.

**Losses while in addiction.** The losses while in addiction affect the tasks of life and are one of the motivations on why people enter treatment (Furr et al., 2015). Work task is about contributing to society. The work task is affected by the following losses: loss of job, loss of goal or dreams, loss of material possessions, financial problems, revocation of driver’s license and loss of ability to think clearly and logically (Furr et al., 2015). Individuals lose the ability to work or maintain work when they are in active addiction.

Community and love tasks are also affected by addiction. Furr et al. (2015) found the following losses while in addiction that affected community and love tasks are witnessed to violence, death of someone special, loss of support from others, loss of romantic relationship, loss of friendships, decline in social life, and committed a crime. SUD takes aware from nurturing and reciprocal relationships, and the individual focuses more on the addictive behaviors (Haberstroh, 2005). Losses within the work, community, and love decrease the social interest of the individuals as they pull away from community feeling.

Losses are associated with the spiritual and self tasks. Examples are damage to self-esteem, memory problems, and loss or damage to spiritual connection (Furr et al., 2015). Haberstroh (2005) stated the loss of maintaining relationship with self and finding the meaning life are ambiguous losses for an addict. In addition the losses in the other task can affect the self and spiritual task. For example losing a job, or relationship can affect the self-esteem and self-image of an individual, and the individual may lose his or her meaning of life.

**Losses upon entering treatment.** Individuals who enter are asked to let go of many aspects of their addictive behaviors. Haberstroh (2005) gave the examples of disassociating with
using peers, losing the comfortable and familiar ways to cope, and admitting the loss of control over the addictive impulses and urges. Furthermore, individuals are grieving the loss of their substance use, and overall way of life (Furr et al., 2015). Consider what we know about grief, research by Fletcher et al. (2015) stated substance use has been an individual’s self-medicating behaviors to gain comfort and support.

Substance use has been a way of coping for most individuals entering treatment (Fletcher et al., 2015). Often times, treatment is about modifying the individuals’ lifestyle and changing their private logic. According to Furr et al. (2015), individuals are asked in recovery to shift their belief system and views on life especially giving up their unhealthy coping skills and more towards wellness.

Considering the complexity of issues present, individuals need support to cope with losses experienced when entering treatment. Ansbacher and Ansbacher (1956) stated drug use is the individual creative way of oppressing the feelings of inferiority and feelings of discouragement. Beechem et al. (1996) found individuals will need encouragement and support to grieve the losses entering treatment, and need helping developing new skills to cope with grief. Furr et al. (2015) stated by addressing the grief issues early on in the treatment setting, counselors are more likely to provide holistic treatment modalities.

Grief and Loss and Mental Disorders

According to Jordan and Litz (2014), it has long been debated that grief is a MHD, yet it is not been included in the DSM-5, or the International Classification of Diseases, 10th edition (ICD-10) as a diagnosis; however, the ICD-10 has identified grief as a contributing factor (Z-codes). Grief has been closely related to depression, and DSM-5 advises clinicians to differentiate between normal sadness and grief from a major depressive disorder (American
Prior to the release of the DSM-5, there was debate on bereavement exclusion being eliminated in depressive disorder criteria (Flaskerud, 2011). According to Fox and Jones (2011), the purpose of the exclusionary criterion was to not confuse depression and bereavement as both have similar symptoms, while being two different conditions where grief is part of the life process and depression is MHD. However, DSM-5 stated depressive symptoms and bereavement can occur together, when this happens the depressive symptoms and functional impairments are made worse by the grief process compared to those struggling with bereavement without depressive disorder (American Psychiatric Association, 2013).

Jordan and Litz (2014) described two types of grief: uncomplicated grief and complicated grief (CG), also known as pathological grief, prolonged grief disorder, or traumatic grief. Howarth (2011) noted uncomplicated grief is the normative grieving process where an individual is able to cope without complications to the changes that are inevitable when loss is experienced; however, when the grief reactions are more debilitating CG may develop as a result. Individuals at risk for developing CG are those with history of trauma or loss, history of mood or anxiety disorder, insecure attachment disorder, or lack of social support (Jordan & Litz, 2014). In other words, CG goes beyond the normal pain of loss and becomes a more pronounced issue of functioning that is further complicated by MHD.

Howarth (2011) stressed the importance of examining CG due to the significant impairments in the social, occupational, and other major life areas. Each tasks of life can be affected by CG. Grief may negatively impact the tasks of life when an individual has a low social interest and lack of support (Hartshorne, 2003). According to Oberst and Stewart (2003), individuals who have a low social interest are discouraged individuals. As Adlerian theory
postulates discouraged individuals who are discouraged have more mental health difficulties, CG may lead the individual to feel stuck in the grief process.

Since individuals are goal-oriented, grief can be better understood when the purpose behind the behavior is explained (Hartshorne, 2003). It would be reasonable to assume that the act of mourning and the process of grief serve a purpose to assist the individual with movement. Hartshorne (2003) stated five possible purposes for grief:

(a) expressing of injustice,
(b) demonstrating sensitivity to others,
(c) modifying one’s worldview,
(d) maintaining a connection with the deceased
(e) reminding oneself of the significance of the deceased to one’s life.

Individuals diagnosed with MHD struggle with losses that affect the tasks of life, which in turn affects an individual’s ability to work and contribute to society (Oberst & Stewart, 2003). Research by Baker and Proctor (2014) found individuals contributed their loss of job due to the mental health symptoms. For example a woman with anxiety is unable to work and is fired from her job. As a result of being fired, she is unable to pay rent for her apartment, and she is homeless.

In addition to job loss, Baker and Proctor (2014) noted another loss as the loss of abilities, skills, and mobility. Yarborough, Yarborough, Janoff, and Green (2016) found individuals with MHD struggled with the loss of self-esteem. Without the skills and abilities, a person can have a loss of sense of self and meaning to life. This has negative impact of the life tasks of spirituality and self. According to Weber (2003), an individual with low self-worth is an
individual who is discouraged, feels inferior, and is striving for significance. Based on this research, it becomes clear that CG is likely to form in individuals who have existing MHD.

Losses in work, spiritual, and self will affect the community task, love task, and low social interest can all contribute to individuals to mistrust others, and lead them to become self-centered (Peluso et al., 2004). According to Oberst and Stewart (2003), distortions of reality caused by MHD can lead to estrangements of useful relationships. Research by Yarborough et al. (2016) found individuals with MHD struggled with the change in relationships with family and significant other as relationships. Considering these factors it is reasonable to assume that CG leads to social isolation, loss of attachment to life tasks, and substance use.

**Bowlby’s Attachment Theory**

One way to develop the concept of grief as it interrelates with COD would be to examine the theory of grief and loss as developed by Bowlby. According to Bowlby (1980), grief can be understood by exploring attachment. Bowlby (1980) defined his attachment theory as:

> a special advantage claimed for the paradigm is that it facilitates a new illuminating way of conceptualizing the propensity of human beings to make strong affectional bonds to particular others and of explaining the many forms of emotional distress and personality disturbance, including anxiety, anger, depression and emotional detachment, to which unwilling separation and loss give rise. (p. 38)

The first part of the definition explains humans have the tendency to form strong bonds with other individuals, which in Adlerian terms, they have strong social connection. The second part of the definition explains the emotions distress and personality disturbance that happens when a human becomes separated from the attachment, or private logic. Hartshorne (2003) supports Bowlby’s work by postulating that grief can be viewed as loss of attachment.
relationship; it should be noted that “relationship” is a broad term that can also include the relationship individuals have with a drug.

Like Adler, Bowlby believed that individuals were goal-oriented and attachment had a purpose (Weber, 2003). Thomson (2010) stated attachment behaviors are needed for offspring survival such as distress calls and “engaging sounds or gestures” (p. 895). This further supports Peluso et al. (2004) who stated two functions for attachment: the protective function is to keep the child close to the mother to avoid danger, and the instructive function builds a secure base in order for the mother to let her child explore the environment.

According to Weber (2003), Adler and Bowlby built their theoretical premises based on social interaction. Attachment focuses on the relationship with an individual, while Adler’s concept of social interest focuses on the relationship with the community (Hartshorne, 2003), while Fletcher (2015) found that individuals develop relationship with the drug. Research by Peluso et al. (2004) included Bowlby’s secure and insecure attachment styles that are seen in the lifestyle of individuals. A child’s views the world through his or her own attachment style, and through his or her worldview began to shape the child’s social interest (Weber, 2003). Peluso et al. (2004) observed securely attached children had higher levels of social interest. Hartshorne (2003) found individuals with secure attachment might be able to grieve better, whereas; individuals with insecure attachment may find it difficult to grieve. Those who struggle with grief may turn to substance (Furr et al., 2015).

Bowlby (1980) developed four phases of mourning by observing people who are responding to loss of a relative over the course of weeks and months and their response to the loss move through phases. The first phase is numbing; family members are left in shock that their loved one is no longer with them (Thomson, 2010). Bowlby (1980) described the phase
could last for a few hours to weeks and are interrupted by anger or outbursts. The second phase includes yearning and searching for the lost figure, and this stage can last for months to sometimes years. The third phase is disorganization and disorientation. In this phase an individual can be assessed in three major categories of unresolved state of mind:

(a) lapses of monitoring of reason,

(b) lapses in monitoring of discourse,

(c) lapses in monitoring of behavior (Thomson, 2010).

The last phase is reorganization; Bowlby (1980) stated the loss of a loved person was one of the most painful experiences, and the only way to be comforted would be the return of the loved one. The goal of reorganization is to help people reorganize their lives around the loss of loved one (Thomson, 2010). This phase is similar to the last objective in Adlerian therapy: reorientation. Adlerian theory postulates that grief affects the tasks of life, reorientation is about recommitting the individual towards a healthy fulfillment of the tasks of life (Oberst & Stewart, 2003).

