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Clinical Director Perspectives on Decision Making of Family Involvement with Clients at Inpatient Substance Abuse Treatment Centers

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Clinical Director Perspectives on Decision Making of Family Involvement with Clients at Inpatient Substance Abuse Treatment Centers

by

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TABLE OF CONTENTS

Pages

List of Tables

Abstract

Literature supports that family members of individuals who abuse substances are significantly influential, whether it be positive or negative (Liddle et al., 2001). Evidence-based family therapy decreases substance use by adolescents (Slesnick et al., 2006). The purpose of this study was to gain the perspectives of clinical directors regarding decision making of family involvement at inpatient substance abuse treatment centers. Clinical directors were the focus of this study due to their experience, credentials, and their ability to oversee all clients and programs in a substance abuse treatment center. Purposeful sampling was utilized to obtain participants. Saturation was reached at three participants. The study used Thematic Analysis to analyze perspectives of clinical directors and identify themes between and among all participants. The data collection utilized were interviews with clinical directors. The importance of family involvement, factors related to choice of model, and evidence-based models preferred were the main themes discovered utilizing Thematic Analysis. Thematic Analysis exhibited all clinical directors in this study perceived family involvement 'essential' and all were not directly in control of decision making regarding family involvement with clients at inpatient substance abuse treatment centers.

CHAPTER I: INTRODUCTION

Addiction

Substance abuse, addiction, and use is becoming an enormous societal problem in both adolescents and adults (Lewis, 2014). Substance abuse has always played a significant role in my life. I honestly did not have any interest in working with the substance abuse population initially for several reasons. My experience was firsthand with family members abusing substances; some became sober. I was ignorant and naive regarding the extent of the entirety of what addiction truly is. My first internship involved working with adolescents in a residential therapeutic community. Most of the substance abuse the adolescents were struggling with was strongly influenced by their family systems and their dynamics. These stories made sense to me and I understood because I experienced some of these situations in my own family system. While in my doctoral program, I decided the substance abuse field was my calling and completed an internship at an inpatient residential site for adults to fulfill requirements for the program and later worked four years at a substance abuse treatment center, which included all levels of care.

My parents informed me of my brother abusing heroin when I was completing my internship for the doctoral program. I believe fate stepped in because although the situation was chaotic, it made me a better therapist and a more sympathetic family member. I was able to empathize with family members of clients more genuinely. Synchronously, I applied the knowledge I learned from clients to my own family. Throughout my years working in the field of substance abuse, I have learned an

abundance of knowledge including substance abuse, mental health, family system involvement of inpatient clients, all levels of care (detoxification, residential, partial hospitalization-also known as PHP, and intensive outpatient), and how roles of each position works in the treatment center. At one point, I was promoted as the detoxification supervisor and still carried a caseload. As a supervisor, my position added more tasks than a primary therapist but not to the extent of clinical directors' tasks.

Since there is a lack of research regarding requirements of substance abuse treatment centers for receiving funding from health insurance companies, I can only speak from my professional experience. Generally, health insurance policies want to assure that clients who are in need of treatment are making progress; meanwhile, they want assurance therapists are utilizing interventions they believe are appropriate. Lewis (2014) stated, "Finances, insurance, time, and other client factors also shape what treatment setting a client enters" (p. 75).

Due to recent cases of fraud, payers have become stricter regarding funding treatment centers. This resulted in treatment centers providing extensive training to therapists on the American Society of Addiction Medicine (ASAM) and meeting the dimensions of criteria. Insurance case managers require therapists to meet each dimension of criteria in order for their clients to continue treatment. Herron and Brennan (2015) stated that "the ASAM Criteria are not intended as a reimbursement guideline, but rather as a clinical guideline for making the most appropriate placement recommendation for an individual patient with a specific set of symptoms and behaviors" (p. 294).

Levels of Care in Substance Abuse Treatment

As previously mentioned, there are several levels included in the continuity of care at substance abuse treatment centers. Some centers may provide all levels of care while others may only provide one level. The focus of this study involves clinical directors of inpatient substance abuse treatment centers, which can include detoxification, residential, and partial hospitalization program (PHP). Clinical directors oversee all levels of care and sometimes there may be a supervisor assigned to each level of care specifically. As a client progresses through the levels of care, the treatment becomes less intensive.

Although not every substance abuse treatment center provides a detoxification unit, detoxification is usually the initial course of treatment. When I worked in the detoxification level of care, I met many clients who either completed detoxification on their own, completed at another facility, or did not need this due to less severe abuse of substances. Lewis (2014) stated that "medical detoxification is the most restrictive treatment setting because the client has reached a level of substance use that is dangerous and even life-threatening if she [sic] were to suddenly stop using the substance" (p. 73). All of the detoxification centers I am aware of are all inpatient, which is appropriate since clients are usually monitored for withdrawal symptoms. Goodman, Hankin, and Nishiura (1997) claimed that "detoxification from particular drugs may require inpatient care" (p. 173).

The level of care followed after detox is either a partial hospitalization program or a residential one. Goodman et al. (1997) explained that "the first few weeks focus on

detoxification from street drugs and engagement in treatment, followed by compliance and increased commitment as the patient becomes regularly involved in counseling and related therapeutic activities" (p. 48). Residential level of care is always inpatient, where PHP can be inpatient or clients travel from the community (home or sober living). Goodman et al. (1997) suggested that a client with drug and alcohol dependence as well as major depression may need inpatient rather than outpatient treatment. The way I explain residential is that it is the setting where the clients receive therapeutic treatment and reside at the same setting. I explain PHP as depending on which treatment center, clients receive therapeutic treatment during the day and reside off site. Lewis (2015) explained inpatient as, "including medical services, individual counseling, group counseling, 12-step mutual support groups, religious services, meals, and shelter" (p. 40).

Clinical Directors of Substance Abuse Treatment Centers

Clinical directors of substance abuse treatment centers usually have more experience than the primary therapists at the centers and sometimes more credentials. Since primary therapists have large caseloads and spend the majority of their time with clients, clinical directors step in during a crisis to assist regarding family matters. Also, clinical directors oversee every client and every therapist in the center. This means the clinical director experiences more varied situations.

In my experiences, clinical directors are able to make decisions regarding clients stepping up or stepping down between levels of care and have the primary therapist document clearly why the decision was made. For example, a client may engage in negative behaviors (sexual behaviors with other clients, using narcotics, or fighting), then

the clinical director meets with the client and therapist, reminds the client of boundaries and rules, and instructs the client to either be discharged or change levels of care.

A primary therapist usually adheres to daily tasks that include caseload groups, individual and family sessions, group therapy, meetings with other departments to review clients, and notes. Primary therapists carry a caseload of a maximum 15 clients, whereas clinical directors are responsible for all clients, which includes all levels of care and every therapist's caseload. Although clinical directors do not see every client individually each day, directors interact with clients and their families on a daily basis. Clinical directors deal with more variety of clients and their families. Clinical directors ensure therapists are completing their daily tasks, as well as assisting therapists with clients who are in crisis (e.g., wanting to leave treatment Against Medical Advice, disobeying the rules, medical issues).

Clinical directors are very involved regarding the treatment delivered in treatment but typically do not make decisions regarding therapy. Due to external requirements (Department of Children and Families, The Joint Commission, and Health Insurance), substance abuse treatment centers must abide by these external standards. For example, a clinical director who comes from a marriage and family therapy background may want to include genograms in sessions and if the health insurance does not see the benefit, they will not pay the treatment center. Clinical directors are in control of creating the daily schedule for clients and face difficult decisions about models of treatment to be used.

This study begins with conclusions generated from past research, which consists of attributes regarding family influence on substance abuse and evidence-based family

therapy approaches used with adolescents and families struggling with substance abuse. My thought process as a marriage and family therapist working in the field of substance abuse has evolved my interest in how decision making of treatment ensues at inpatient substance abuse treatment centers. More intriguing is the perceptions of clinical directors who have worked with clients and their families in substance abuse treatment centers. The focus of this research is to explore perspectives of clinical directors regarding decision making of treatment in inpatient substance abuse treatment centers. Family therapy and non-family therapy approaches, risk factors, and protective factors will be explored.

Natural Systems Theory

My preferred model of family intervention with substance abusing clients is Natural Systems Theory. Murray Bowen began his work with schizophrenic patients that later evolved into family therapy. In many family systems, an individual in the system may become problematic and may result in other family members exhibiting anxiety. Bowen (1978) explained that excessive using occurs when anxiety within the family system is elevated. Anxiety increases for those dependent on the one struggling with substances.

When there is imbalance within the family system, individuals reciprocate negative situations with negative reactions and behaviors. This pattern may turn into a vicious cycle which the increase of drinking will increase the levels of anxiety and vice versa. Without intervention, the substance abuse problem could potentially move through the generations (Bowen, 1985) and also progress to substance abuse in the individual

family members. Adolescents may feel using drugs and alcohol is acceptable due to their family members using drugs and alcohol. Once an adolescent is faced with challenges or obstacles, they often turn to substances to escape, feel better, or to cope by numbing his or her pain (Gorski, 1996).

In reviewing the work of Bowen, it may be assumed that addiction originates from the family system patterns: “Certainly the over functioning of some family members will result in under functioning in others” (Bowen, 1978, p. 260). Each system functions by balance. The balance may be positive or negative and in this case, when an individual is overcompensating or undercompensating, others within the system will adjust to this. Bowen (1978) further claimed that the individual struggles with his or her own expectations and out of a rich sense of responsibility. The individual increases his or her isolation and then increases the substance abuse, which starts an unhealthy pattern struggles. It seems to me that when an individual distances her or himself from the system, it creates a cycle that is complemented by the family system distancing as well; thus creating a dependence on substances.

The genogram is a highly effective tool in discovering the history of relationships, mental health, addiction, and death. When working with families and addiction, a genogram can show patterns of addictive behaviors throughout generations and assist in the process of uncovering denial. Genograms are created by therapists based on the information given by the clients. “Together, the symbols provide a visual picture of a family tree: who the members are, what their names are, ages, sibling positions, marital status, divorces, adoptions, and so on, typically extending back at least three generations

for both partners" (Goldenberg & Goldenberg, 2008, p. 192). Other characteristics of family history can be included on a genogram such as, recovery, relationship patterns, origin of cultures and dates of deaths--all of which can be very significant factors in therapy.

Negative patterns, such as substance abuse, can often be seen as a multigenerational issue that is passed from parent to adolescent, then leading into adulthood. Bowen (1978) described multigenerational transmission process as an overall pattern of the family projecting as it involves particular children and not others, as it transmits through multiple generations. Individuals may be aware of negative patterns over generations and make efforts to change while other individuals are unaware of their roles and actions.

Bowen (1976) presented the multigenerational transmission process, which entails severe dysfunction believed to be the result of chronic anxiety transmitted over multiple generations (Goldenberg & Goldenberg, 2008, p. 189). We tend to relate this process toward the negative patterns throughout generations that influence negative behaviors. Positive aspects, like success and accomplished individuals, also transmit throughout generations. Titelman (2008) suggested that "patterns of substance abuse exist in families. Members may repeat the substance abuse, marry others with substance abuse, or take a position of abstinence from substances, often within the structure of a religious organization" (p. 315). Even though an individual may be aware of repeated negative aspects, this lifestyle is comfortable and what they know.

According to Bowen (1978), an individual's level of differentiation is based on the level of differentiation of that individual's parents, by the kind of relationship the individual has with the parents, and how unresolved emotional attachment to the parents is handled in adolescence. Some characteristics of an undifferentiated individual include someone who is addicted to drugs or alcohol, emotionally immature, and triggered by uncomfortable situations. Bowen (1978) also suggested that when a child evolves into an individual with a lower level of self than his or her parents, marries an individual with equal differentiation of self, the marriage produces a child with a lower level. This child will then marry someone with an equal level, and the next marriage creates an individual with a lower level who marries at that level, creating a process that transmits through each generation, and decreases the levels of undifferentiation. The levels of undifferentiation transmit to the following generations until interventions are sought. Negativity may grow through each generation with more severe issues, such as drug and alcohol abuse.