It can be suggested that building a person’s social interest could help a person move into phase four of mourning of reorganizing. A well-developed social interest functions like a support system to help an individual cope with losses by helping individuals build relationships with other individuals could help the individuals connect with their community by helping them find purpose in the community again without the loss (Hartshorne, 2003). For example, if the grief is from loss of friendships, than the individual can seek a new group of friends that are supportive of their new lifestyle and norm of life.
Stages of Grief

Whereas Bowlby (1980) viewed grief as a disruption in attachment, Kübler-Ross’s stages of grief are used as a tool to assess grief and loss. Kübler-Ross (1969) created the stages of grief after observing the patients with terminal illness, and how they responded to the terminal illness. The stages of grief identified in the model are denial, anger, bargaining, depression, and acceptance. Adlerian theories would suggest that individuals are goal-oriented; the stages could be seen as safeguarding behaviors to help individuals cope with loss (Stolz & Kern, 2007). Kübler-Ross and Kessler (2005) stated there is no a typical way to grieve; therefore, everyone will go through these stages differently. According to Hartshorne (2003), individuals will grieve different due to their individual lifestyles and private logic.

Understanding the stages of grief can help professionals understand the purpose behind the grief, and the behaviors exhibited during the grieving process, help understand the movement through the tasks of life. Calderwood (2011) notes the stages of grief are well known and incorporated by many helping professionals and lay people due to their incorporation in many articles, brochures, and Internet sites. Kübler-Ross and Kessler (2005) hoped that by understanding the stages of grief would individuals would be able to cope with life and loss more effectively.

Denial

The denial stage is known as the initial stage and the first reaction to grief. Kübler-Ross (1969) stated the unconscious mind wants to believe we are immortal; therefore, death is hard to conceive to the conscious mind. The denial stage is often described as the disbelief, or shock stage (Kübler-Ross & Kessler, 2005). Hartshorne (2003) stated one purpose of grief is an expression of injustice. Denying the loss is one example of injustice.
This stage is similar to the first of mourning by Bowlby: numbness. Kübler-Ross and Kessler (2005) explained individuals are not literally denying death has happened as much as the individuals are paralyzed, or blanketed, with numbness. The numbness helps individuals cope with the loss in order to not feel overwhelmed (Kübler-Ross & Kessler, 2005). The numbness is an example of safeguarding behavior to protect an individual from feeling inferior. According to Hartshorne (2003), individuals may feel superior to grief and may not believe that loss could happen to them. Kübler-Ross and Kessler (2005) stated eventually, the numbness will fade and the reality of the loss will set in.

**Anger**

Anger is another stage in the grief described as feelings of rage, envy, and resentment (Kübler-Ross, 1969). According to Paivio (1999), anger is a powerful emotion that has impact on social relations and self-organization. In the case of death, an individual is mad at either the loved one for dying, or mad at him or herself for letting the loved one die (Kübler-Ross & Kessler, 2005). Anger is another way to express injustice of the loss. In addition, anger demonstrates sensitivity to others (Hartshorne, 2003), and therefore, while disruptive, indicates the power of attachment and connection.

According to Kübler-Ross and Kessler (2005), anger is a necessary stage because for most people anger is manageable and a way to cope with the emotions underneath the anger. Anger is seen as the secondary, or defensive emotion to cover underlying emotions like hurt, fears, or shame (Paivio, 1999). Anger is a safeguarding behavior to prevent feeling the emotions of hurt, fear, or shame associated with loss. Kübler-Ross and Kessler (2005) found individuals start to work on the emotions under once the anger starts to fade.
Bargaining

The third stage of grief is bargaining. Individuals do not like to feel the pain of the loss and will try to negotiate their way out of the hurt (Kübler-Ross & Kessler, 2005). Kübler-Ross (1969) described this bargaining as way to postpone dealing with the loss. In other words, Kübler-Ross and Kessler (2005) said bargaining is a tool to give the psyche time to adjust and to restore order from the chaos created by the loss. Hartshorne (2003) argues that another purpose of grief is to modify the worldview and lifestyle, and bargaining can help an individual reorganize one’s private logic to help adapt to the major change.

According to Kübler-Ross and Kessler (2005) described bargaining’s companion as guilt, which includes a maze of “if only…” or “what if...” Ansbacher and Ansbacher (1956) described guilt as an aggressive, safeguarding behavior to provide distance and promote withdrawing. According to Hartshorne (2003) one of the purposes of grief could be the individual does not want to lose the attachment with the deceased. Combining this with the Kübler-Ross theory. Guilt is a way for an individual to stay connected with the deceased. Thinking of the “if only” or “what if” may make an individual feel like they still have a connection with the loss.

Depression

Depression is described as withdrawal from life, left in the fog of sadness, and wondering if there is any point of moving forward (Kübler-Ross & Kessler, 2005). Since grief is related to sadness, Hartshorne (2003) stated individuals might feel the need to grieve to show how much they cared about the loss. Kübler-Ross and Kessler (2005) indicate another purpose for depression is to protect individuals by shutting down the nervous system in order to adapt to something the individuals are not ready to handle.
Like the DSM-5, Kübler-Ross and Kessler (2005) also cautioned individuals to be aware of the differences of grief-related depression and clinical depression. Flaskerud (2011) stated treating grief like a mental illness infringes on the healthy mourning rituals. Each culture will grieve and mourn differently, and the depression helps cope with the loss (Hartshorne, 2003). Kübler-Ross and Kessler (2005) encourage individuals to allow the depressed feeling to be felt and explored as part of the healing process.

Acceptance

Kübler-Ross and Kessler (2005) stated acceptance is not about an individual being okay with the loss but accepting the reality of the loss, and recognizing this new reality is a permanent change. Kübler-Ross (1969) noted acceptance is not “the happy stage,” but the stage is where there is no longer pain, and there are more good days than bad. Movement into acceptance can help an individual move from felt minus to perceived plus.

Acceptance has purpose in grief. First, acceptance could be to help an individual modify his or her lifestyle without the loss, and help the individual stay connected with the loss. Second, acceptance helps an individual to move through the tasks of life without complications. When an individual starts moving through the tasks of life without complications, the individual will also be improving his or her social interest.

Transtheoretical Model

TTM has been used and implemented in different treatment programs for addiction and mental health (Calderwood, 2011). By studying different therapies, Prochaska, Norcross, and DiClemente (1994) discovered each therapy has the same goal of change; the difference in therapies was how they changed. TTM included the stages of change and the process of change. TTM was developed to assess where the person was in the stages of change, and which process
of change is implemented depending on the stage of change (Prochaska & DiClemente, 1982). Stoltz and Kern (2007) found integrating the lifestyle, therapeutic phases in Adlerian therapy, and TTM can help understand the change process better.

**Stages of Change**

The most well known dimension of TTM is the stages of change (Migneault et al., 2005). Prochaska & DiClemente (1982) discovered the stages of change when studying smokers, and the smokers appeared to fall into four categories of change:

1) thinking about changing,
2) determined to change,
3) actively modifying their behaviors,
4) maintaining their changes

Over time the stages of change have been modified and the stages have been renamed. The five stages of change are precontemplation, contemplation, preparation, action, and maintenance. Each stage of change has a different purpose and affects the tasks of life. Professionals can apply the Adlerian therapy phases to help individuals move through the stages of change.

**Precontemplation.** Prochaska and DiClemente (1982) discovered there was a stage that preceded the change, and they called it precontemplation. Precontemplation is the stage where individuals do not see a problem and are not planning on taking action in foreseeable future (Prochaska & Velicer, 1997). Prochaska, Norcross and DiClemente (1994) described precontemplators as individuals whom are resistant to change and are in denial. People in this stage do not intend to change.
Norcross, Krebs, and Prochaska (2011) described most individuals in this stage as unaware of a problem despite family, friends, neighbors, or employees who may see and continually express concerns about the problem. Since emotional problems can stem from problems in the tasks of life, individuals in treatment at this stage are usually changing for someone else (Prochaska et al., 1994). Individuals hope to solve to problems of tasks of life when entering treatment.

In order to help individuals through the precontemplation stage, helping professionals use the first two phases to Adlerian therapy of building a relationship (first phase) and assessing the lifestyle and psychological dynamics (second phase). Stoltz and Kern (2007) found the goal of building the relationship with the individual is to facilitate a discussion about the problem instead of trying to solve the problem. Next, the phase of assessing the lifestyle and exploring psychological dynamics helps give insight to the private logic of the individual to better understand why the individual may be in denial or unaware of the problem.

**Contemplation.** Contemplation is the stage where people start to become aware of their problem and start thinking about making a change (Norcross et al., 2011). Prochaska et al. (1994) stated in this stage a common phrase is “I do not want to feel stuck.” People in this stage struggle with positive evaluation of their problems, but have not made a commitment to change (Norcross et al., 2011). Prochaska and Velicer (1994) stated individuals are aware pros and cons, and the balance between the pros and cons can produce ambivalence that can keep individuals stuck in contemplation stage for a long period of time.

In addition to continuing building the relationship and assessing the lifestyle, the helping professional starts to give insight. According to Stoltz and Kern (2007), the individual and professional to interpret the lifestyle and private logic. The individual starts to see how the
problem and the private logic are affecting the tasks of life. Individual begins to weigh the pro and cons of change and how the change will affect the movement through the tasks of life.

**Preparation.** Individuals in this stage are intending to take action and are reporting small behavioral changes (Norcross et al., 2011). McConnaughy, DiClemente, Prochaska, and Velicer (1989) described individuals in this stage as having made the decision to change and they are making clear attempts resolve the problem. Prochaska and Velicer (1997) stated individuals in this stage typically have a plan for action such as joining a self-help group, or buying a self-help book.