If we are viewing an individual struggling with substance abuse through the lens of differentiation of self, we may assume these individuals are undifferentiated. Bowen (1978) explained that individuals who are differentiated cope better with life stresses. Their life path is more structured and successful, and they lack humanity problems. Family systems assist in creating an adolescent’s path towards differentiation or undifferentiation. Although individuals can be surrounded by their family system handling life stresses appropriately, some result in abusing substances starting in his or her adolescent years.

Bowen further explored Walter Toman's (1961) concept of sibling position, which is very insightful when working with differentiation of self. According to Bowen (1978), Toman's ideas provided a different way to understand how a particular child is chosen as the focus of the family projection process. Personality profiles exhibit a way to understand the level of differentiation, as well as how the projection process transmits through generations. This proposes indentifying differentiation based on an individual's order among siblings, as well as which sibling is the focus.

Sibling position may be a clear guide in therapy to gain insight into why an individual may be undifferentiated and why this individual may be the focus of complaints from the family system. Usually whatever sibling position a parent is, that parent will focus on the child that shares the same sibling position of that parent. This could lead the child to become undifferentiated, which can lead to the possibility of drug and alcohol abuse. According to Bowen (1988), whatever sibling position one is born into is not definitively a negative or positive aspect.

Although concepts included in the theories of Bowen are unique and make sense to utilize in family therapy, most substance abuse treatment centers implement evidence-based practices pertaining to substance abuse specifically with families and clients in treatment as opposed to other family therapy approaches that could be useful and not specifically tailored to the substance abuse population. Many researchers agree that intergenerational transmission is linked to substance abuse outcomes. For example, Liddle et al. (2001) suggested that "the consequences of adolescent drug abuse extend to

the next generation" (p. 652). Consequences, as well as behaviors are passed on most likely without notice or regard.

I find the characteristics of Natural Systems Theory to be very useful, especially with substance abuse clients and their families. Although I gravitate towards Natural Systems Theory more than any other theory, this branch of therapy is not typically supported in substance abuse treatment centers. Therapists are given flexibility to utilize approaches we specialize in but substance abuse treatment centers require clinical staff to utilize approaches specifically tailored to substance abuse, as well as documenting specific interventions are being utilized based on funding.

I believe the concepts of Natural Systems Theory assist clients and their families recognize the continuation of negative patterns throughout generations and provides the opportunity to extinguish the patterns from transmitting to future generations. I have seen many clients take notice to patterns within their family system, make sense of this, and work on changing. I have also observed clients and families struggle, be in denial, and resistant to changing. There have been many clinical directors with whom I have worked who appreciate family therapy approaches but enforce what external agencies demand. Struggles I experience are times I feel some family therapy approaches would be useful in a given situation and to my dismay, other forms of interventions are to be utilized. In general, I have observed also that evidence-based approaches are preferred. Currently, Natural systems theory is not an evidence-based approach.

Curiosity

How do clinical directors make decisions regarding family involvement in substance abuse treatment centers? Do clinical directors share family system views similarly? If every clinical director believes family involvement is important, what are common patterns, and what are strategies that seem to be successful according to their perceptions? These were questions that began to occur to me.

Since the numbers are increasing with individuals abusing substances, the conversations are also increasing, which should encourage parents to be more aware of the dangers and signs. Families usually are aware of their loved one abusing substances but may be unaware of the extent of professional help available. Family members may believe the individual abusing the substances is the issue and not recognize they play significant roles in the family system. This study exhibits the significance of family involvement of clients receiving treatment at inpatient substance abuse facilities by analyzing data provided by clinical directors. This study supports the question of how decisions are made at inpatient substance abuse treatment centers regarding family involvement.

In Chapter II, I review the literature on evidence-based approaches to the treatment of substance abuse which involve families. In Chapter III, I explain the qualitative methodology and analysis utilized in this study, which gained perspectives from clinical directors of substance abuse treatment centers regarding the decision making of family involvement in treatment. In Chapter IV, I discuss the results of the study and in Chapter V, I discuss the results and implications

CHAPTER II: LITERATURE REVIEW

Substance Abuse in the Family

Gorski (1986), who specializes in relapse prevention, explained that many family members are in denial that they have a problem that requires specialized treatment. The family members are likely to deny their role in the family and direct personal and family problems upon the individual struggling with addiction. Denial is very common in family systems regarding substance abuse. Much like my own experience, it is a struggle to accept a family member is abusing hard drugs. Many clients and their families are not only in denial of their negative behaviors, but also are resistant towards the guidance of professionals.

I have learned that even though each family system is unique in many aspects, addiction is a aspect that is very consistent throughout all family systems. Our family systems usually unknowingly transmit generational patterns that are attributes to an addiction lifestyle, including behaviors, parenting skills or lack of, and interpersonal views. There may be parents or guardians who behave negatively towards their children or the child may be telling him or herself negative characteristics which will decrease self-esteem over time. Peele (2007) suggested that believing in and accepting your children due to them then struggling with accepting themselves. It is best to appreciate their unique gifts, especially ones external to academics. Over the years, the common denominator I have observed with clients is low self-esteem. Many clients are in a viscous cycle of feeling negative about him or herself initially and continue to use because of the guilt of shame of their actions in active addiction.

Risk Factors

According to SAMHSA (2016), risk factors increase the likelihood of initiating using substances, that include regular and harmful use, and other mental health and behavioral problems related with using (p. 3-4). Many parents may view obvious risks, such as negative peers that lead to substance abuse as opposed to their influence in their adolescents' lives. When risk factors come to mind, many parents may not consider the family system or some other systems adolescents belong to.

Adolescents' abuse of drugs and alcohol is may be often associated with peer pressure and the pressure to be accepted. This may be true; however there may be other underlying factors that lead to such negativity. According to Gilbert (1997), peers are the most powerful predictor of substance use among children, but the family is vital regarding prevention. The adolescents who feel close to their families will most likely avoid engaging in risky. Gorski, coined the idea that risk and protective factors promote positive adolescent behaviors and encourage high-risk behaviors such as substance abuse. Examples of risk factors are parent substance abuse, negative family structure and few prosocial support systems (Gorski, 1996). Families with a prevalence of substance abuse often exhibit limited protective factors and are overwhelmed with risk factors, which may impact the family's functioning and crisis management. Gorski (1996) claimed that the goal is to teach families how to implement protective factors and create more structure into the family.

SAMHSA (2011) stated that "stress and psychological trauma are among a number of environmental risk factors that can contribute to the development of mental

health or substance use problems in children and adolescents and also can increase the severity of such problems" (p. 8). Due to many children and adolescents not disclosing their trauma, offering resources may be difficult and mental health issues may increase over time without help. There could be possibilities where parents are not aware of their children experiencing trauma or believing they do not have a risky environment.

Risk factors are not secluded to one area of an adolescent's life. Hawkins, Catalano, and Miller (1992) suggested that risk factors can be separated into factors of society and culture, which exhibit legal and normal expectations of behavior. The other group of risk factors include individuals and their environments at school, with peers, and family. Since children do not have the same freedoms as adults, their environment at home can be controlled more efficiently by their guardians. The possibility of adolescents abusing substances in the home is not likely since adult supervision most likely will be in place. Adolescents most likely would rather use substances outside of their home and without adult supervision.

Many people may have their theories as to why an individual begins using substances. Unfortunately, there is not one absolute answer to why or how addiction begins. In life, many of us are instructed to stay away from risky or dangerous situations. The programs that were available in the past and some currently enforce abstinence and are not providing the severity or reality of what consequences come or what to be aware of.

Protective Factors

Gorski (1996) suggested that in order to prevent substance abuse in adolescents, protective factors must be built into the family structure. Protective factors involve several characteristics such as social connections with peers and parental interaction. Parents and family members with a substance abusing family member may be unaware that a family pattern of substance abuse may be influencing the member's substance use. It is important for parents or guardians to increase protective factors and decrease risk factors throughout the life of a child and also after the crisis has been treated. SAMHSA (2011) suggested that stability within the family system, relationships that are supportive, a community that is strong, and faith groups can assist in the prevention of problems from developing in children that leads into adolescent years. These protective factors may also support that assists children cope with using substances and mental health, if the problems develop (p. 8).

Relapse is relatively common among recovering substance abusers. A recovering individual may come across obstacles and triggers that may cause him or her to relapse and use alcohol or drugs. Gorski specializes in relapse prevention and how to learn the signs of relapse before it becomes using. Gorski (2009) explained that "one of the primary tasks in adolescent development is to learn how to responsibly manage strong feelings and emotions." Adolescence is a crucial developmental path to adulthood. This is a critical period of time when an individual begins to learn more of the world and testing boundaries.

Adolescents may use whatever means of coping with problems that naturally occurs for them. This means, they may use mechanisms that have worked for them in the past and behaviors modeled by others. Peele (2007) stated that the individuals least likely to mature into adulthood are at increased risk for abusing substances. Many children appear to have this deficit more recently (p. 82). We learn as children what behaviors reward us with the results we desire. Parents may provide immediate gratification to their children without realizing the consequences.

Wolin, Bennett & Jacobs (1988) concluded from their studies regarding assessing rituals in alcoholic families that the results of their study supported their initial hypothesis of ritual disruption, which was those children from family systems with precise dinner times provided evidence of decreased possibility of alcoholism transmission than others (p. 235). Family dinners are common rituals within family systems and these rituals are also protective factors that could improve the prevention of adolescent substance abuse. Dinner together with the entire family could promote a strong bond between adolescents and their parents, which could prevent risky behaviors and substance abuse characteristics.

Many parents do not realize the impact they have on the lives of their children. I believe substance abuse has become an epidemic in our society for a plethora of reasons. Both parents usually work now, technology is constantly advancing, and values and togetherness are not sacred like they used to be. We often concern ourselves with substance abuse when it has already become a problem instead of being proactive with prevention. Peele (2007) stated that “what kids need to protect them from addiction are

the fundamentals of a life: a sense of meaning and involvement, purposeful activity and achievement, caring about themselves and others, and the ability to manage themselves. The importance of these values and skills is not surprising. What's surprising is that we've lost sight of these being the best antidotes to addiction" (p. 7).

The majority of characteristics among clients' stories share similarities between each other. With that being said, there may be patterns within these family systems that are not viewed with significance. Gorski and Miller (1986) stated addiction has been exhibited as a family disease that affects all members of the family system, requiring them to get treatment. The individual struggling with substance abuse needs treatment, as well as the other family members for coaddiction (p. 171). Codependence and enabling occurs too often within family systems. The other family members in the system become dependent on the chaos that surrounds the individual struggling with substance abuse. Family members enable for fear of losing the relationship with the substance abuser or not wanting him or her to suffer. Manipulation plays a significant role as well.

Preventative Coaching Strategies

The more common concerns of parents or guardians is making sure their children are healthy, sheltered, educated, nourished, fed, and clothed. Although we are not sure of the cause, providing certain attributes to children prior to adolescence may prevent the child from having the desire to try a substance or continue using. Children need structure and attention. Structure is a strategy that can be presented to parents. However, the consistency and formation are what need to be detailed regarding structure to the parents.

Involving parents and guardians as early as possible may be more beneficial than during their child's adolescent years or when substances have already been introduced.

For many decades, resources for education of substance abuse have been provided in school systems, religious systems, medical systems, etc. These programs have mostly targeted children to prevent the use of substances and provide awareness and education. Kosterman, Hawkins, Spoth, Haggerty, and Zhu (1997) experimented with the Preparing for the Drug Free Years (PDFY) and stated sessions are structured to provide increased knowledge to parents about risk factors and the value of including their children regarding interaction. Sessions also coach parents how to communicate expectations of their child's behavior and coach children and the parents skills for children to resist peer pressure to avoid engaging in risky behaviors. The PDFY program teaches parents to manage family conflict, and to express love and other positive feelings with interactions (p. 340). The PDFY provides sufficient training in all appropriate areas, such as coaching parents, educating children, and resolving conflict in a healthier manner. By providing education to parents regarding what common risk factors that lead to substance abuse, they may be more open to guidance as opposed to limiting teaching them only parenting skills. Family dynamics are always changing with society norms, which means there is most likely less family bonding occurring than decades ago.