The phase of insight continues to be important to this stage. Although the individuals in this stage are committed to change, they have not necessarily resolved their ambivalence to change (Prochaska et al., 1994). Stoltz and Kern (2007) found the individuals in this stage began to see how their lifestyle serves and counters the desire for change. Individuals began to make a plan to address the problem in order to improve the tasks of life and modify the lifestyle. Individuals are working on changing their private logic.

Individuals in the preparation stage need encouragement. Calderwood (2011) found people in this stage are full of emotions such as confused, overwhelmed, hesitant, and guilty. Encouragement is enlisting the individual’s strengths and creative abilities to solve the problem, as well as building the self-confidence and allowing room for mistakes (Stoltz & Kern, 2007). Individuals need to know they have the ability to change, and the ability to continue to change even if they make a mistake.

**Action.** The action stage is where individual began implementing the changes in their lives such as modifying behaviors, environment, or experiences, (Norcross et al., 2011). This stage is where clients begin to work on changing and asking for help with implementing action
INTEGRATING THE TTM AND STAGES OF GRIEF

strategies (McConnaughy et al., 1989). According to Calderwood (2011), an individual in action stage is transforming his or her new identity and meaning in life. In the action stage, individual are addressing and modifying their roles in the tasks of life.

Helping professionals uses reorientation and reeducation in Adlerian therapy in action stage. Individuals in reorientation are making movement from behavioral intention to behavioral action (Stoltz & Kern, 2007). Prochaska and Velicer (1997) stated individuals in the action stage are making overt modifications in their lifestyle within the last six months.

Individual continue to need encouragement in the action stage. Since relapse is common in this stage, Stoltz and Kern (2007) found deliberate encouragement is needed to reassure individuals of their own abilities and helping individuals recognize the impact of their choices. Encouragement helps individuals gain the self-confidence needed to continue with the change.

**Maintenance.** In the maintenance stage, an individual continues to prevent relapse (Norcross et al., 2011). Prochaska et al. (1994) emphasized the importance of working to consolidate the gains made in the action stage, and not having a strong commitment to maintenance can lead to relapse. Relapse in this stage can cause a person to move back to precontemplation or contemplation stages.

This stage happens approximately six months after the initial action stage, and can continue for lifelong (Prochaska et al., 1994). Since maintenance is lifelong, Stoltz and Kern (2007) emphasized individuals continue to need to further the reorientation, encouragement, and restructuring in the maintenance stage. In maintenance stage, individuals continue to maintain the behavior changes. Individuals need continued encouragement to continue the behavior change especially when the changes affect their tasks of life. Individuals will need to continue to build a support system.
Processes of Change

Processes of change have been researched to understand how people change. Prochaska et al. (1994) defined the process of change as any activity used to “modify thinking, feeling, and behaving” (p. 25). The process of change can help with modifying the lifestyle and changing the private logic to ensure change. Prochaska and DiClemente (1982) studied 18 therapies and developed a list of different processes of change. Although many processes of change have been evaluated, a core set of 10 has been well validated (Migneault et al., 2005). Each process of change has unique and different goals.

Consciousness-raising. Consciousness-raising is one of the processes of change, and the most widely used process. Prochaska et al. (1994) compared this process to Freud’s basic objective of making the unconscious conscious. The purpose of the consciousness-raising is to increase the level of awareness and insight. Prochaska and DiClemente (1982) described two different types of consciousness-raising to help increase insight: feedback and education.

Feedback is generating information based on the client’s own actions and experiences including cognitive process and structure (Prochaska & DiClemente, 1982). According Stoltz and Kern (2007), with help of a professional, individuals will start interpreting their behaviors and possibility of change with questioning, exploring, and disclosing of cognitive, private logic, and lifestyle dynamics. Feedback is about gathering information on how the problem, lifestyle, and private logic affect the tasks of life.

Education is generating information from environmental events including learning more about the problem (Prochaska & DiClemente, 1982). Individuals start learning more about how the problem is affecting their community. Education can help individuals increase their social interest (Oberst & Stewart, 2003). Stoltz and Kern (2007) found education is key to help
Social liberation. The next process of change is social liberation. Prochaska et al. (1994) described this process as any new alternatives in the external environment that can help the change begin, or continue to change. Examples of social liberation identified by Prochaska et al. (1994) and Prochaska and Velicer (1997) include advocacy organization, support groups, or non-smoking areas.

Social liberation can help with increasing the social interest of the individual. Corey (2013) noted social interest is about contributing to welfare of others and striving for betterment of the humanity. Not only does contributing to the external environment help the individual, but also helps other people who are making a similar change, thereby increasing the grieving individuals social connection. Prochaska et al. (1994) stated not only does social liberation make action more possible, but also increases self-esteem as individuals come to believe in their own power and ability to change.

Emotional arousal. Emotional arousal is learning about defenses of change on a deeper feeling level (Prochaska et al., 1994). Traditionally, the process has been called catharsis or dramatic relief. Individuals are affected by emotions and emotions can lead individuals towards action stage (Prochaska et al., 1994). Prochaska and Velicer (1997) give examples of emotional arousal such as psychodrama, grieving, personal testimonies, and media campaigns. Emotions from the techniques should arise emotions, and hopefully lead individuals to change.

It can be argued that emotional arousal helps with the individual’s movement in therapy. According to Stoltz and Kern (2007) emotional arousal can help move the individual from one stage of change to the next. Individuals discuss how their problem is affecting their tasks of life.
in the insight phase. Seeing how the problem is affecting family, friends, and work can surface uncomfortable emotions. The emotions can possibly lead an individual to change.

**Self-reevaluation.** Self-reevaluation is an assessment about the self and the problem (Prochaska & Velicer, 1994). This process is about giving a thoughtful and emotional assessment of the problem and thinking about what kind of person the individual wants to be once the problem is conquered (Prochaska et al., 1994). Norcross et al. (2011) used self-reevaluation as a tool to encourage clients to create positive images of them, and envision what their world would be like if they made the change.

This change process can be useful in the insight phase of Adlerian therapy. In this process it is important to reassess morals and values and how those morals and values have been affected by the problem (Prochaska & Velicer, 1997). According to Oberst and Stewart (2003), a lifestyle assessment will prompt questions about family dynamics and relationships including assessing the family values and the childhood experiences affect the cognitive schema. Corey (2013) stated self-reevaluation could help individuals reframe their thinking created in childhood to consciously create a new style of living.

**Environmental reevaluation.** Environmental evaluation is about reassessing how the presence or absence of an individual’s personal habits affects the social environment (Prochaska & Velicer, 1997). Prochaska and DiClemente (1982) stated individuals could change their response or experience to a particular consequence without changing the consequences. Environmental reevaluation increases the social interest of an individual.

Like self-reevaluation, this process of change is also useful in the insight phase of Adlerian therapy. Prochaska and Velicer (1997) gave examples of empathy training, documentaries, and family intervention as ways to revaluate the environment. For example, a
man who is thinking about quitting smoking may consider how his smoking is affecting his family and his home. After reevaluating, he may decide that quitting would be in the best interest of his family and his home.

**Commitment.** Commitment, or self-liberation is about an individual dedicating to the change their private logic and lifestyle. This is where a person makes the choice to make the change. The first part of commitment is the individual making the commitment privately that he or she is going to make a change (Prochaska et al., 1994). Prochaska and DiClemente (1982) described this process as an individual is becoming more aware of alternatives and consciously choosing the new alternatives. An individual would be aware on how the new alternatives will help with movement in the tasks of life.

In order to make the commitment even stronger, the individual needs publicly commitment to change (Prochaska et al., 1994). Helping professionals would instill encouragement in all the phases of Adlerian therapy to continue to foster the commitment of the individual. Stoltz and Kern (2007) found the phrase often used in Adlerian therapy, “the courage to be imperfect,” helps encourage individual and helps the individual feel more self-liberated. The courage to be imperfect helps the individual to not give up on his or her commitment to change even if he or she makes a mistake.

**Countering.** Countering, or counterconditioning is learning healthier alternatives behaviors that can be substituted for the unhealthy behaviors (Prochaska & Velicer, 1997). Individuals are able to change the response to particular stimuli (Prochaska & DiClemente, 1982). Prochaska et al. (1994) used the example instead of getting high; a drug user goes jogging to cope with the urge to use. In this example the stimuli is the urge to use. The changed response is going jogging instead of using.
Countering is process of change is used in the insight and reorientation phases of Adlerian therapy. According to Stoltz and Kern (2007), part of the therapy is for the individual to gain insight on the private logic, and the insights allows the individual to start developing new ways of problem solving to prompt positive changes in behavior. Changing the response to stimuli could be seen as a way to make changes to the private logic.

**Stimulus control.** Stimulus control is similar to countering. The difference is that instead of controlling the response to the stimuli, the stimuli are controlled by changing the environment (Prochaska & DiClemente, 1982). Prochaska et al. (1994) used the example of removing alcohol or narcotics from the home. In this example, the stimulus is the alcohol and narcotics, and it was removed from the living environment.

Stimulus control has important role in Adlerian therapy. In the insight phase of Adlerian therapy, individuals develop insight on how certain stimuli are affecting the environment (i.e. individual’s community, home, workplace, etc.). According to Prochaska et al. (1994), stimulus control is about restructuring the environment to reduce the possibility of relapse into old behaviors. Part of the reorientation phase of Adlerian therapy, individuals start to develop ways to regulate the stimuli in the environment (Corey, 2013).