Sloboda and David (1997) provided several programs available for parents in prevention of substance abuse. Sloboda and David (1997) discussed Project STAR "In the parent program component, parents work with their children on Project STAR homework, learn family communication skills, and get involved in community action" (p.

20). This program is relevant due to including a component for parents and not targeted for youth only. Not only is it a program incorporating parents, but the parents also work with their children.

Another program Sloboda and David (1997) discussed is: “The Strengthening Families program contains three elements: a parent training program, a children’s skills training program, and a family skills training program” (p. 26). The Strengthening Families program includes all necessary components as well. Since families attending the program will have their own habitual ways of communicating and behaving, adjusting to new skills may be challenging. An issue that may pursue is perhaps parents may not continue being consistent, which will result with the children being at risk. In order for this program to be successful not only for the children, but also for the family maintaining strengths.

Although family systems are highly influential with adolescents, we have to consider the external systems the children belong to outside the family. Children spend the majority of their day in school so it is vital strategies are equally as continuous and structural. Sloboda and David (1997) exhibited another program, the Adolescent Transitions Program (ATP) and stated that “the goal, through collaboration with the school staff, is to engage parents, establish norms for parenting practices, and disseminate information about risks for problem behavior and substance use” (p. 28). An interesting aspect of this program is establishing parenting norms. This can be challenging as well due to culture norms for parents. Parents may resist and believe their skills do not have any relationship to risk factors.

Many prevention programs are aimed towards a child or adolescent audience. Titelman (2008) stated the dependency in a relationship implies the dependency of substances and the individual struggles to anticipate independence as a result (p. 316). Many individuals may assume addiction is a choice and the individual abusing substances is at fault. Therefore, programs are usually aimed at adolescents instead of parents or guardians due to lack of knowledge of addiction and mental health.

Resources in Systems

Families who are naive about addiction are usually not knowledgeable about the resources and solutions available to assist the individual struggling towards recovery. There are resources in our society to assist with recovery, including treatment centers and support groups such as Alcoholics Anonymous (AA) and Narcotics Anonymous (NA). These support groups do not require any monetary payments so it is virtually available to everyone in all communities. Gorski (1989) enforces all individuals in recovery to have knowledge of the twelve steps due to the program working if you do the work and these groups are readily available in most areas and are usually free of charge. The twelve steps are usually the first choice in recovery from substance abuse and codependence (p. 2). Many families will not be proactive and attempting to utilize these resources to prevent such issues. Families may be in denial, may believe the substances are a phase, not be aware of community resources and programs, or may not be aware of the severity.

Stanton (1997) stated that “it has become generally recognized that a very small proportion of people with problems in drug dependency or abuse are actually engaged in treatment or self-help groups” (p. 161). Families who are naive about addiction are

usually not knowledgeable about the resources and solutions available to assist the individual struggling towards recovery or the individual may not be aware of resources available.

Smart Recovery is another support group for individuals in recovery and maintaining abstinence. Horvath and Yeterian (2012) explained, “Founded in 1994, SMART Recovery now appears likely to endure and to be of interest to individuals specifically seeking a science-based, self-empowering, and self-reliant approach to addiction recovery” (p. 103). This entity focuses more on science-based support, unlike AA, that utilizes spirituality. Many individuals are resistant towards AA due to no belief in a god or religion. Although the word god is used heavily in AA, it is not a reference to religion. SMART Recovery bases the program on evidenced based practices.

Another branch of recovery support is Celebrate Recovery and is described as a Christ-centered, 12 step recovery program for anyone struggling with hurt, pain or addiction of any kind. It is a safe place to find community and freedom from the issues that are controlling our lives (Celebrate Recovery-First Assembly, n.d.). This idea focuses heavily on Christian beliefs and combines both the church community with individuals in recovery from substances.

The result of addiction may possibly be avoided if parents and children are willing to become involved in any, if not all resources available to avoid the devastation of addiction. Although utilizing resources may not completely guarantee the absolute prevention of substance abuse, utilizing the resources do not consist of risk, where not utilizing the resources may increase the risk factor of addiction.

Peele (2012) claimed that the concept of abstinence have taken on an unrealistic quality in the United States, since specifically American children and adolescents are the most medicated population in history. The foremost medications in America are psychotropic ones (p. 285). It appears mental health disorders have severely increased with this population and the lack of healthy coping mechanisms are not as common. Many individuals are prescribed narcotic psychotropic medications, which can be abused and addictive. The option for non-habit forming psychotropic medications is available and if these are prescribed instead, we may lower the risk of possibility of substance abuse occurring.

Each individual within a system plays a specific role. The family system is a team and the system should work together to take advantage of every resource available in order to prevent the travesty of addiction. Programs and resources should be aimed more towards parents and guardians since these individuals are raising children. Throughout several decades, resources have been available to communities in order to help prevent adolescent substance use. Clinical directors are typically equipped with knowledge of resources in the system and apply this to their work with clients and their families.

Evidence-based Family Approaches to Treatment

Multidimensional Family Therapy

Multidimensional Family Therapy is an evidence-based practice that Liddle et al. (2001) described, “Multidimensional Family Therapy (MDFT) is an outpatient, family-based treatment for adolescent substance abuse” (p. 658). This component of family therapy, focuses on multidimensional aspects, which means we are examining each layer

of the family system. Liddle et al. (2001) further illustrated MDFT as an approach that focuses on thought process, regulation of emotions, avoidance of drugs for coping, parenting practices, and anyone else using in the family. MDFT also addresses the patterns of interaction that may connect the start and continuation of substance use (p. 659).

Family therapy theories have been extracted from experience and research, which represents which model is appropriate based on needs of the client. Since substance abuse affects each family member in the system, family therapy interventions are vital. Liddle et al. (2001) claimed from their research findings the results support the significance of MDFT significantly reducing substance abuse with adolescents and implementing positive developmental progression (p. 652). With this being identified, MDFT should automatically be implemented into treatment of adolescents struggling with substance abuse.

As therapists, we are very much aware of the influence families have on our identified clients. Liddle et al. (2001) found, “parental monitoring and changes in parenting practices prevent or delay drug involvement and are related to a decrease in adolescent drug use even after a pattern has been established” (p. 653). If these findings are accurate, MDFT can serve as significant assistance with parenting techniques, leading to decreased risk factors and substance abuse progressing.

Liddle et al. concluded (2001) from their findings: longitudinal studies supports that functioning issues in the family system are commonly prior to the negative behaviors of the adolescent (p. 654). The evidence of dysfunction within family systems continues

to increase with intensity of substance abuse among adolescents. Studies conducted over long periods of time are exhibiting the correlation of adolescent substance abuse and unsatisfactory familial relationships within the system. Liddle et al. (2001) further claimed that "MDFT interventions are based on research-derived knowledge about adolescent and family development and adolescent drug abuse and problem behavior formation" (p. 658). This verifies the research pertaining to MDFT continues to progress and provide more conclusions and relevance towards more evidence-based practices.

From experiences conducting family therapy and integrating techniques, our predictions of outcomes are sometimes accurate, due to the simplicity of change or no changes within the system at termination of treatment. We evaluate communication and behaviors and gradually measure decrease in negative aspects. Liddle et al. (2001) stated that MDFT treatment resulted in improvement in family functioning. The adolescent's family environment is, therefore, a valid predictor of adolescent substance use and substance abuse treatment success. Families seek therapy most times when there is crisis or discomfort within the system. Liddle and Dakof (1995) claimed that family therapy is dependent on the interactions in family relationships, as well as the initiation and the maintenance of substance abuse (p. 512). Behaviors are flexible in the sense of possible change if every individual makes efforts in the system to improve. When there are strong connections between family relationships, the intensity of positive of negatives behaviors thrive.

According to Liddle and Dakof (1995), some family therapies are more effective than group and individual therapy regarding decreasing drug use or complete

discontinuation (p. 517). The complete abolition of substance use while participating in family therapy possibly will not happen. Adolescents are generally part of several systems besides their families that could possibly influence his or her use of decrease of substance abuse.

Structural-Strategic Family Therapy

The evidence-based practice Structural-Strategic family therapy is also used with adolescent substance abuse and the family system. Stanton et al. (1982) have created the Structural-Strategic approach and explain that it applies structural theory as the foundation, creates new patterns through enactment, applies joining, tests boundaries, restructures the family, and accommodates the family. The approach then applies Haley's strategic model with a specific focus on a change of symptoms, events external to the session, and creating a specific plan. Although other family therapy approaches are included, structural-strategic family therapy also incorporates some of its own original features.

The Center for Substance Abuse Treatment (2004) described Structural-Strategic therapy as when there are struggles within the family structure regarding hierarchy imbalances. Structural-Strategic family therapy, along with other methods, could return balance to the family's relationships (p. 86). There are several aspects to keep in mind regarding these balances. The therapist may conceive a different ideal balance compared to a family member. Since the therapist takes leadership in session, he or she can structure treatment goals appropriately.

Stanton et al. (1982) explained that substances provide a solution to the struggle of allowing independence or not. In contradiction, this allows the individual to be close and distant or proficient and not capable at the same time (p. 30). This hypothesis makes sense to me due to the influence of the adolescent's family and internal conflict the adolescent faces. Stanton et al. (1982) further concluded that "an understanding of these concepts, and their integration into a homeostatic model, can provide the basis for effective treatment" (p. 30). Again, this is another example of evidence-based treatment and this approach also exemplifies the importance of family involvement.

The Center for Substance Abuse Treatment (2004) reported that the adolescent years is when substance abuse often starts due to the adolescent making an attempt at individuation (p. 56) regarding Structural-Strategic therapy. An attempt at individuation is pursued by every adolescent and the result of substance abuse appears to happen when the process is not achieved. This idea is similar to Bowen's concept of differentiation; during adolescent years, children are starting to learn independence but still have a connection to their family system. Again, the family system is the major influence since the individuation is a compromise between the adolescent and parents. This means if parents restrict adolescents from experiences, the substance abuse increases.

Most theorists stress the importance of adolescent years being the common time of experimenting with substances. Stanton et al. (1982) stated that substance use usually originates during the adolescent years. This is attached to the process of getting older, trying new behaviors, gaining independence, developing relationships with others external to the family system, and eventually moving out. Coinciding with this idea, we

cannot disregard the dynamics of the family. Family involvement is very important during adolescent years, whether negative or positive. Stanton et al. (1982) claimed that family involvement is usual and appropriate for adolescents, since they are still underage and presumably have not left home yet.

Some techniques suggested by the Center for Substance Abuse Treatment (2004) included reestablishing boundaries between the family and external systems and realign the subsystem and generational boundaries. Integrating boundaries between relationships in a system and with external systems can be challenging. Stanton et al. (1982) suggested that the move that is prominent in this approach is to engage the parents together regarding the individual struggling with substance abuse. This is important; the absence of this part will maintain the negative interactions in the system (p. 133). Many parents struggle with boundaries due to the desire to be loved by their children and want their children to be happy. Boundaries are meant to protect children, so it is important for parents to teach healthy boundaries, as well as how to implement crisis.

Gladding (2007) referred to Stanton et al. (1982) as the detailed work of these researchers highlights how important family dynamics are and the importance of family involvement in treatment. Many individuals believe substance abuse is an individual problem and that environment and systems are irrelevant; meanwhile, Structural-Strategic therapy involves all members in the family system and addresses the adolescent's negative behaviors.

Jiménez, Hidalgo, Baena, León, and Lorence (2019) conducted a study utilizing Structural-Strategic therapy and concluded that " the reduction in adolescent problematic

behavior both at external and internal level confirms the usefulness of structural–strategic therapy" (p. 9). Since Structural and Strategic therapy approaches work, it would make sense that Structural-Strategic therapy shows results as well. As therapists, we are very versatile regarding which approaches we use because every client, family, or couple may need different approaches depending on their issues.

Many family therapy approaches are brief, and treatment is not terminated until both therapist and clients agree their goals have been achieved. We have to be conscious of how our clients are adapting to change. Stanton (1992) explained if changes are too drastic, the family may become stuck. This is when a therapist will be contacted to aid the family. Clients seek treatment for resolution to their current issues, and it would be detrimental to not provide appropriate services.

Brief Strategic Family Therapy

Brief Strategic Family Therapy (BSFT) is another evidence-based family therapy intervention aimed at treating adolescents struggling with substance abuse. Szapocznik, Schwartz, Muir, and Brown (2012) claimed that "BSFT is a short-term (approximately 12 sessions), family-treatment model developed for youth with behavior problems such as drug use, sexual risk behaviors, and delinquent behaviors" (p. 134). The attractive feature of BSFT is targeting the negative behaviors of the adolescent and involving the family system as opposed to treating only the individual.

Szapocznik et al. (2012) explained that BSFT was created initially to relate Cuban immigrant families in Miami to their cultural values, while including elements from Structural and Strategic Family Therapy. What makes BSFT unique is taking the family

interactions at the current time and restructuring them. These particular engagement techniques- are exclusive to BSFT. Although a specific population was initially on the focus, expanding to all populations provided similar results. The interactions between family members are closely observed in session and then managed accordingly to decrease adolescents' high-risk behaviors. Zarate, Roberts, Muir, and Szapocznik (2013) claimed that "because the family is an important context for adolescent development, the BSFT model intervenes directly at the level of the family system, diagnosing and restructuring maladaptive interactions" (p. 108), whereas other evidence-based approaches focus on several systems influencing the adolescent.

Many therapists in the field may report clients will work on their issues within the limitations of the session time as opposed to continuing the work to change outside of the session. A common struggle between client and therapist is completing tasks in between sessions, which decreases the likelihood of desired changes. Szapocznik et al. (2012) stated that "because changes are brought about in family patterns of interactions, these changes in family functioning are more likely to last after treatment has ended, because multiple family members have changed the way they behave with each other" (p. 135). Family systems, like all systems, are like a sports team; the success of achievement cannot happen without the members working together as a team.

BSFT focuses on the families and clients primarily, however, the therapist is structuring the sessions. By therapists joining with clients and their families, participation and engagement most likely will increase. This could then provide better results, especially decrease in drug use. Szapocznik et al. (2012) concluded from their study that

the therapists who maintained increased levels of joining throughout treatment were associated with better drug-use results with adolescents (p. 141).

The model of BSFT incorporates three entities that must work in harmony in order to be successful. In order for BSFT to produce change, the therapist, family system, and identified patient must engage in treatment. Szapocznik et al. (2013) stated that BSFT entails intervention tools to engage families in treatment, then become an accepted member of the family, to create a framework for change, and attempts to change the interactional patterns that prohibit families from achieving their own goals. According to this statement, BSFT coincides with the concept of second-order cybernetics. The therapist becomes included in the family system, as opposed to an outsider. She works with the family and no longer facilitates. Becvar and Becvar (1999) explained this as, "A dance in which all are involved and whatever we create, we create together" (p. 38).

As we gain perspective of what issues family systems are struggling with, it is also important we recognize the adolescent's sole issues, as well as the issues that disperse into the family system that assist in maintaining the negative interactions and keep the problems alive. Szapocznik et al. (2013) explained, " One of the most important innovations of the BSFT approach has been the belief that challenges in engaging families into treatment are derived from the same interactional problems maintaining the adolescent's problem behaviors" (p. 208). The family system becomes habitual to the negative interactions that allocate for the problems to exist, which explains why clients often struggle to engage in change and therapy.

Szapocznik et al. (2012) suggested that the goals that must be set are to extinguish or decrease the problem behaviors of the adolescent, known as the 'strategic or symptom focus,' and to change family interactions that maintain the adolescent's problem behaviors, known as 'system focus'. Since the family system has maintained responses to the detrimental behaviors of the adolescent, the system must reverse their interactions with the adolescent. Each individual plays a role in the system and that existing role has continued the cycle of behaviors and responses. Many family members believe they are not guilty of influencing how others react in the system and identify the adolescent as the problem instead of recognizing their contributions.

As therapists, we most often do not observe clients and their families outside of the session and in the community. Robbins et al. (2009) claimed that "only more recently have studies been conducted to examine the impact of family therapy in real world settings, with results indicating that family-based interventions are at least as effective as other empirically-based approaches in reducing adolescent drug use" (p. 269). This implies that there are other options to provide BSFT.

According to Szapocznik et al. (2013), the model of BSFT shows if specific strategies for engagement can improve the probability of family engagement and retention in the treatment of adolescents, which will produce better outcomes. By conducting several studies utilizing BSFT, the results show a decrease in drug use and an increase in participation of adolescents and family members.

Multisystemic Therapy

Multisystemic Therapy (MST) is another derivative of family therapy that specifically targets adolescents engaging in substance use that is an evidence-based approach. Burns, Schoenwald, Burchard, Faw, and Santos (2000) stated, "MST targets changes within the family, within naturally occurring systems around the family, and between the family and these systems" (p. 308). MST, like other theories, supports the idea of systems being influential with adolescents regarding change. The systems closest to the client and the family are focused on due to intersecting between each other as well as sharing the client across these systems. Henggeler, Schoenwald, Borduin, Rowland, and Cunningham (1998) pointed out that MST looks at family (and extrafamilial) strengths as important factors for change.

When we dissect attributes (i.e., peel away layers) of the adolescent, we are exploring what influences the functioning or lack thereof within the family system. Slesnick, Bartle-Haring, and Gangamma (2006) suggested that by viewing adolescent drug abuse from a family systems view, the focus is on the way adolescent functioning is related to parental, sibling, and extended-family functioning. The functioning of the adolescent is also related to communication patterns, as well as the interactions within and between family subsystems. The behaviors and actions may be the predominant focus, but we are then ignoring important factors such as communication and interaction between the family members.

When working with families and clients who are struggling with substance abuse, there may be times we are faced with resistance from the family members when

attempting to assert change. Slesnick et al. (2006) explained, “Improvement in individual functioning, such as substance use, is assumed to be related to change in family interaction patterns targeted by the intervention” (p. 277). Some therapists have witnessed clients progress significantly in recovery when distancing themselves from their family system in the event that no changes are made within the system. Additionally, some therapists notice substance abusing clients thriving when the system gradually changes in a positive direction.

Given the research conducted with substance abuse clients, we can assume clients will most likely relapse (if sober), implement no change, or increase substance use if their family system is not involved or making positive changes. Slesnick et al. (2006) concluded that evidence supports family-based therapy is sufficient in reducing levels of adolescent drug abuse and effects can last at least six to twelve months after termination of treatment. This is reasonable to consider since there has been research supporting family systems affecting the adolescents’ functioning, whether it be positive or negative.

Burns, Schoenwald, Burchard, Faw, and Santos (2000) suggested that “MST is a pragmatic, goal-oriented treatment that seeks to help families make changes in the youth’s environment through intensive intervention” (p. 287). The emphasis on “intensive” should be placed due to MST consisting of working so closely with the client and their immediate systems. Furthermore, Henggeler et al. (1998) stated that “MST is an empirically grounded intervention with a comprehensive quality assurance/improvement protocol that is delivered using the home-based model of service delivery” (p. 42). The foundation of MST is intimate and intensive due to the therapeutic intervention setting

being in the homes, which is the environment where most family relationships and/or connections interact within the system.

Although family systems are where risk and protective factors usually originate, we also have to consider the adolescent's systems not involving family. Huey, Henggeler, Brondino, and Pickrel (2000) explained that "in light of social-ecological theory and supporting research, MST aims to impact antisocial behavior by altering key aspects of the youth's social context in ways that promote prosocial behavior rather than antisocial behavior" (p. 452). Many individuals may engage in prosocial behaviors at home within the family system and engage in antisocial behaviors outside of that system. This will then involve exploring each individual's social context to comprehend and then transform.

Huey et al. (2000) claimed that MST adherence was correlated with family functioning improving, as well as the adherence of caregivers was correlated with decreases in delinquent behavior. In regards to this information, the correlation with adolescent negative behaviors and their peers appears to be of significance. When the adolescents were actively participating the MST treatment, the reduction of negative peers coincided. Lochman and Van den Steenhoven (2002) implied that "prosocial behaviors and skills should prevent the development of risk factors for substance abuse and strengthen the factors that protect against substance abuse" (p. 58).

Henggeler et al. (1998) pointed out that "rigorous evaluations (i.e., randomized clinical trials-the gold standard of research) with juvenile offenders have shown that MST can significantly reduce youth antisocial behavior (i.e., criminal offending, substance

abuse) in comparison with other types of interventions" (p. 8). This evidence supplies us with the opportunity to utilize MST for antisocial behaviors outside of the family system. Many individuals who abuse drugs and alcohol suffer from criminal offending, which is usually related to the desperation to retrieve a substance.

There may be parents who possibly believe the issue of substance abuse is in the control of the adolescent only. MST provides techniques for parents to implement to reduce negative behaviors that influence substance abuse. Lochman and Van den Steenhoven (2002) explained that research suggests that parenting that was harsh, poor supervision and parental warmth are aspects commonly related to conduct problems and adolescent substance. These factors shows a foundation for most preventive parent intervention programs. These factors are important to consider for parenting classes and educating parents about the factors that increase risk of their adolescents abusing substances.

Azrin, McMahon, Donahue, Besalel, Lapinski, Kogan, et al. (1994) explained that the results of their study that "the relationship of the *S*s with their families also improved. The happiness/satisfaction measure of the parents with the youth *S*s improved as did, although to a lesser, non-significant degree, the youths' happiness/satisfaction with their parents" (p. 864). These results show that their behavioral therapy changed the level of happiness with parents and adolescents regarding their relationships. Even though the adolescents reported less change than the parents, the positive change still proposes a difference due to therapeutic interventions.

The evidence-based practice of MST provides a plethora of research supporting decreases in negative behaviors and substance abuse, as well as improved parenting skills. Burns et al. (2000) stated that "in contrast, the evidence base for MST is characterized by considerable controlled research, but little diversity among investigators" (p. 309). The investigators may be experts with MST and possibly bias, where the studies lack the variety of investigators of other well established interventions.

Compare and Contrast

The evidence-based family therapy approaches reviewed in this chapter share similar concepts and ideas. The common factors these approaches share include family involvement, substance abuse treatment, and addressing problematic or high risk behaviors of the client. Evidence-based programs are preferred for funding purposes (HHS, 2016). Implementing evidence-based treatment in substance abuse treatment centers could increase likelihood of client and family connection, as well as increasing chances of sobriety. Rambo, West, Schooley, and Boyd (2013) reviewed Structural-Strategic models and explain MDFT is a treatment specifically aimed towards misbehavior and substance abuse with adolescents, MST involves a specific analytic process, and BSFT accentuates the therapist exploring accommodations with the family (p. 117).

The approaches reviewed in this chapter are derivatives of previous family therapy approaches and have added specific concepts. Each family therapy approach detailed studies utilizing their models. Structural Family Therapy was created by Salvador Minuchin with his colleagues in the 1960s (Vetere, 2001, p. 133), which is one

of the foundation models. Another foundation model is Strategic Family Therapy, which was established in the 1950's (Haley, 1973, p. 18). MDFT was established first, followed by Structural-Strategic therapy. BSFT was established in the early 1980's and MST followed in the later 1980's.

Compared to other evidence-based family therapy approaches, MDFT differs by "Thinking in terms of what one has to accomplish first, we start with adolescent and parent engagement, beginning with fundamental activities to not only engage but to accomplish" (Liddle, 2013, p. 98). Other approaches address the family system or external systems, while MDFT focuses more on the parents, adolescent, and their interactions.