**Contingency management.** Contingency management is also known as rewards, or reinforcement management. Prochaska and Velicer (1997) defined contingency management is providing consequences for going in certain direction. Rewards have been found to be successful in changing behavior than punishments (Prochaska et. al., 1994). Examples of contingency management are self-praise or buying something with the money saved from giving up a certain behavior.
The process of contingency management is important part of the encouragement process in Adlerian therapy. Encouragement by definition means to build courage and is important part of the change process (Corey, 2013). Prochaska et al. (1994) found other individuals can be useful in providing positive reinforcement for change. Positive reinforcement especially from others can help encourage the individual to continue with the change.

**Helping relationships.** Helping relationships are finding people to help and be supportive in the change process. Prochaska et al. (1994) stated helping relationships are about finding support, caring, understanding, and acceptance. They provide examples of sources of support are building rapport, therapeutic alliances, or buddy systems, similar to those seen in Alcoholic Anonymous, Celebrate Recovery, and other support groups.

Healthy helping relationships allow the person changing to not feel alone in the change process. Healthy helping relationships assist with the encourage process. Encouragement is about showing the individual is not alone in the process of change (Corey, 2013). Helping relationships starts to build the individual’s community feeling. Building the community feeling with individuals starts to increase the social interest.

Helping relationships is important part of the Adlerian therapy phases. The first phase is to establish the therapeutic relationship with encouragement and cooperation (Oberst & Stewart, 2003). A healthy therapeutic relationship will continue to be important as the relationships moves through the phases of therapy. Individuals start to building helping relationships outside of therapy to continue the change.

**Effects on the Brain**

Attachment, grief, and substance use have been shown, through a variety of research to have similar effects on the brain. Understanding how the impact on brain structure and
functioning changes as a result of these events can provide clinicians with more insights and potential lead to more holistic therapeutic interventions.

Research by Siegel (2015) found individuals who experience difficulty regulating emotions are at an increased risk of developing concerns with substance use. Dopamine (DA) is a neurotransmitter, which in addition to serotonin, impacts an individual’s mood and emotional regulation (Seo, Patrick, & Kennealy, 2008). Illicit substance use generally increases levels of dopamine in the brain leading to feelings of euphoria and dissociation from negative feelings and internal processing (Inaba & Cohen, 2014); therefore, Blum et al. (2012) state that substance use could be self-medication to increase the dopamine (DA) function in the brain. It would seem the purpose of substance abuse is to avoid the uncomfortable emotions experienced throughout the grief and loss process.

DA and oxytocin (OT) have been research to affect the brain with addiction, grief, and attachment. DA has been well-validated role in substance use (Burkett & Young, 2012). According to Blum et al. (2012), genetic factor increases the risk of substance use problems, which could be due to possibility of low DA function called DA resistance. Love (2014) found OT hormone associated with the social behavior, also has a relationship with DA. Furthermore Bethlehem, van Honk, Auyeung, and Baron-Cohen (2013) note that oxytocin appears to interact with the dopaminergic pathway. By conceptualizing grief as a loss of attachment it can be assumed that the neurochemical interactions resulting from loss can have a profound effect on an individual’s functioning. Oxytocin, being the primary neurotransmitter involved in attachment and bonding it has been hypothesized that social attachment could be seen as an addictive behavior due to the overlap in brain chemistry (Burkett & Young, 2012).
Dopamine

Mesolimbic DA system governs many aspects of reward, reinforcement, and attachment in the brain (Burkett & Young, 2012). Mesolimbic DA system, also known as the reward system, function is to promote survival by reinforcing needs like eating, sex, and drinking (Inaba & Cohen, 2014). According to Blum et al. (2012), when mesolimbic DA system is activated, DA that is located in the ventral tegmental area (VTA) is released into the nucleus accumben (NA), where just the right amount of DA produces a sense of well being and happiness.

Prefrontal cortex also has an important role in the mesolimbic DA system. Prefrontal cortex, associated with cognition, motivation, decision-making, and emotion, will send glutamate to help guide motivated behavior (Love, 2014). According to Inaba and Cohen (2014), once the right amount of DA is released the prefrontal cortex will send glutamate to VTA to stop the release of DA.

Inaba and Cohen (2014) report that the amygdala, located in the midbrain, has a role in the mesolimbic DA system due to the function of emotional memory like remembering pain from a fall, trauma from wartime, intense pleasure from a perfect ski run, or erotic sensation of a first kiss. According to Love (2014), amygdala is recruited during the stimulus-reward learning to help remember the reward for the future.

**DA and substance use.** Burkett and Young (2012) found all known drugs of abuse cause the release of DA in the NA. For example Blum et al. (2012) found amphetamines will increase DA levels, causing overstimulation of pleasure. As a result, research by Blum et al. (2013) found physical changes in the critical areas in the brain that control judgment, decision-making, learning, memory, and behavior. According to Inaba and Cohen (2014), since the brain
chemistry is altered in substance use, an addicted individual is unable to stop the cravings for drugs, which results in the person engaging in drug seeking behaviors.

When drugs activate the mesolimbic DA system, the result is feeling satisfaction, a high, or relief from emotional or physical pain known as euphoria (Inaba & Cohen, 2014). Siegal (2015), stated substance use has been attempts by the individual to control the emotions related to problems in relationships or sense of self. According to Blum et al. (2012), since the drugs will release two to 10 times the amount of DA, other natural rewards like food and sex are less pleasurable.

**DA and attachment.** In a study conducted by Burkett and Young (2012), it was found that DA and NA also affect attachment. NA has been shown to play a role in social attachment such as sibling and maternal relationship (O’Connor et al., 2008). In a study with maternal rats, increase of DA was released in NA in the rats when licking and grooming with their pups (Love, 2014). Burkett and Young (2012) found that maternal behaviors generate powerful motivational behaviors.

Romantic relationships also called pair bonds have been research in regards to attachment. Prairie voles were studied because of the similarity to human pair bonding, and DA played a major role in prairie voles with forming a bond with the mating partner (Burkett & Young, 2012). Blum et al. (2012) found DA levels affected the pair bonding in terms on how an individual perceives and treats the other individual. Love (2014) found pair bonded male voles will exhibit more afflictive behavior towards its mate and more aggression towards strangers.

**DA and grief.** The mesolimbic DA system is also affected by grief and loss. O’Connor et al. (2008) found that individuals with CG has greater reward-related activity than people with uncomplicated grief. Research by O’Connor and Arizmedi (2015) also found the reward center
was significantly active in the brains of individuals with CG compared to those with uncomplicated grief. Yearning is behavior associated with grief, and correlates with reward NA activity in individuals with CG compared to individuals with uncomplicated grief (O’Connor & Sussman, 2014). This suggests that when a person is struggling with grief, the reward center is active.

According to Blum et al. (2012), mesolimbic DA system is known as the pleasure, or reward center. O’Connor et al. (2008) does not suggest that an individual with CG is satisfied or rewarded with grieving, but because it activates the reward center, it serves as a craving response making it difficult for the individual to adjust to the reality of the loss. O’Conner and Sussman (2014) noted studying the purpose of the yearning with individual with CG can help the individual understand the decease is gone and adjust to new reality.

In addition to NA being activated in individuals with CG, the amygdala was also activated, which may drive avoidance behaviors (O’Connor & Arizmendi, 2015). Siegal (2015) found memories from traumatic past provide immediate feedback to the amygdala to activate the flight or fight response associated with distress. According to Furr et al. (2015), the losses experienced prior to addiction and while abusing substances include trauma such as childhood abuse or witnessing violence. Blum et al. (2012) found individuals who are most vulnerable to substance use are those living stressful environment.

**Oxytocin**

According to Burkett and Young (2012), oxytocin (OT) is a hormone involved in social information processing. Love (2014) stated OT is historically known as a prosocial hormone due to OT is reaction to a variety of social stimuli. Burkett and Young (2012) found OT is released
during labor, nursing, touching, massage, nipple stimulation, orgasm, and is higher in early relationships. Therefore, this neurochemical plays a crucial role in social connection.

OT is present during maternal bonding, pair bonding, altruism, peer relationships, and trust (Love, 2014). Burkett and Young (2012) stressed the importance of the release of OT in brain to maternal behavior. Lower levels of OT were found in socially deprived children interacting with their mothers (Hurlemann & Scheele, 2016). Siegal (2015) found children with unsecure attachments are more likely to develop behavior problems and SUD.

OT levels have an effect on romantic relationships. Hurlermann and Scheele (2016) noted not only was there higher levels of OT in early romantic relationships, but also higher levels of OT was associated when couples exhibit higher interactive reciprocity and spend more time thinking about each other and the relationship. It is reasonable to assume OT released during romantic relationship help with the formation of long-term bonds (Burkett & Young, 2012). Hurlermann and Scheele (2016) also note OT levels decrease with the loss of partner, which could be translated quickly to stress-related disorders like depression and anxiety.

**Oxytocin and Dopamine**

OT and DA receptors have been shown interact to increase maternal and pair bonding and increases motivation (Love, 2013). In terms of love and relationships, Blum et al. (2012) stated DA will start the process of bonding, and OT will make the particular partner more appealing by triggering feeling of comfort. Burkett and Young (2012) found OT is released in the mesolimbic DA system to modulate behavior. Research by Blum et al. (2012) found in animal experiments if either the DA or OT were blocked, the mothers would ignore their offspring.
Burkett and Young (2012) discussed the strong relationship between human love and drug addiction. Hurlermann and Scheele (2016) also noted social relationships can be a behavioral addiction that increases OT into the reward system that can promote bonding behaviors. Thus, providing evidence that an individual's relationship with the drug, and the loss of this relationship can lead to a grief and loss response in the way of a death. According to Love (2014), pair bond development is influenced by DA activity in the NA. This is similar how drugs affect DA in the NA.