BSFT is also aimed for adolescents with problematic behaviors and substance abuse. What differs BSFT from other evidence-based approaches are principles that Zarate et al. (2013) explained that as family members influence one another, patterns of family interaction repeat and become predictable, which influences the behavior of each family member, as well as intervention planning, which address patterns of interaction that have been directly linked to the negative behavior of the adolescent. BSFT is similar to other family therapy interventions, however, the therapist is the individual implementing change in the system. By joining with families, this assists with the process, provides comfort the family, and produces increases in changes. Szapocznik, Zarate, Duff, and Muir (2013) claimed that therapists utilize techniques that include joining, tracking and eliciting, reframing/creating a motivational context for change, and restructuring throughout treatment to extract change.

MST includes unique components, such as the therapist is always available and can collaborate with any of the client's systems at any time (LaFavor and Randall, 2013, p. 102). MST also focuses and makes sense of the correlation or "fit" between the client's problems and extensive systems (LaFavor and Randall, 2013, p. 100). The adolescent's ecology consists of five systems (family, individual, community, school, and peer) according to LaFavor and Randall (2013), then further explained within these systems, we assume other factors within the other systems have an influence on the behaviors of the child.

Research Question

There are significant evidence-based models of family treatment for use in substance abuse treatment. In practice, clinical directors will make the decision on which models are implemented within a particular inpatient substance abuse treatment center. Is there space for models significant for generations due to their training in the field, such as natural systems theory? Are models chosen instead from among the evidence-based approaches, and if so how are decisions made between these models? These are the questions I will explore in my study. There are no previous studies relating to the decision making behaviors of clinical directors in this area.

CHAPTER III: METHODOLOGY

This study was designed to exhibit the perspectives of clinical directors in inpatient substance abuse treatment centers focusing on decision making of treatment. Chapter I entailed how substance abuse has played a pivotal role in my life, along with my journey of transitioning from growing up in addiction, to experiencing addiction as a therapist, to balancing and collaborating the two worlds along with my beliefs, views, and experiences. Chapter II explored a review of literature pertaining to research previously conducted with adolescents and their substance use, resources, lack of resources available, and family influence. In Chapter III, I will portray and explain the qualitative methodology that was utilized in this study.

This study asks the research question, "How are treatment decisions made in substance abuse treatment centers regarding family involvement?" A qualitative option was more beneficial than a quantitative option due to the experiences of these clinical directors defining their view of family systems. These aspects rely on the principles of the participants and how they view family involvement with a client in substance abuse treatment. The participants shared similar views towards family involvement, however, their experiences are different in context. The research question provides insight from some clinical directors who may lack extensive education or training in marriage and family therapy but work closely with clients and their families.

Qualitative Research

Qualitative research was selected for this study due to the method corresponding appropriately within the marriage and family therapy field. Gergen (2014) claimed that the aim for therapists typically is to provide insights from more testable propositions that may surface or expand upon nominal statistical reports. This method of research also supports the question of, "What do clinical directors of inpatient substance abuse treatment centers perceive about utilizing the family system of clients in treatment?" Allan and Eatough (2016) explained that "qualitative research has the potential to add depth, complexity and integrate both a subjective and intersubjective stance when researching" (p. 406). Each participant's perspective is subjective, therefore, is not able to be quantitatively measured.

According to Trochim and Donnelly (2008), "Qualitative measures are any measures where the data is not recorded in numerical form" (p. 142). Qualitative research allows different perspectives as opposed to numerical facts. Although it may be possible to quantify the answers supplied by the participants, there is not a story to support the numbers. I identified what clinical directors experience and found important about utilizing families of clients in substance abuse treatment centers so answers varied for each participant.

Chenail, Duffy, St. George, and Wulff (2011) explained that "whereas quantitative researchers use statistics, qualitative researchers employ words to achieve the same effect" (p. 272). Although qualitative research is generally measured and conducted without numbers, the data can still be measured accordingly depending on which analysis

is utilized. The quantity of something significant participants relay may not be measured; it is the quality of what is being portrayed is what is significant. The significance of data is determined by the individual conducting the analysis.

Creswell (2013) explained that "we conduct qualitative research when we want to *empower individuals* to share their stories, hear their voices, and minimize the power relationships that often exist between a researcher and the participants in a study" (p. 48). Qualitative research can appear more welcoming for participants to provide extensive answers. As marriage and family therapists, we are comfortable hearing stories of individuals and are usually able to notice aspects that may be important that were not noticed previously. Once extensive data is provided by the participants, the researcher must review thoroughly and select what is important and common among the participants.

Qualitative Research as the Preferred Methodology

A qualitative approach for this study was the most appropriate due to each participant was expected to provide distinctive results. Piercy and Benson (2005) claimed that "family therapy researchers can expand considerably the ways in which they represent and share their findings" (p. 107). The intention of this study was to expand on the perspectives of clinical directors utilizing family of clients at inpatient substance abuse treatment. I feel qualitative research was the best methodology for this study due to having less restrictions and being able to view with systemic lens, without conclusions being rigid and not open for interpretation.

Qualitative research involves varieties of conclusions. Piercy and Benson (2005) suggested that “such methods of bringing findings to life are applicable to research topics in the field of family therapy” (p. 107). As a marriage and family therapist, there are a vast amount of intricate aspects to explore within the scope of family therapy, especially in the field of substance abuse. Substance abuse is an entity of mental health that may be confusing and misleading. Qualitative research allows us to make conclusions based on our own experiences and possibly portray new ideas to readers.

Bateson (1972) stated, “The word ‘learning’ undoubtedly denotes *change* of some kind. To say *what kind* of change is a delicate matter” (p. 283). Although we may all be in the field of mental health, we still have different views or beliefs of what change is. As I conducted the research and analysis for this study, others may learn something different than what I believed I have learned, as well as what other individuals may see that as valuable or not.

I discussed in Chapter II the importance of family influence and involvement regarding adolescents struggling with substance abuse, whether family involvement is positive or negative. As therapists, we may share similar experiences when involving families in therapy but with different outcomes and perceptions. I believe perceptions may differ throughout each specialty and experience. Family involvement appears to be vital through the recovery process with clients struggling with substance abuse and each entity of the mental health field proceeds with therapeutic methods appropriately.

Generic Qualitative Research

The specific experience I was interested in studying was perspectives of clinical directors in decision making at inpatient substance abuse treatment centers focusing on involving families of clients. Percy, Kostere, and Kostere (2015) described this method as, “Generic qualitative inquiry investigates people’s reports of their subjective opinions, attitudes, beliefs, or reflections on their experiences, of things in the outer world” (p. 78).

I am already familiar with the shared experience of being a therapist but have not experienced the role as clinical director myself. The perceptions of clinical directors regarding involving families of clients in substance abuse treatment is interesting due to their experience, expertise, and having a different role than the therapists they manage. Percy et al. (2015) suggested that if one desires to focus on opinions, experiences, and the explanation of occurrences from the past, generic qualitative inquiry would be the most appropriate methodology rather than other approaches, such as phenomenology.

When I conducted interviews with the participants, I wanted to know about who is involved with making decisions about family involvement with clients. I was interested in concluding how decisions are made regarding to what extent families are involved and how the process happens. I was focused on the events of what has happened with family involvement and not how the participants feel about the events. Caelli, Ray, and Mill (2003) claimed that “generally, the focus of the study is on understanding an experience or an event” (p. 4).

As a marriage and family therapist, I was intrigued to examine the experiences of clinical directors overseeing inpatient substance abuse treatment centers and how family

involvement happens and how the decisions are made regarding treatment. Percy et al. (2015) explained that “actually, researchers considering people’s subjective ‘take’ on actual external happenings and events should consider generic qualitative inquiry as their approach” (p. 79).

Thematic Analysis

Given the literature review in Chapter II, we conclude family systems play a significant role in the lives of individuals struggling with substance abuse. Every clinical director has worked with families of clients in treatment. Thematic analysis made the most sense to use in this study, as Braun and Clarke (2006) defined, “Thematic analysis is a method for identifying, analyzing and reporting patterns (themes) within data. It minimally organizes and describes your data set in (rich) detail” (p. 79). Thematic analysis appears to be flexible and a less complex way of analyzing data compiled from interviews. The questions I asked were open ended and the expectation was the data received provided data to an extensive capacity.

Since substance abuse treatment centers are similar in many ways; it may be presumed what clinical directors report will also be common between them. Braun and Clarke (2006) further explained that “through its theoretical freedom, thematic analysis provides a flexible and useful research tool, which can potentially provide a rich and detailed, yet complex, account of data” (p. 78). My goal was to obtain data as detailed as possible from interviews to provided more options to select themes from. If the data was not so extensive, then exploring codes and searching for themes would have been limited.

I adhered to the phases of thematic analysis according to Braun and Clarke (2006), which starts with familiarizing myself with the data. The more familiar I was with the data, the process of searching for commonalities became easier. Braun and Clarke (2006) suggested that "during this phase, it is a good idea to start taking notes or marking ideas for coding that you will then go back to in subsequent phases" (p. 87). Since I received an abundance of data from the interviews, I noted aspects I found significant. To obtain the data to read, I converted the verbal interviews into written form and transcribed as accurately as possible. Braun and Clarke (2006) expressed that "if you are working with verbal data, such as interviews, television programmes or political speeches, the data will need to be transcribed into written form in order to conduct a thematic analysis" (p. 87).

The following step in the thematic analysis is generating initial codes. Braun and Clarke (2006) stated that "this phase then involves the production of initial codes from the data" (p. 88). I may have found potential codes during the initial reading of the transcriptions and this step refers me back to review the transcript and what I initially thought was significant. Therefore, it benefited the accuracy of data by reviewing the topic at hand, perspectives of inpatient substance abuse center clinical directors decision making regarding family involvement in treatment.

The third step in thematic analysis involves exploring the transcript for themes. According to Braun and Clarke (2006), "Essentially, you are starting to analyze your codes and consider how different codes may combine to form an overarching theme. It may be helpful at this phase to use visual representations to help you sort the different

codes into themes" (p. 89). This step of the analysis was more time consuming than the first and second step due to searching for specific items as opposed to reading and making potential notes.

I interpreted the information differently each time I reviewed the data. Smith, Flowers, and Larkin (2009) stated that "criteria for validity will need to be flexibly applied; something that works for one study will be less suitable for another" (p. 184). I reviewed the data several times to assure I discovered the same themes. It was crucial for the data to represent the experiences of clinical directors, specifically the decision making of treatment. Braun and Clarke (2006) claimed the fourth step is reviewing the themes and suggest some themes may not really be themes due to a lack of data supporting them or the data is too different and some separate themes may eventually form one theme. By completing this step, I increased the accuracy of themes and assured the data made sense.

The fifth step in thematic analysis is defining and naming themes. As Braun and Clarke (2006) explained that each theme needs a detailed analysis and telling a story that relates back to the research question. It is important to consider the themes individually and how they relate to each other. Step five appeared complex and much precision was necessary in order to successfully complete the analysis and report. If themes are not named or categorized in relation properly, the research question of "how are treatment decisions made in substance abuse treatment centers" would not exhibit the original focus. The final step in thematic analysis is producing the report. For step six, Braun and Clarke (2006) articulated the analysis must exhibit a account of the story that makes sense, where you can see the data within and across themes.

The aim of conducting any research is to obtain an abundance of data that is rich and detailed. In order to me to obtain such thorough data, I initiated this by creating questions that elicited the information I wanted. Smith et al. (2009) suggested that "in phrasing particular questions, it is important to choose formulations which are open (rather than closed), and which do not make too many assumptions about the participant's experiences or concerns, or lead them towards particular answers" (p. 60). Since I already have the experience of asking open ended questions due to my role as a therapist, I achieved rich details by conducting the interviews like I would with a client in a session.

I aimed for participants to provide rich, detailed answers so I was able to have a vast array of information to utilize and analyze. My goal was to primarily focus on what the participant provided and did not make assumptions or implement my thoughts or bias.