**Integrating the Transtheoretical Model and Stages of Grief**

When an individual with COD is dealing with grief and loss, one goal of treatment is to encourage movement towards reorganizing and modifying the client's lifestyle without the use of substances. In other words, an individual may need help adjusting to his or her “new normal”. From an Adlerian point of view, the purpose of grief behavior is helping to modify the lifestyle and worldview of individual in such a way as to reach the new normal. Similarly, Thomson (2010) described Bowlby’s stages of mourning is an outline on how a bereaved person is comprehending and revising sense of self and world that must co-exist without the loved one.

Brain chemistry is affected by grief, attachment, and addiction, the brain also needs to readjust to change its wiring and networking to accommodate for the new lifestyle. Due to the similarity between the neurobiology of attachment and neurobiology of addiction, treatments for grief and loss can be similar to treatment applied to substance cravings (Hurlermann & Scheele, 2016). Loss of attachment could be difficult to cope because the attachment is no longer activating the DA and decrease in OT. Therefore, we, as counselors and helpers, must be acutely aware of the possibility that substances may be a way to cope with grief in order to activate the reward center.
Furr et al. (2015) state that being aware of the losses an individual is encountering and helping the client adjust to the changes may help prevent further use of illicit substance use. The loss may also be affecting the tasks of life negatively, which could affect the social interest and community feeling of an individual, leading to increased isolation and intensified cravings for illicit substance use. TTM is designed to help individuals make a change in their lives (Prochaska et al, 1994). TTM is a tool used to help improve the tasks of life and help increase social interest. Calderwood (2011) found implementing TTM could help move individuals with COD towards behavioral change and reorganizing their lives around the “new normal” after a loss.

According to Prochaska et al. (1994), Kübler-Ross and Kessler (2005), and Corey (2013) individuals adjust to change differently; therefore, it is important to understand that the different stage and phase models are not linear, rather they tend to be cyclical with clients moving in and out of the stages for a variety of reasons throughout the change process. Prochaska et al. (1994) stated although linear progression of the stages is ideal; it is rare due to relapses. When relapses happen after a change, an individual may return to precontemplation or contemplation stage. Kübler-Ross and Kessler (2005) stated in regards to stages of grief:

People often think of the stages as lasting for weeks or months. They forget that the stages are responses to feelings that can last for minutes or hours as we flip and out of one and then another. We do not enter and leave each individual stage in a linear fashion. We may feel one, then another, and back again to the first one. (p. 18)

Bowlby (1980) noted the phases of mourning are not clear-cut, and the individual may oscillate in and out of phases for a time. Also, Corey (2013) described the phases of Adlerian psychotherapy as not linear, but rather the phases can be better understood when weaved together.
Using these insights may allow counselors to integrate the stages of grief. TTM could help better serve individuals who are suffering from COD, and grief issues adjust to the loss and prevent relapse. Each stage of grief will be affected differently based on the stage of change of the individual. As the individuals are going through the stages of change and stages of grief, the processes of change are applied to increase movement from one stage to the next.

**Precontemplation**

**Stages of grief.** Individuals in the precontemplation stage will experience each of the stages of grief. According to Kübler-Ross and Kessler (2005), individuals not accustomed to the emotions accompanied with grief. Haberstroh (2005) found the emotional pain is unbearable that the individual will turn to familiar behaviors like substance use to cope. The stages of grief in the precontemplation stage could be viewed as safeguarding defenses to avoid being dealing with the problem.

**Denial.** Precontemplation is the stage where the individual does not see a problem. Regarding grief, a person may be denying that they are grieving. Hence, the related stage of grief would be denial. According to Calderwood (2011), the denial stage does not necessarily mean the person denies the loss but may be denying the amount of work to deal with the loss. Kübler-Ross and Kessler (2005) described the denial is more about the psyche not being able to process the loss. Like Bowlby’s first stage of mourning, numbness, Calderwood (2011) described the bereaved individual is numbed due to the inability to describe the feelings developed after the loss.

COD population often struggles with denial in the precontemplation stage. According to Beecham et al. (1996), denial is one of the obstacles in the recovery process. Mueser and Gingerich (2013) found an individual with MHD often underreport substance use problems
because of the denial associated with addiction. Beechem et al. (1996) described denial to avoid feelings of losses, and using has been a way to cope. Losses upon entering treatment have included the loss of drug use. Beechem et al. (1996) found the initial stages of recovery should include the loss of individual’s substance of choice as the principle loss.

According to Prochaska et al. (1994), denial is a safeguarding defense mechanism. Beecham et al. (1999) added the safeguarding defense mechanism is to avoid the feelings of shame and guilt from losses experienced before treatment. In other words, COD individuals have used denial as a safeguarding mechanism to avoid the feelings associated with grief. As a result, the individual’s private logic may develop defenses to cope with the feelings. According to Prochaska et al. (1994), defenses are denial and minimization of the problems associated with COD and grief, it is therefore reasonable to say that denial of their MHD and SUD is part of the process when they cease substance use.

**Anger.** The anger stage is another stage of grief seen in the precontemplation stage. Like denial, anger can be safeguarding mechanism to cope with the feelings associated with grief. According to Prochaska et al. (1994), one of the safeguarding mechanisms in the precontemplation stage is rationalizing reasons why the problem behavior is not wrong in order to continue the behavior. Paivio (1997) found one type of anger is instrumental anger, which is expressed when individuals want to control, intimidate, or force others to give in to what they want. Instrumental anger could be expressed through rationalization in order for the individual to stay unaware of the problem.

Anger could work simultaneously with denial to avoid coping with losses. Finnell (2003) found not all COD individuals are ready to address their problems or ready to give up substance use. Kübler-Ross (1969) found individuals would feel angry when their life activities and plans
were interrupted because of diagnosis of illness. Being diagnosed with SUD and MHD can make individuals angry because they may not be ready to change their lifestyle. Anger in the precontemplation stage affects the community of the individual. When an individual does not want to display his or her feelings on the true source of the problem, he or she may redirect the feelings to someone or something else (Prochaska et al., 1994). According to McConnaughy et al. (1989), individuals in treatment in the precontemplation stage wish to change others or the environment or were asked to attend treatment by the courts or significant others. Anger is the emotion expressed when an individual feels forced.

**Bargaining.** According to Kübler-Ross (1969), after anger is expressed, forms of bargaining start in order to postpone the losses. According to Prochaska et al. (1994), individuals who enter treatment at this stage are usually pressured by outside forces, and rarely in treatment change themselves. In terms of COD and grief, individuals enter treatment in the precontemplation stage to appease their spouses, family, work, or courts and to avoid further losses. Entering treatment is the creative way the individual is coping with problems in the tasks of life caused by substance use and MHD (Oberst & Stewart, 2003); this may increase cravings for substances (Mueser & Gingerich, 2013).

**Depression.** Depression may also be a stage of grief experienced in the precontemplation stage. Prochaska and Velicer (1997) stated individuals in the precontemplation may be individuals who tried to make the change but has been unable to do so. Negative consequences of having both SUD and MHD include relapses, hospitalizations, medical problems, homelessness, legal problems, not taking medications, and unfinished treatment programming (Mueser & Gingerich, 2013).
Reoccurring problems are discouraging. Prochaska et al. (1994) stated certain people in the precontemplation stage have given up the hope of change. It may be helpful for helping professionals to view depression that is often part of the withdrawal process as more complicated than the biological components, and consider the psychological aspects of grief as contributing factors to resistance.

**Acceptance.** The goal of the helping professional helps the individual move into acceptance. According to Prochaska and Velicer (1997), individuals are in the precontemplation due to being unaware, or uninformed of their problem. Furr et al. (2015) described individuals in substance abuse treatment are often dealing with unresolved grief issues, and may not realize they need to grieve. Patterson and Nochaski (2010) found to move from the precontemplation stage to contemplation stage; the individual would need to acknowledge and be aware of a problem.

**Processes of change.** Certain process of change can help lead the individual to acceptance of the problem associated with COD and grief. Calderwood (2011) found there are certain techniques for each process of change that are appropriate for this level of change. Prochaska et al. (1994) suggests being mindful of the process of change used in precontemplation stage, as individuals in this stage are not ready for action.

**Helping relationships.** Helping professionals is one type of helping the relationship. According to Stoltz and Kern (2007), building a therapeutic relationship is an important part of the precontemplation stage. In the first phase of Adlerian therapy, it is important to establish the person-to-person contact rather than focusing on the problem (Corey, 2013). The importance of the relationship is to support the individual even if he or she is not ready to change.
In addition to building the relationship, the helping professional would move into the second phase of Adlerian therapy, exploration of psychological dynamics (Stoltz & Kern, 2007). Furr et al. (2015) encourage helping professionals to explore the types of losses experienced by individuals in substance abuse treatment. Helping professionals can explore how the losses are affecting the problem.

When exploring losses in treatment, timing is an important factor (Furr et al., 2015). Prochaska et al. (1994) described individuals in precontemplation stage may not ready to make a change and should not be treated like they are in the action stage. According to Furr et al. (2015), individuals may not be ready to work on their grief early in recovery.

In addition to helping professionals, other helping relationships can include family, employers, friends, professionals, and support groups. Due to the substance use, many individual have lost intimate relationship with family and loved ones (Haberstroh, 2005). According to Prochaska et al. (1994), individuals in the precontemplation stage can take advantage of helping relationships by letting the helping relationships identify their safeguarding behaviors. Helping relationships in this stage can start to increase the social interest.

**Social liberation.** Support groups are a form of social liberation. Prochaska et al. (1994) stated to use social liberation, the individual first needs to be aware of the alternative. Patterson and Nochaski (2010) stated having someone outside of the treatment program talk about consequences of using could make an individual more aware of his or her problem. Support groups are an alternative to finding people who are dealing with similar problems. Support groups could be an alternative place that people may feel less alone.

Twelve step meetings are the most common meetings treatment programs individuals in COD treatment attend. The purpose is to help clients become aware of the problem when they
are in the precontemplation stage (Patterson & Nochaski, 2010). The first step is “we admitted we were powerless over alcohol—that our lives had become unmanageable” (Alcoholics Anonymous World Services, Inc., 1981, p. 1). Attendance to support groups can help lead individuals to accept the problem.

Support groups are another method to increase social interest and increase movement in the tasks of life. Losses associated with addiction have been a loss of relationships, which impacts the tasks of life. Support groups can help increase the support in the community and love tasks of life. Support groups can bring awareness to new identity with people who are dealing with the similar problems. According to Patterson and Nochaski (2010), helping professional become aware of the individual moving through the precontemplation stage by assessing the individual’s conversation with other group members, and the individual’s knowledge of when the meetings are taking place.

**Consciousness-raising.** According to Prochaska et al. (1994), the power of knowledge could influence an individual to change. In the precontemplation stage, grieving individuals with COD benefit from the education approach of consciousness-raising. Education can be applied to gather information through reading material or watching an informative video (Prochaska et al., 1994). According to Mueser and Gingerich (2013), an important part of education is educating individuals on the nature of substance use and how substance use affects MHD. Beechem et al. (1996) encouraged helping professionals to educate individuals on what to expect when they are grieving. Although, Calderwood (2011) does caution helping professional to educate only when the individual is ready, as some individual in the precontemplation stage may not be ready to learn about change process or struggles that lay ahead.
In the precontemplation stage, grieving individuals with COD benefit from the feedback approach of consciousness-raising. Stoltz and Kern (2007) in the insight phase of Adlerian therapy, the purpose of the behavior is to assess as part of consciousness-raising. Haberstroh (2005) found substance use has been the safeguarding mechanism to cope with losses. In the precontemplation stage, individuals may be in the denial stage of the grief and not realize they are grieving. According to Furr et al. (2015), helping professionals may find it beneficial to introduce and assess an individual for grief problems.

**Emotional arousal.** In addition to consciousness raising, developing emotional arousal in the precontemplation stage can move an individual to contemplation stage (Stoltz & Kern, 2007). Calderwood (2011) found an important part of emotional arousal the precontemplation stage is validating feeling and reassuring the individual that it is okay to be in the precontemplation stage. COD treatment should include information about goals and how a substance affects those stated goals. According to Stoltz and Kern (2007), in combination with consciousness rising, emotional arousal helps evaluate how the problem can contribute and deter from the individual’s stated goals.

**Contemplation**

**Stages of grief.** After admitting and accepting there is a problem, an individual starts to ponder if and how he or she will make changes now that he or she is aware of the problem (Prochaska et al., 1994). Although the intense emotions from the losses are less overwhelming, the individual is still ambivalent and unprepared to make any significant changes (Calderwood, 2011). As the individual is contemplating about the changes he or she needs to make, he or she will be going through the different stages of grief.
**Denial.** Denial has a role in the contemplation stage. According to Mueser and Gingerich (2013), individuals with COD in treatment are asked to change their recreation activities, friends, their way of thinking, and their way of coping with their mental health symptoms. Individuals in contemplation stage are searching for absolute certainty every aspect of the change is necessary (Prochaska et al., 1994). Individuals may not be ready to give up a certain aspect of the recovery process without knowing for certain that it will help. Thus, the purpose of the denial behavior is to avoid dealing with further losses.

**Anger.** According to Kübler-Ross and Kessler (2005), underneath the anger are more feelings including the pain of the losses. Individual in contemplation stage are experience feelings of fear and anxiety (Prochaska et al., 1994). Individuals in the contemplation stage could become angry when learning what they have to give up to start the change process. Substance use has been ways to cope with the anger from past losses (Haberstroh, 2005). Kübler-Ross and Kessler (2005) found as individuals work through their anger, then they can work on the emotion underneath the anger.

**Bargaining.** According to Kübler-Ross and Kessler (2005), bargaining is doing anything to spare the loss. Prochaska et al. (1994) described individuals in the contemplation stage are often wishful thinkers, who think they can go on living like they do, but with different consequences. Individuals may start negotiating what they will and will not give up to avoid dealing with losses. For example, “I will stop using the substance, but I will still hang out with my friends.” Prochaska et al. (1994) found individuals in this stage want the changes to be easy and will try to minimize the losses in recovery.

According to Kübler-Ross and Kessler (2005), another form of bargaining is the guilt of thinking what they could have done differently. Li, Stroebe, Chan, and Chow (2014) defined
guilt in regards to grief as the moral transgression in which individual believe their action or inaction resulted in the loss, and the individual feels pain and responsibility for the loss. Furr et al. (2015) found individuals continued to drinking due to the losses they have experienced while they were in active addiction. Individual in contemplation stage may feel guilty due to the losses; however, may not be ready to address the guilty feeling.

**Depression.** Individuals may develop depression in the contemplation stage due to the losses. Prochaska and Velicer (1997) stated in this stage individual weigh the disadvantages and advantages of the change. Individuals in the contemplation stage will tend to view disadvantages of change as insurmountable and the advantages as unattainable because of the amount of work needed to make the change (Stoltz & Kern). Change that seems impossible could make individual feel sadness and despair. Prochaska et al. (1994) described the lack of motivation and procrastination as part of the personality of individual in contemplation stage. Depression is discouraging in the contemplation stage.

**Acceptance.** When individuals enter the contemplation stage, they start with a form of acceptance from the stage of grief about their COD and associated losses. Part of the contemplation is weighing the pros and cons of the changing including the losses associated with the change (Stoltz & Kern, 2007). The reality of change sets in the contemplation stage when individuals learn the different aspects of recovery and sobriety; especially focusing on the losses that happen once they enter treatment (Furr et al., 2015). These losses are accumulated with losses already experienced before addiction and while in addiction.

**Processes of change.** As individuals are contemplating changes, it is important to apply the appropriate processes of change. Processes of change used in the contemplation stage should help individuals develop more awareness of the problem (Prochaska et al., 1994). Research by
Finnell (2003) found individuals with COD experience greater variability in their feelings and thoughts when trying to remain sober than individuals with SUD alone. According Stoltz and Kern (2007), the processes of change should help with the continued insight into the private logic and lifestyle is important to this stage in order to move individuals into the next stage.

**Consciousness-raising.** Consciousness-raising continues to be important at this stage. While people in the contemplation stage like to read and learn about the problem, they are not ready to prepare for action until they have a greater understanding of their problem or behavior (Prochaska et al., 1994). Consciousness-raising can help people focus on awareness of the problem and the benefits of changing (Norcross et al., 2011). Calderwood (2011) found individuals in contemplation stage are more willing to learn about the grief process and expectations of the journey. Once people are aware of how the change will benefit, they are more likely to be certain that they want to change.

Consciousness-raising is an important part of the insight phase. According to Stoltz and Kern (2007), as the client is weighing the pros and cons, the helping professional can gather insight on how the lifestyle dynamic is impacting the behavior. Understanding the lifestyle can help interpret the purpose behind the grief. In the contemplation, individuals are learning more about the safeguarding behaviors. Prochaska et al. (1994) found as individuals in the contemplation stage become less defensive about their behaviors, they can learn more about the problem and how it affects them. An individual with COD is more willing to learn about the grieving process and may be more open to discussing the different losses.

**Emotional arousal.** Another process of change to use in this stage is emotional arousal. Emotions can be a powerful tool and help get adrenaline moving, which helps move a person from contemplation stage to preparation (Prochaska et al., 1994). For instance, individuals start
learning about the grief, fear, guilt, or regret if they do not change (Norcross et al., 2011). Research by Furr et al. (2015) found individuals could benefit from learning about the connection between the emotions related to grief and the recovery process. Individuals are encouraged to learn more about grief to strengthen their recovery process.

Techniques for emotional arousal can help move individuals into the preparation stage. Calderwood (2011) found the following techniques useful for a grieving individual are identifying feelings, instilling hope, and validating feelings. Also, Prochaska, et al. (1994) gave the following two examples of emotional arousal: using imagination to visualize the consequences if the change does not occur, and watching movies related to the problem. Individual with COD could watch a movie related to the problem and start to realize the losses experienced during substance use. Individuals could also visualize emotions associated with consequences of continued substance use.

**Self-reevaluation.** Self-reevaluation is an important process of change in this stage. Through emotional arousal and consciousness-raising, people start to reevaluate their lives and their problem. Calderwood (2011) listed the following as strategies for self-reevaluation:

(a) Individuals could document feelings, thoughts, and behaviors;

(b) having individuals consider who they want to be at the end of the process;

(c) having individuals list the fortunes and misfortunes to focus on the positive and map out what misfortunes need to process in therapy.

The importance of self-reevaluation in this stage is to have individuals focus on reasons for the change to make a decision to change (Prochaska et al., 1994). Insight in the private logic and lifestyle can help individuals reevaluate their lives as they are weighing the pros and cons (Stoltz & Kern, 2007). Furr et al. (2015) found in early recovery; individuals start to evaluate the
immediate losses of the substance use, people and place associated with use, and substance use as a coping skill. Individuals start to evaluate how their substance use has been impacting their lives.

**Environmental reevaluation.** In addition to self-reevaluation, individuals will be evaluating how the problem is affecting the social environment. Individuals began to gain awareness on the positive and negative of being a role model to others (Prochaska & Velicer, 1997). Mueser and Gingerich (2013) found individuals start to see how their substance use and mental health has been affecting their family and friends; however, individuals may have difficulty with dissociating with using friends.