Sampling

The sample I sought for this study are clinical directors of inpatient substance abuse treatment centers. I utilized purposeful sampling due to selecting the sample purposively instead of using a probability method. This type of sampling assisted in providing insight into a specific experience (Smith et al., 2009).. The sample originally was seeking up to five participants or when saturation was reached. Saturation was met at three clinical directors who currently hold or have held the role of clinical director at an inpatient substance abuse treatment center.

The purposeful sample also included the requirement of working with clients and their families at their facility. Creswell (2013) suggested that the considerations involved in selecting the purposeful sample includes who will be selected as participants for the

study, the sampling strategy, and the size of the sample. There was up to five participants in this study, depending on when saturation was reached. Munhall and Chenail (2008) suggested that when the data appears to be repetitive from the group or individual, the saturation point may have occurred and there may not be new information to attain.

Participants

The participants of this study were clinical directors of inpatient substance abuse treatment centers either currently working at facilities or have in the past. Chapter II provided a literature review of evidence-based family therapy approaches with individuals struggling with substance abuse but the literature on the perceptions of clinical directors regarding decision making with treatment at inpatient substance abuse facilities has not been examined or studied. Therefore, I was seeking data to fill the gap of how treatment decisions are made in substance abuse facilities and provided the importance of implementing family involvement with substance abuse clients by gaining perspectives of clinical directors.

Clinical directors are required to be licensed as a Marriage and Family Therapist, Social Worker, or Mental Health Counselor. Certified Addiction Professionals (CAP) were also considered due to being accepted as a license at many substance abuse facilities. The participants that were selected provide family involvement at the substance abuse treatment center they hold the position of clinical director. Since there is typically only one clinical director per treatment facility, the participants were from varied centers. Due to the extent of data that was analyzed, more than five participants would be overwhelming.

I obtained participants by contacting current clinical directors I know or professionals who have been clinical directors in the past of substance abuse treatment centers. I contacted the participants by phone call. When I made contact with each participant, I confirmed they have had or currently hold the position of clinical director. Once the participants agreed to volunteer, I scheduled a time and place to meet somewhere private to conduct the interview, as well as providing each of them with an informed consent form to sign. Upon meeting each participant, I reviewed the consent form again for assurance. According to Smith et al. (2009), "We believe it is good practice to revisit the issue of consent within the interview itself, with specific oral consent being sought for unanticipated emerging sensitive issues" (p. 53).

In order to adhere to ethical procedures and privacy, all notes and recordings were only in my presence and locked in a cabinet when not in use for data collection or analysis. I withheld the participants' identifications anonymous to assist with confidentiality. The participants consisted of three females between 32 through 39 years old and were all Caucasian. The data provided by the participants assisted with contributing to further evidence of the importance of involving family systems with individuals in substance abuse treatment.

Data Collection

The participants were purposefully selected who were specifically clinical directors who work at inpatient substance abuse treatment centers. I specifically sought out this population, which made this sampling unique. The audio recordings accompanied me and I listened closely to retrieve every word spoken in a private setting. I utilized a

software application on my cellular phone, Otter.ai, that transcribes conversations as the conversation is occurring. Otter.ai also categorizes words that were repeated in the interviews which immensely assisted with finding themes among the participants.

Once the recordings were transcribed, I printed each interview separately, and then highlighted what appeared to be significant. Smith and Davies (2010) suggested that "you would usually number the lines of a transcription, so that when you start to work with your data, you can easily retrieve the quotes that you want to use" (p. 148). This concept appears to make sense since the data was easier to retrieve when reviewing. I created codes (by conducting) this method due to seeking experiences of clinical directors regarding involving families of clients at inpatient substance abuse treatment centers.

The Interviews

The interviews with the participants took place at various locations that without any interruptions. The interviews were face to face and in person. I asked each participant the same set of questions that were pertaining to their perspectives of family involvement with clients. A digital voice recorder was used to record the interviews in order to capture and transcribe at a later time. A voice recorder application,(Otter.ai) on my cellular phone was also used as a backup. Otter.ai records audio and transcribes conversations as they are occurring. This software application assisted with transcriptions, finding themes, and sub-themes. Lapel microphones were used for each participant and myself during the interviews to ensure the highest quality of sound.

The responses varied between the participants, based on how they answered the questions. Since the participants were not aware of the questions prior to the study, there

were moments they needed time to think about their experiences and respond. I also anticipated forming the question differently if a participant did not understand a question. The following are questions I asked during the interviews:

1. How and to what extent do you involve families in treatment?
2. What models of family therapy do you promote or support at your treatment center?
3. How and why are these treatment decisions made?

I asked follow up questions after some of these questions and the follow up questions varied on the answers the participants provided. Since I was seeking very detailed data, I felt some answers could be more elaborate. Some follow up questions were asked after the interview.

According to Creswell (2013), "The interview is a dialogue that is conducted one-way, provides information for the researcher, is based on the researcher's agenda, leads to the researcher's interpretations, and contains 'counter control' elements by the interviewee who withholds information" (p. 173). Since I am the researcher, the interviews were interpreted by me. This included and excluded elements that others may or may not depict as significant themes. Therefore, my interpretations were of significance of what I was trying to explore, while others may find significance in other aspects.

Creswell (2013) explained that "instead, the nature of an interview sets up an unequal power dynamic between the interviewer and the interviewee. In this dynamic, the interview is 'ruled' by the interviewer" (p. 173). It was vital, just like in any session with

a client of mine, that the participants felt comfortable and openly discussed their experiences with clients and the involvement of their families. Some participants were familiar with my non-judgmental attitude and were aware of my stance of equality in power.

Data Preparation

Only with completed consents from the participants, I digitally recorded each interview and later transcribed the interviews. I became more versed with the data by recording and transcribing the information from the interviews. I relied on the recordings of the interviews first and then referred to my notes as support. Although I might have my own experience and assumptions, it was important I was aware of this and I did not allow it to interfere with the data that was intentionally being sought after. I gathered all the recordings, listened, and transcribed them on to a Microsoft Word document.

Data Analysis

In the data analysis of qualitative research, the organization of transcripts for analysis, condensing data into themes by coding, then narrowing down the codes, and ending with a representation of the results are included (Creswell, 2013). Thematic Analysis appeared the most appropriate for this study due to the perspectives of clinical directors experiences working at inpatient substance abuse treatment centers was what I intended to record. I took a thorough approach by using thematic analysis to take what the participants shared with me and generated similar themes among the participants. The data collected demonstrated the importance of family involvement, regardless of which mental health field each participant was educated or trained in.

Creswell (2013) claimed that “besides organizing files, researchers convert their files to appropriate text units (e.g., a word, a sentence, an entire story) for analysis either by hand or by computer. Materials must be easily located in large databases of text (or images)” (p. 182). I organized files by utilizing a variety of tools. I listened to the audio recordings and also reviewed notes from each interview to either correspond or disregard themes. Since I digitally recorded the interviews, I filed using a computer and also by hand. The interviews were unique in detail and were compared to each other. Accentuating common themes were useful findings for the purpose of this study. The thematic analysis sequence of data analysis was distinguished and illustrated when the interviews were conducted, completed, and the transcripts of the interviews were established.

I reviewed the audio recordings, notes, and transcripts of the interviews several times to assure the data was completely accurate. By conducting these practices, the data analysis is legitimate and accurate. Creswell (2013) explained that “the process of coding involves aggregating the text or visual data into small categories of information, seeking evidence for the code from different databases being used in a study, and then assigning a label to the code” (p. 184). By adapting this idea, the data was properly categorized. If coding is not properly detailed and broken down, then the analyzing process will be rather difficult, may be confusing, and possibly inaccurate.

According to Creswell (2013), “Themes in qualitative research (also called categories) are broad units of information that consist of several codes aggregated to form a common idea” (p. 186). By exploring the transcripts to find potential codes, this

supported themes that were generated. I created more than enough themes throughout repeated reviews of the transcripts and I reviewed them several times to help narrow down the amount of themes in the end. Exploring themes from the transcripts involved reviewing the transcripts several times to classify correctly and accurately. By applying this detail, new categories were found, removed, and changed.

My first step after completing the interviews matching audio recordings to the correct participants. I transcribed each interview completely before moving on to the next. I wanted to ensure data would not be misplaced with a different interview. Once the transcripts were completed from the audio recordings of the interviews, I carefully read through and highlighted what I found significant about the perspectives of clinical directors regarding decision making with family involvement at inpatient substance abuse treatment centers.

When exploring the transcripts initially, I took notes of what I found significant. My goal was to become as familiar with the data as possible. Maguire and Delahunt (2017) suggested that “the first step in any qualitative analysis is reading, and re-reading the transcripts” (p. 3355). Involving family members of clients in substance abuse treatment appeared broad and the intent of this study was to identify what clinical directors found relevant, if any, by utilizing families of clients in substance abuse treatment. I took notice to commonalities and distinct details when reviewing the data, which assisted in narrowing down the themes of relevance.

When conducting any research study, it should be obvious to any seasoned researcher to review his or her data repeatedly in order to assure valid results. Maguire

and Delahunt (2017) suggested that “you should be very familiar with your entire body of data or data corpus (i.e., all the interviews and any other data you may be using) before you go any further. At this stage, it is useful to make notes and jot down early impressions” (p. 3355). I reviewed the interviews more than once and read the transcripts several times to assure I was familiar with the material and gained an idea of how the analysis will be outlined.

After gaining familiarity with the data, I then created primary codes. Creswell (2013) stated that “the process of coding involves aggregating the text or visual data into small categories of information, seeking evidence for the code from different databases being used in the study, and then assigning a label to the code” (p. 184). The course of this process helped alleviate confusion and organization. Since each interview included an extensive transcript, the process of coding made searching for themes less complex.

According to Maguire and Delahunt (2017), “Coding reduces lots of data into small chunks of meaning. There are different ways to code and the method will be determined by your perspective and research questions” (p. 3355). By generating codes, the data collected from the interviews had more meaning and portrayed a clear idea of what themes were established. During the coding process, I changed the method used to code. This depended on the richness and length of information.

Maguire and Delahunt (2017) when referencing open coding stated “That means we did not have pre-set codes, but developed and modified the codes as we worked through the coding process” (p. 3355). Open coding appeared the most appealing due to the attribute of coding process changing appropriately to fit what I was looking for. I

believed by having the opportunity to not conform to codes set prior to the study, this allowed me to utilize more material to classify.

Since I was not aware in advance of what codes were found and represented, I was be open to the possibility of different ideas appearing. Creswell (2013) stated that "codes can represent information that researchers expect to find before the study, surprising information that researchers did not expect to find, and information that is conceptually interesting or unusual to researchers (and potentially participants and audiences)" (p. 186). I expected these aspects to be a possibility and planned to incorporate this information in the research.

My next step was to generate themes. Creswell (2013) suggested that categorization includes distinguishing five to seven universal themes. I generated more than the necessary amount of themes in the beginning of the analysis and narrowed the themes down to the suggested amount. According to Maguire and Delahunt (2017), "Most codes are associated with one theme although some, are associated with more than one" (p. 3356). With this in mind, I reviewed the themes and narrowed down the possibilities.

Noon (2018) reported that in order for a topic to become a theme, the standard was at least two participants discussed it. This concept made sense and this is how I executed my process of developing themes. The process was rigorous and needed repetition for accuracy. I chose themes based on the frequency of each participant. Once I generated initial codes and themes, I then interpreted the data gathered.

Ethical Considerations

Due to being the researcher for this study, I was mindful of the ethical considerations of the participants. I made sure safety was the priority of the participants, by avoiding or imposing risk. In regards to abiding by ethical standards, I did not begin any recruitment of participants until this study was approved by the Institutional Review Board (IRB). Once the study was completely approved by the IRB, I then acquired participants. As previously stated, I reviewed the consent form and the content of the study with each participant upon meeting for the interview.

All participants were provided a consent form prior to the study to read and sign. Smith et al. (2009) stated that a vital point to start any project is to avoid harm and it is important that you always assess whether talking about sensitive issues might constitute harm for any participants. The nature of this study did not impose any direct possibility of harm but there was a possibility of participants feeling vulnerable and uncomfortable.

The consent form provided familiarity to the participants about the purpose of the study, their role in the study, and any possible risks involved. The participants were informed of their right to leave the study at any time, without any repercussions, and their participation was absolutely voluntary. The participants were informed that there is no compensation by participating in this study. All participants were informed of any possible risks by partaking in the study.

The participants varied in emotions due to past encounters and experiences of their clients and their families. I led the interviews with the utmost empathy, especially since I could relate. If there was any time a participant appeared uncomfortable, I planned

to pause and ensure the participant was at ease and willing to continue the interview. Fortunately, the participants did not appear uncomfortable and did not report discomfort either. There may have been times throughout the interviews that participants did not share their personal perceptions so I kept the participants' identities anonymous. I informed the participants that their identities will be anonymous and assure them that I was the only individual listening to the audio recordings and transcribing.

Position of the Researcher

Due to some participants being past colleagues of mine, bias was a possibility to stem from my position as the researcher. Although I am friendly with these participants, therapy tactics were expected to be different than from one therapist to another, especially as a clinical director. Since the purpose of this study was to conclude the perspectives of clinical directors, I was mindful of not imposing my ideations on to the participants. By imposing or influencing the participants, the data I collected would not be valid and skew the actual information I was trying to conclude. In order to avoid this from happening, I only asked questions without providing any other information during the interviews.

I prepared as a researcher to obtain information from clinical directors that I was unaware of. Although all entities of the field have similar aspects, I was more interested in specifically what perspectives each participant provided regarding decision making of family involvement of clients at inpatient substance abuse treatment centers. I was also interested in what each participant found relevant, or possibly not relevant to family

involvement in substance abuse treatment. Some follow up questions were also asked which elicited more data from the participants.

CHAPTER IV: RESEARCH FINDINGS AND DISCUSSIONS

The results exhibited in this chapter are perspectives of clinical directors of inpatient substance abuse treatment centers and the decision making regarding family involvement with clients. Generic qualitative research was the methodology used for this study and thematic analysis was conducted in order to examine common categories of decision making of family involvement at inpatient substance abuse treatment centers. Interviews between the researcher and participants were utilized to obtain the desired data by audio recordings and later transcribed. The transcriptions were completed by using an application that transcribes while recording and the researcher manually transcribing by meticulously listening to the audio recordings of the interviews.

As Braun and Clarke (2006) suggested, I first became very familiar with the transcripts to obtain common themes. The themes I hypothesized prior to the interviews included family involvement decisions were not in control of the clinical directors, clinical directors believe family involvement importance, the health insurance policies dictate interventions appropriate to be utilized with clients, and family therapy evidence-based practices were not implemented into treatment. The participants ranged from the age 32 through 39. Two of the participants were Licensed Clinical Social Workers and both currently hold the position of clinical director of inpatient substance abuse treatment centers. The other participant was a Licensed Marriage and Family Therapist, who held the position of clinical director in the past. I initially intended to obtain data from up to five participants until saturation of data was reached. Saturation was met at three participants.

My intent of this study was to explore the treatment provided for clients at inpatient substance abuse treatment centers by interviewing clinical directors. The data provided rationale of what I wanted to confirm and exhibited the importance of family involvement. Braun and Clarke (2006) suggested that "what is important is that the theoretical framework and methods match what the researcher wants to know, and that they acknowledge these decisions, and recognize them as decisions" (p. 80). The themes and sub-themes extracted from the data are represented by tables of each participant corresponding with their descriptions.

Description of the Participants

The intent for up to five participants until saturation was reached. Saturation met at three participants. Participants were all Caucasian females, holding a position of clinical director, and were between 32 through 39 years old. The inclusion criteria requirements for participants were they were clinical directors of inpatient substance abuse treatment centers, had a minimum of 3 years experience working in the field of substance abuse, and there was family involvement with clients at their facilities.

Participant One: Sue

Sue held the role of clinical director of an inpatient substance abuse treatment center in the past. Sue has worked in the field of substance abuse for over three years and has worked in several facilities that work with clients and their families. Sue is a Licensed Marriage and Family Therapist, has obtained a CAP, and holds a Master's degree and a Doctorate in Marriage and Family Therapy.

Table 1

Emerging Themes and Descriptive Statements: Sue

Themes	**Sub-Themes**	**Descriptive Statements**
Importance of Family Involvement	Family Therapy Programs	"I think it's necessary because it's not just the addict that's impacted by their actions and the things that they do when they're using." "A lot of it has to do with family dynamics, and roles that either allows the addict to continue using, or are reasons why they use in the first place."
Factors Related to Choice of Model	Fit With Clients Health Insurance Requirements Owner's Preference	"I was more interested in how they were meeting their clients and how whatever approach they're using, fit or didn't fit with the clients." "We would just craft our notes to meet insurance needs." "As a family therapist, not really the same ideas, but same essential concepts throughout both practices, which seemed to work out fine." "Well, as far as insurance is concerned, they want evidence based." "Yeah, there's a there's a lot of decisions that are made administratively that are based on money. Essentially, it's a business I guess." "It was more the owners telling me what to do and to make up their minds what our therapists do."
Evidence-Based Models Preferred	Psychoeducational Strengths Based/ Solution-Focused Structural	"I was not able to use any family therapy models per se."

Participant Two: Rebecca

Rebecca currently holds the position of clinical director at an inpatient substance abuse treatment center that involves families. Rebecca has worked in the field of substance abuse for over six years and has worked with families of clients in several facilities. Rebecca is a Licensed Clinical Social Worker and holds a Master's degree in Social Work.

Table 2

Emerging Themes and Descriptive Statements: Rebecca

Themes	Sub-Themes	Descriptive Statements
Importance of Family Involvement	Family Therapy Programs	"My stance is families are essential to treating clients with substance use disorders." "Family engagement, family involvement is essential, and keeping clients involved in treatment. And helping to resolve some of their core issues related to their family." "My company has a family support phone line that families can call in, which is essentially like a phone call Al-Anon meeting where they can speak with a therapist."
Factors Related to Choice of Model	Fit With Clients Health Insurance Requirements Owner's Preference	"There is a level of, you know, independence in regards to what the client is looking for." "The client and their families make a lot of decisions." "Depending on the clients treatment plan, and really where they're at, we make decisions collaboratively as a team regarding implementing." "There are other things that we do take into consideration when we're formulating a treatment plan. Of course, insurance." "So for example, if a client is coming to our facility for insurance, and they do not have, you know, benefits for residential level of care, unless they're medically compromised in some way, shape, or form, then we would send them to our PHP level of care for reimbursement reasons. But obviously, that's a reality of any business."
Evidence-Based Models Preferred	Psychoeducational Strengths Based/ Solution-Focused Structural	"So primarily we're providing families with psycho education. We're providing them with support along the lines of like an Al-Anon type of affiliation." "We provide family members about the treatment process, almost like what to expect when your loved one is in treatment type of deal. We primarily focus on psychoeducation, support, setting boundaries, etc." "In our PHP level of care, we have a family program, which is a lot of like cognitive behavioral solution focused."

Participant Three: Jennifer

Jennifer is currently a clinical director at an inpatient substance abuse treatment center. Jennifer has worked in the substance abuse field for over three years and works with families of clients regularly. Jennifer is a licensed Clinical Social Worker and holds a Master's degree in Social Work.

Table 3

Emerging Themes and Descriptive Statements: Jennifer

Themes	**Sub-Themes**	**Descriptive Statements**
Importance of Family Involvement	Family Therapy Programs	"Obviously we really do want family involvement, especially for clients who are struggling with physical addiction or mental health because, you know, important counseling is involved." "When I was at the PHP program, we had a weekend where it was like a whole weekend, once a month for the families come out, and do like this intensive work with a client. We have an outside contractor, who I believe is a LMFT and she does some really good experiential interventions with the families. It's really intense. It's really good." "However, not all family involvement is a positive support with being in active addiction themselves."
Factors Related to Choice of Model	Fit With Clients Health Insurance Requirements Owner's Preference	"Person Centered, like experiential person centered that is how a client receives therapy." "Assess the situation, where the clients are at." "The insurance companies know what works. Getting them on board, learning about boundaries, and educating them on the disease of addiction. Also, setting up aftercare, it will be more, possibly successful." "Also, once they have completed detox level of care, usually, the insurance companies are looking for, family involvement, or their aftercare plans, and if they are going home." "In regards to Structural Therapy decided as a model we use, I would say it was integrated through clinical research, insurance, and just the clinical department overall. The COO also probably played a large part in that because her background is

		clinical."
Evidence-Based Models Preferred	Psychoeducational Strengths Based/ Solution-Focused Structural	"We do just basic psychoeducation, educating families." "I think the main one that we have been promoting is family Structure therapy, is that Structural? I think that's what it is, the Structural one." "More or less role plays, CBT, and Motivational Interviewing."

Essential Themes

The essential themes derived from this study were established by becoming familiar with the data. The data consisted of audio recordings from interviews and were later transcribed. After the recordings were transcribed, common themes were highlighted. Braun and Clarke (2006) proposed that "a theme captures something important about the data in relation to the research question, and represents some level of patterned response or meaning within the data set" (p. 82). This idea especially applies to the themes established in this study due to the participants sharing very common perspectives among each other. Questions were answered regarding the importance of family involvement at inpatient substance abuse treatment centers, factors related to the choice of models utilized, and the evidence-based models preferred. The main themes and sub-themes will be exhibited.

Table 4

Essential Themes and Sub-Themes

Essential Themes	**Sub-Themes**
Importance of Family Involvement	Family Therapy Programs
Factors Related to Choice of Model	Fit With Clients Health Insurance Requirements Owner's Preference
Evidence-Based Models Preferred	Psychoeducational Strengths Based/ Solution-Focused Structural

Importance of Family Involvement

Family involvement with clients struggling with substance abuse was reported by all of the participants that it is essential. Only one of the participants is a practicing Marriage and Family Therapist, while the other two participants are Social Workers, yet all participants reported high importance of family involvement to the question, “How and to what extent do you involve families in treatment?”

Two of the participants reported family programs at their treatment center to assist with involving families of the clients, while the other participant reported the facility she practiced did not provide a family program catered to working with families and the clients. The perspectives of all the participants exhibited clients affected by their families, which included parents abusing substances themselves, retaining clients in treatment, and the roles within the family system being affected by the client's lifestyle.

Factors Related to Choice of Model

All the participants reported varied entities influencing the models chosen for clients at their inpatient substance abuse centers. This question inquired, “What models of family therapy do you promote or support at your treatment center?” Another question

related to this question was “How and why are these treatment decisions made?” There were three sub-themes within this main theme. Participants reported best fit for the client, health insurance requirements, and preferences of the owners to be factors that influence the models chosen at their facilities.

The participants reported the treatment accommodated each client individually, which means clients are provided with individualized treatment plan catered to their specific needs. Clients are varied regarding their treatment needs and the treatment individualized depends on several factors that the participants discussed. The participants reported clients deal with mental health issues, trauma, and other external factors besides the actual substance abuse.

A common factor the participants reported was health insurance requirements when asked about any family therapy approaches utilized at their treatment centers. All of the participants reported health insurance requirements include specific interventions to be utilized in order to be reimbursed. One participant discussed the health insurance companies conduct research and base their requirements only on that. A participant reported her treatment center will sacrifice payment from health insurance if they believe the client needs do not match what the health insurance requires.

One participant specifically reported she was directed to utilize interventions or models according to the owner's preference at her facility. The same participant added the requirement may have been directed by other external entities that she was unaware.

Evidence-Based Models Preferred

The participants other than the Marriage and Family Therapist reported they were able to implement family therapy based approaches at their facilities. The Marriage and Family Therapist reported there were not any Family Therapy models she was able to implement into the program due to not having the families involved. This ties into the theme of Factors Related to the Choice of Model. The Marriage and Family Therapist did report she was to direct her staff to utilize evidence-based approaches that was required by health insurance. All participants reported they were not the ones who made the decisions of which evidence-based models were utilized at their facility. Every participant reported insurance makes decisions regarding what interventions are to be used with clients for reimbursement reasons. Additionally, two participants reported the owners make many decisions regarding evidence-based approaches. There were also three sub-themes within this theme, that included psychoeducation, Strengths Based/ Solution-Focused, and Structural Approaches.