**Helping relationships.** Continuing to building the therapeutic relationship, assessing the lifestyle, and starting to interpret the lifestyle are important parts of Adlerian therapy in contemplation stage (Stoltz & Kern, 2007). In the therapy process, helping professionals reinforce encouragement (Ansbacher & Ansbacher, 1956). According to Prochaska et al. (1994), individuals in the contemplation stage are self-doubters and can benefit from acceptance and caring. Individuals with COD and grief problems are viewed as discouraged individuals with low social interest. Ansbacher and Ansbacher (1956) found helping professionals can help build the courage needed to make changes and build social interest. Helping professionals can use the other process of change to build encouragement.

Individuals in the contemplation are looking for empathy and warmth with individuals around them. Adler described empathy as “to see with the eyes of another, to hear with ears of another, to feel with the heart of another” (Ansbacher & Ansbacher, 1956, 135). Prochaska et al. (1994) stated individuals in the contemplation stage are looking for understanding and the knowledge of others who with similar experiences. Individuals with COD benefit from group
intervention where they can discuss the benefits and costs to abstaining from substance use (Mueser & Gingerich, 2013). One of the group session topics could include discussing the losses associated with COD. As a result, individuals can relate with others who have experienced similar losses in their lives.

**Preparation**

*Stages of grief.* Individuals in preparation stage are continuing to reevaluate the problem; however, they have increased confidence about the decision to change (Prochaska et al., 1994). According to Calderwood (2011), grieving individuals in the preparation stage recognize the need to move forward after the loss. Despite accepting the reality of losses and the need to change, people in the preparation stage will most likely encounter the other stages of grief.

**Denial.** Although denial of the problem has decreased, individuals in the preparation stage may still struggle with the idea of letting go (Calderwood, 2011). The purpose of denial in this stage could relate to one of Hartshorne’s (2003) purpose of grief: maintain a relationship with the deceased. Individuals could view letting go as breaking the connection from the losses.

**Anger.** Making changes could be a difficult process (Prochaska et al., 1994). Calderwood (2011) found the preparation of letting go could raise overwhelming emotions. Anger could be a way to cope with the overwhelming emotions. Overwhelming emotions of losses could lead to relapse (Furr et al., 2015). Relapses in preparation stage could be frustrating for an individual. Prochaska et al. (1994) found another frustration is individuals in preparation stage want the change to happen after accepting the problem.

**Bargaining.** Another overwhelming emotion in the preparation stage is guilt of letting go (Calderwood, 2011). According to Li et al. (2014), guilt in bereavement increases the
feelings of remorseful emotion. The decrease of OT after a loss can increase symptom of stress-related disorder such as depression (Hurlermann & Scheele, 2016). DSM-5 criteria for depression include a symptom of “excessive or inappropriate guilt” (p. 161). Prochaska et al. (1994) found in this stage there is still lingering ambivalence that needs to get resolved. The guilt of letting go of losses experienced with COD may be one of the reasons for the ambivalence.

**Depression.** According to Calderwood (2011), when the idea of letting go is difficult to accept, it can lead individuals to depression. For some individuals with COD, major depression may be the diagnosis. Individuals may start to consider medications for MHD (Mueser & Gingerich, 2013). Depression in grief can trigger symptoms of MHD including major depression, post-traumatic stress disorder, and anxiety (Jordan & Litz, 2014). DA in the mesolimbic reward center and the social cues of OT create positive reinforcement of partner and drug addiction; therefore, when individuals have loss of partner or abstinence from drugs, it can increase depressive-like symptoms (Burkett & Young, 2012). Individuals with depressive disorder are more vulnerable to develop bereavement-related depression that may result in antidepressant treatment (American Psychiatric Association, 2013). Jordan and Litz (2014) noted helping professionals should distinguish if the depression symptoms are related to bereavement or a depressive disorder.

**Acceptance.** Calderwood (2011) found as an individual began to accept the reality of the loss, they began to prepare for change without the loss. Acceptance is not about feeling content about the losses, but accepting the reality of the losses (Kübler-Ross & Kessler, 2005). Furr et al. (2015) found treatment for SUD should grief to help individuals develop coping skills for their losses.
**Processes of change.** As individuals move into acceptance of losses, they start to apply the process of change to prepare for action. Prochaska et al. (1994) encourage individuals in the preparation stage to take their time in the stage and not rush into the action. Furr et al. (2015) individuals with COD and grief problems could benefit for preparing to grieve for the losses associated with COD to prevent relapses.

**Self-reevaluation.** The self-reevaluation process of change continues at this stage. The preparation stage is about reevaluating self and the problem, becoming more confident in the decision to change, and increasing positive images of self (Norcross et al., 2011). The focus is on what life would be like without the problem. In the preparation stage, individuals start to focus on how the impact of the change will affect the tasks of life. Individuals may benefit from being aware of how they respond to the stages of grief as it relates to recovery.

Prochaska et al. (1994) found one technique is start turning from old behaviors and to start focusing on the future rather than the past. Individuals with COD would start visualizing what their life would be like without substance use and with stable mental health. Stoltz and Kern (2007) found the process of encouragement help evaluate strengths and abilities to make the change.

**Commitment.** Commitment is the next process of change useful in this stage. This process of change can be challenging due to the anxiety of the uncertain future (Prochaska et al., 1994). Calderwood (2011) stated a decisional balance could be useful at this time to increase commitment especially if someone is dealing with the guilt of leaving the losses behind. Decisional balance can show a person that they are making the right change. Prochaska et al. (1994) advised for people to take the small steps to decrease anxiety. Commitment is not only
about telling others about the commitment to change but also letting others know about the plan of action.

**Social liberation.** Social liberation is a useful process of change in the preparation stage. Individuals in the preparation stage are developing action plans (Stoltz & Kern, 2007). Patterson and Nochaski (2010) suggested individuals in the preparation stage should be continuing to attend support group meetings and sharing their plans with others. Prochaska et al. (1994) suggested individuals in the preparation stage have an easier going public with their action plans.

**Helping relationships.** In Adlerian therapy, the helping professional starts to share insights on the lifestyle by interpreting the underlying motives behind the behaviors (Corey, 2013). Calderwood (2011) suggested since grief is different in every individual, a helping professional may be needed to develop an appropriate action plan. Stoltz and Kern (2007) found helping professionals’ role is to instill encouragement, help with developing an action plan, help the individual continue with the plan even if he or she makes mistakes.

Helping professional can help individuals repair past, harmful relationships due to the COD (Mueser & Gingerich, 2013). Calderwood (2011) stated helping professionals help educate families and friends that grieving process is not going happen quickly. Mueser and Gingerich (2013) encouraged family and friend to be part of the treatment to learn about the recovery process. Social interaction can increase OT needed for attachment and bonding (Love, 2013). Bonding and attachment can increase the natural DA in mesolimbic DA system; thus, increased DA can reduce drug craving and relapses (Blum et al., 2012).

**Action**

**Stages of grief.** In the action stage, people are working on their plan to change and implementing them in their lives (Prochaska et al., 1994). Since acceptance stage is about
accepting the reality of the loss, action stage is seen as the stage where individuals start making changes without the losses. Kübler-Ross and Kessler (2005) has noted acceptance is part of the process, not the end point. Individuals may continue to move through the stages of grief.

**Denial.** Denial can manifest in the action stage. Prochaska et al. (1994) stated a pitfall in the action stage: the myth of the magic bullet or a simple solution to the problem. According to Calderwood (2011), making change is going to take a great deal, time, energy, and emotions. Individuals may be in denial on the amount of work it will take to grieve and develop a new lifestyle.

Denial could also come in the form of taking preparation stage lightly (Prochaska et al., 1994). Although many individuals will equate change for action, Prochaska and Velicer (1997) point out that action stage is only one of the stages of change. Since there is no simple solution for complex behavioral problems, individuals need to take their time in the planning stage to develop the necessary groundwork for change (Prochaska et al., 1994). Green et al. (2015) found individuals with COD who were able to achieve recovery took a significant amount of time. To move from the denial stage, individuals with COD would need to embrace that change takes time and hard work.

**Anger.** The reason for anger in this action stage is to cope with pain that individual may experience. According to Calderwood (2011), despite making overt changes, the individual could still be struggling emotionally with wanting to move forward, or letting go of the past. Kübler-Ross and Kessler (2005) noted anger had been a way to cope with the pain of the losses. Furr et al. (2015) found pain from losses is one of the reasons individuals with SUD go back to substance use.
Anger could a way to cope with the frustration of the action stage. Green et al. (2015) found individuals with COD struggle problems when they enter treatment including relapses and medication compliance. After the denial of the simple solution start dissipate, anger may set in as the frustration of the amount of work and time recovery will take.

**Bargaining.** Bargaining behavior can manifest in the action stage. Change is going to take time and energy, and some individuals are not going to want to make sacrifices needed for change (Prochaska et al., 1994). Bargaining is a way to postpone the necessary sacrifices. According to Furr et al. (2015), due to the guilt and shame associated with past losses, individuals with COD may not be ready to work on the losses from the past.

**Depression.** Depression may be an emotion expressed in the action phase due to an individual not wanting to move forward or let go (Calderwood, 2011). Kübler-Ross (1969) described a type of depression where individuals start focusing on impending losses. Individuals with COD may not want to deal with impending losses. Furr et al. (2015) found unresolved losses can result in relapses.

**Acceptance.** Acceptance in the action stage is not only about planning for change, but putting the plan into action (Calderwood, 2011). Mueser and Gingerich (2013) found in individuals with COD in the action stage of treatment are motivated to make changes in their substance use. Calderwood (2011) found individuals who are grieving are working on transforming their identity and seeking out a new meeting of life. Individuals are looking ways to improve their tasks of life.

**Processes of change.** Processes of change applied in the action stage should help individuals re-education and reorientation phase of the Adlerian therapy (Stoltz & Kern, 2007). Prochaska et al. (1994) found in the action stage; it is important to combine a variety of
techniques at the proper time to bring desired change. The different processes of change in the action stage have examples of appropriate techniques.

**Commitment.** Action begins with commitment as the cornerstone of the stage (Prochaska et al., 1994). According to Stoltz and Kern (2007), action stage is where behavioral changes are most visible along with a cognitive and emotional commitment to change. Also, Calderwood (2011) found commitment is about recognizing there may be periods of ambivalence about the change and relapse is possible. Since relapse is a vulnerable part of the action stage, Stoltz and Kern (2007) urged helping professionals to continue to instill encouragement to help reinforce their commitment.

**Countering.** Reorientation and re-education can start with the process of change of countering. Prochaska et al. (1994) identified countering as substituting unhealthy coping skills for healthy ones (i.e. new activities, exercise, relaxation, etc.). Calderwood (2011) also found new hobbies, support groups, finding new friends can help a bereaved individual develop new meaning to life. Mueser and Gingerich (2013) found countering can be used to teach COD individuals interventions to cope with cravings and temptations to use like going to self-help groups, learning alternative coping skills instead of self-medication, and developing a relapse prevention plan.

Another example of countering is changing the thinking process. Prochaska et al. (1994) called this counterthinking, which is replacing negative thoughts with positive thoughts. Individuals have developed basic mistakes in which they act if the basic mistakes are true (Corey, 2013). In the action stage, Stoltz and Kern (2007) recommended individuals are challenged in the re-education and reorientation phase to test the basic mistake. According to
Corey (2013), reorientation is about changing the basic mistakes and private logic to effective ways of being.

Countering can be helpful for individuals with COD and grieving in their tasks of life. For the spiritual and tasks of life, individuals may start focusing on the new meaning of life and a new sense of identity. For community task of life, individuals may start to develop new friendships and support through their new activities. For the work task of life, individual may start new jobs. For love task of life, individuals may start to develop new intimate relationships. Countering will increase social interest and community feeling.

**Stimulus control.** Another process of change to use in this stage is stimulus control. Avoidance is a key technique in this process because it eliminates the temptation (Prochaska et al., 1994). Regarding grief, avoiding certain places that remind people of the losses is an example of stimulus control. Mueser and Gingerich (2013) stated COD individuals are asked to avoid certain places and people. Prochaska et al. (1994) advised that avoidance was not a sign of weakness, but a way for individuals to prevent problems starting.

When avoidance is not possible, it is important for individuals to prepare for possible triggers (Prochaska et al., 1994). According to Mueser and Gingerich (2013), individuals with COD learn in treatment new interpersonal skills of refusing drugs if they see their drug dealer, or go to a party where there is using. Calderwood (2011) found individuals who are grieving need to practice coping skills triggered by memories of the losses. Prochaska et al. (1994) found practicing effective response to possible triggers help better prepare individuals in dealing with real life situations.

Like countering, stimulus control also affects the tasks of life and can move individuals towards social interest. Avoidance may mean avoiding friends, leaving a significant
relationship, or leaving a job, which can impact the community, love, and work tasks of life. Also, avoidance can impact the identity of the individual (self-talk), and how the individual defined the meaning of life (spiritual task). Avoidance can feel like additional losses individuals experience. However, individuals can start implementing countering techniques to replace the avoided places and people.

**Contingency management.** The contingency management process of change is important at this stage. Stoltz and Kern (2007) found contingency management is important to help sustain the change and move the individual into maintenance stage. Prochaska et al. (1994) found affirmations is one type of contingency management. Calderwood (2011) stated individuals in the action stage are looking for support and courage to make the change. Affirmations are a form of encouragement that can help individuals move into the next stage. According to Mueser and Gingerich (2013), individuals with COD want affirmations about changes that they are making.

**Helping relationships.** According to Prochaska et al. (1994) stated action stage is the busiest stage; therefore, the individuals need to depend on their helping relationships. In the action stage, helping professionals are needed to help individuals continue their commitment, foster encouragement, and continue with reorientation and re-education (Stoltz & Kern, 2007). Helping professionals should continue to provide support and empathy through throughout the process of treatment.

In addition to helping professionals, family and friends play an important role in the action stage. According to Prochaska et al. (1994), family and friends can help individuals apply the different processes of change (i.e. exercising together, helping to rearrange the home, putting
the change in writing, etc.). Mueser and Gingerich (2013) found engaging the social network with COD treatment results in better outcomes.

**Social liberation.** Social liberation is an important part of the action stage. Prochaska and Velicer (1997) describe social liberation as the social opportunities or alternatives. Attending support group meetings in the action stage can decrease relapses in treatment (Mueser & Gingerich, 2013). Green et al. (2015) found support groups help individuals overcome addiction, provide community integration, and provide spiritual support. Support can increase social interest and positive movement in the tasks of life.

**Maintenance**

**Stages of grief.** Continuing the change is not always easy. Stoltz and Kern (2007) stated new behaviors developed in the action stage are challenged by the social and environmental situation in the maintenance stage. Individual may experience denial, anger, bargaining, and depression of the stages of grief at this stage. Calderwood (2011) found negative emotions of grief may occur due to anniversaries, special events, or certain reminders of the loss. Furthermore, overconfidence, self-blame, and daily temptations are internal challenges that are related relapses (Prochaska et al., 1994). Stoltz and Kern (2007) stated to prevent relapse individuals continue to apply the new behaviors.

**Processes of change.** Prochaska et al. (1994) stated in the maintenance stage, use of the processes of change is more about maintaining the use of the change processes. Listed below are examples of different processes of change that help with the maintenance stage.

**Helping relationships.** Helping relationships continue to be important. Helping professionals may be needed to assist individuals with further re-education, encouragement, and restructuring when faced social implications (Stoltz & Kern, 2007). Individuals may need to
continue to attend support groups meetings to prevent relapse and to continue to be involved in recovery community (Patterson & Nochaski, 2010). Mueser and Gingerich (2013) found a maintaining relationship with family leads to higher rates of remission of substance use. Helping relationships in the maintenance supports the individual continued movement towards social interest.

**Commitment.** In addition to helping relationships, commitment is an important process of change in the maintenance stage. Prochaska et al. (1994) found individuals need to renew their commitment to their change by giving themselves credit for the changes especially during triggers. Calderwood (2011) found individuals are able to applying coping strategies when triggered. Corey (2013) stated when individuals are a commitment to change; then they are more willing to set up tasks for themselves.

**Countering and stimulus control.** Countering and stimulus are about creating a new lifestyle and thinking in the change process (Prochaska et al., 1994). In the reorientation phase, individuals have made the decision to modify their goals and act as if they were the individuals they want to be (Corey, 2013). Individuals may have to continue to avoid certain people and places in this stage (Prochaska et al., 1994). Stoltz and Kern (2007) stated individuals continue to catch themselves using old behaviors in the maintenance stage. Prochaska et al. (1994) found discovering new activities and thinking patterns will be ongoing work in the maintenance stage.

**Conclusion**

Grief and loss can be challenging for many individuals with COD. Hartshorne (2003) found individuals struggle with grief due to the losses affecting the tasks of life as individuals. Bowlby (1980) discussed individuals grieve as part of mourning for the loss of attachment. Hartshorne (2003) discussed that the purpose behind grief is to modify their worldview, express
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injustice, maintain a connection with deceased, demonstrate sensitivity to others, and remind oneself of the connection with the deceased. Research by Furr et al. (2015) found individuals with COD are experiencing many losses that can be overwhelming and lead to relapse.

The brain chemistry is another reason the COD population struggle with grief. Addiction, attachment, and grief affect the mesolimbic DA system in the brain. Drug use overtakes the mesolimbic DA system. Also, OT is released in the mesolimbic DA system promoting attachment, which further complicates the grief and loss process on a biological level. OT levels decrease when the attachment is not longer there. Research by Inaba and Cohen (2014) found drug use is one way individuals to cope with emotional pain.

When individuals encounter grief and loss, they need to make changes in his or her life to move forward. Calderwood (2011) argues individuals can benefit from the stage of change language to understand that grief processes. By helping individuals through the stages of change, applying processes of change complicated interaction of the biological nature of attachment and loss, as well as being aware of the stages of grief within the stages of change can help individuals cope with the grief and loss in their lives and help them readjust and reorganize their lives without the loss, creating a new normal. Reorganizing their lives will include modifying the lifestyle and private logic to be able to create positive movement within the tasks of life within this new norm.

In conclusion, the COD population in treatment needs help to cope with losses in their lives. Individuals struggle with losses because of the attachment formed with the losses. For COD individuals, drug use has been a way to cope with the losses. To help individuals cope with grief, helping professionals need to be aware of the stages of grief, biological and psychological components of attachment and loss, the stages of change, and implement the
process of change into therapy. Helping individuals cope with losses in an Adlerian holistic manner can minimize the chance of relapse.

Relapse continues to be a consequence of having co-occurring MHD and SUD (Mueser & Gingerich, 2013). Treatment programs are moving to integrating mental health and substance abuse services for the COD individuals to improve recovery outcomes and prevent relapses (Padwa et al., 2013). In order for treatment to be successful, individuals will need to evolve from denial to acceptance, which involves the grieving process (Beechem et al., 1996). Adlerian theory argues each part of the individuals needs to be treated for successful outcomes (Corey, 2013). Therefore, losses associated with COD are important to address for individuals to maintain recovery.
References


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