Two of the participants reported psychoeducation was provided for families of the clients more than anything else. The participants believed psychoeducation alongside behavioral therapy was important for families due to unawareness of their loved one's substance abuse, along with behaviors to learn about and how to prepare for successful recovery. One participant discussed a phone line family members can call to inquire about their loved ones in treatment, support like Al-Anon, and education of what to expect.

One participant discussed Strengths Based and another participant reported Solution-Focused was utilized at their treatment centers. According to Gladding (1995), Solution-Focused therapy targets behavioral patterns that are nonproductive and repetitive, breaking those patterns, and implementing positive views for families towards negative situations, and doing things differently (p. 242). This approach coincides with Strengths Based, which Patterson, Williams, Edwards, Chamow, and Grauf-Grounds (2009) described as "Identifying family strengths gives the therapist and family an opportunity to discover, or rediscover, positive qualities about individuals within the family and the family as a whole" (p. 121).

One participant reported the therapists at her treatment center utilize Structural Therapy with their clients. The participant struggled to remember the name of the approach initially. Gladding (1995) described that the Structural Therapy approach "emphasizes the family as a whole, as well as the interactions between subunits of family members" (p. 203). As previously discussed in Chapter II, the Structural-Strategic approach is a derivative of Structural Therapy.

Participants were contacted after the interviews for follow up questions to answers they provided. When Rebecca was asked, "What is your personal definition of Solution-Focused Brief Therapy," she stated "Rather than processing past events, identifying a current/present problem and implementing a tangible solution." Jennifer was asked "What is your personal definition of Structural Therapy" and replied "It addresses the functioning within the family and focuses on creating structure. Structural

interrupts dysfunction and then balances the relationships in the family system." The participants appeared to be aware of the basic concepts of these family therapy models.

Table 5

Universally, Partially, and Unique Shared Themes Among Participants

	Sue	Rebecca	Jennifer
Importance of Family Involvement	X	X	X
Family Therapy Programs		X	X
Factors Related to Choice of Model	X	X	X
Fit with Client	X	X	X
Health Insurance Requirements	X	X	X
Owner's Preference	X		X
Evidence-Based Models Preferred		X	X
Psychoeducational		X	X
Solution-Focused/Strength Based		X	X
Structural Therapy			X

Evaluation Criteria

A qualitative study is deemed accurate when the research is trustworthy. Lincoln (1995) suggested a trustworthy study requires the qualities of "credibility, transferability, dependability, and confirmability" (p. 277). Reliability is not necessary when collecting data for a generic qualitative research study due to the data sometimes is not able to be quantified (Percy, 2015, p. 79).

Credibility was achieved by the researcher spending sufficient time with the participants, not rushing the participants, and not implementing any bias or leading questions. The participants included colleagues of mine from the past, as well as referrals by other colleagues. The researcher continued to recruit participants until saturation was reached. Saturation was reached at three participants due to common themes discovered. I

reviewed the informed consent with the participants, so I felt assured that they understood the study.

I assured transferability was reached by utilizing purposeful sampling of clinical directors of inpatient substance abuse treatment centers that involve families in the client's treatment. The data received from the interviews of the participants was unedited and exhibited as the participants answered. Participants provided their perspectives about family involvement, decision making of treatment for clients, and models and approaches utilized at their facilities.

Dependability was reached in this study by the researcher assuring another researcher would be able to conduct the same study by following this study. Shenton (2004) suggested that "if the work were repeated, in the same context, with the same methods and with the same participants, similar results would be obtained (p. 71)."

The confirmability of this study was achieved by providing unedited statements from the participants and I did not allow my biases to control or corrupt the data. According to Shenton (2004), confirmability is identified when the data is provided by the participants in relation to their perspectives, not the qualities or preferences of the researcher.

Summary

The conclusion of themes discussed in this chapter were very similar among the participants. It appears the data provided by the participants is valid since all the participants did not know each other, worked at different substance abuse treatment centers, and were interviewed at different locations and times. The data revealed themes

of the importance of family involvement, factors related to the choices of models utilized, and evidence-based approaches preferred at the inpatient substance abuse centers of these participants. Participants provided narratives of their perspectives and experiences as clinical directors.

This study was conducted to obtain what, if any, family therapy approaches are utilized or evidence-based practices with families of clients at inpatient substance abuse treatment centers. Themes that were highlighted exhibit clinical directors believe family involvement is important, clinical directors are not the primary decision makers regarding treatment of clients, and there are not a variety of family therapy models being implemented. All the participants reported therapy models and interventions are dictated by health insurance requirements and clinical decision making occurs external of documentation in charts of the clients. When substance abuse treatment centers do not staff enough therapists to provide services for clients, family therapy also becomes limited. Although all the participants discussed the importance of family involvement, only Rebecca and Jennifer had family programs at their treatment centers. The literature in Chapter II provided research supporting the influence of family systems on individuals, whether the influence is the initiation of substance abuse or is a positive influence.

A priority the participants discussed was what treatment plan fits best with each individual client. The evidence-based family therapy approaches reviewed in Chapter II were not part of treatment for any of the participants. MDFT, MST, BSFT, and Structural-Strategic Therapy was not utilized at the inpatient substance abuse treatment

centers the participants referenced. The participants also discussed their treatment centers provide psychoeducation to the families. Psychoeducation is relevant due to many families unaware of treatment process and education of addiction. Psychoeducation provides

Based on the data provided by the participants in this study, the themes support how decision making occurs regarding family involvement at inpatient substance abuse centers. The participants reported decision making includes entities such as the owner's of the treatment centers and health insurance requirements. If clinical directors are aware of the importance of family involvement, it is most likely others working in the field believe the same. The concern is the professionals who work directly with the clients are not the primary decision makers of models utilized at inpatient substance abuse treatment centers.

CHAPTER V: DISCUSSION AND IMPLICATIONS OF THE STUDY

In this chapter, themes that were discovered throughout the data will be supported by the literature reviewed in Chapter II. This chapter entails my discussion of conclusions based on the results of this study. I will also discuss the limitations of this study, my personal reflections, suggest future research, and suggest implications for the fields of substance abuse and Marriage and Family Therapy. As I discussed in Chapter II, the literature regarding perspectives of clinical directors of substance abuse treatment center clients and their families is nonexistent. My assumption is, by gathering perceptions of experts in the field, we will have a better understanding of common patterns through experience that are significant to evaluate.

Comparative Data Review

Importance of Family Involvement

All of the participants in this study reported family involvement is essential for clients at inpatient substance abuse treatment centers. The literature reviewed in Chapter II exhibited the importance of family involvement with clients in substance abuse treatment. The participants in this study, who were clinical directors of substance abuse treatment centers, provided their perspectives of why they believe family involvement with this population is essential.

Participant one was Sue, who stated, “A lot of it has to do with family dynamics, and roles that either allows the addict to continue using, or are reasons why they use in the first place.” Not only does past research support this, but I have also observed this pattern or cycle with clients and their families in substance abuse treatment. Stanton

(1997) called this the ʻfamily addiction cycleʼ and described this as abusing drugs is one occurrence within a sequence of behaviors, which is a response to the behaviors of others. Rebecca participant two stated, “Family engagement, family involvement is essential, and keeping clients involved in treatment. And helping to resolve some of their core issues related to their family.” Families usually are the ones who push clients into treatment, are contacted when their loved wants to leave treatment prematurely to completion and sometimes are able to retain clients in treatment.

Participant three, Jennifer, discussed a factor of family involvement the other participants did not discuss. Jennifer stated, “However, not all family involvement is a positive support with being in active addiction themselves.” Research supports this as being a high risk factor for adolescents abusing substances in the future. Gorski (1996) pointed out risk factors include parent substance abuse, negative family structure and few limited support systems.

Sue reported her treatment center did not include family therapy programs that include the family and client. Rebecca and Jennifer reported their treatment centers provided family therapy programs. These programs typically consist of families of clients visiting in person and participating in therapy with their loved ones. Some substance abuse treatment centers have a weekend dedicated to conducting these events.

Factors Related to Choice of Model

A common theme among the participants was the factors related to the choice of models used at their treatment centers. Participants discussed this when asked the question “How and why are these treatment decisions made?” All of the participants

shared different factors that influenced the treatment they provide for their clients. The sub-themes are fit with client, health insurance requirements, and owner's preference.

Every participant discussed clients receiving treatment that was the right fit for them. Sue discussed this: “I was more interested in how they were meeting their clients and how whatever approach they're using, fit or didn't fit with the clients.” Although the treatment provided at substance abuse facilities are usually the same among different businesses but each client receives individual treatment from their primary therapist, which is specifically catered to his/her needs. Rebecca stated, “There is a level of, you know, independence in regards to what the client is looking for.” Since addiction is not one size fits all, this appears to be appropriate. Clients have experienced other factors that influence their addiction, such as trauma (sexual, physical, verbal, and emotional abuse), PTSD from the trauma, mental health diagnoses, homelessness, family members actively using, and legal issues. A therapist will accommodate each client appropriately based on what the client reports. Jennifer discussed, “Assess the situation, where the clients are at.” Most clients remain at inpatient treatment centers for approximately thirty days, which does not allocate for much intense treatment. It is important to assess each client and address his/her specific needs.

Another common sub-theme the participants discussed was health insurance requirements being a factor that influence what interventions and models are used in treatment at inpatient substance abuse centers. Sue reported “Well, as far as insurance is concerned, they want evidence based,” which ties the question of what models are preferred and who makes the decisions about treatment. Rebecca stated, “There are other

things that we do take into consideration when we're formulating a treatment plan. Of course, insurance." Respectably, some health insurance companies do conduct research regarding evidence-based practices but the struggle appears when a specific approach would benefit the client and is not accepted by health insurance companies.

Jennifer stated that "also, once they have completed detox level of care, usually, the insurance companies are looking for, family involvement, or their aftercare plans, and if they are going home." This is another aspect I have experienced an abundance of times working at inpatient substance abuse treatment centers. Many health insurance case managers request the aftercare plans and sometimes even dictate what they will accept. Overall, health insurance requirements are reasonable but there is not much family therapy based models they encourage therapists to use. Stanton (1997) explained that there were studies that compared family therapist approaches to nonfamily approaches, which concluded the nonfamily conditions had higher rates of dropping out.

Sue and Jennifer reported the owners of their treatment centers had involvement in choosing models for treating clients and families. Sue stated "It was more the owners telling me what to do and to make up their minds what our therapists do." Sue informed me outside of the interview that the owner of the treatment center she worked at did not have training or an education in any mental health entity so this interesting. Sue also reported health insurance or another external pressures could be involved that she was not aware of and the owner was following that other factor. Jennifer explained "The COO also probably played a large part in that because her background is clinical." This makes sense due to the owner's familiarity of family therapy based approaches.

Evidence-Based Models Preferred

All the participants discussed evidence-based models of preference at their treatment centers, regardless of where the decision making originated from. Participants elaborated on this aspect of the interview when asked, “What models of family therapy do you promote or support at your treatment center?” Within this theme, sub-themes of Psychoeducational, Strengths Based/ Solution-Focused, and Structural models were established. Sue did not discuss psychoeducation provided for families of clients at the treatment center she worked at. Rebecca reported “We provide family members about the treatment process, almost like what to expect when your loved one is in treatment type of deal. We primarily focus on psychoeducation, support, setting boundaries, etc.” Many families of clients are unaware of the extent of their loved one's addiction. The last treatment center I worked, we were required to contact the families within twenty-four hours and provide them with a psychoeducation packet to assist with exactly what Rebecca was speaking about.

Jennifer stated “We do just basic psychoeducation, educating families.” Although Jennifer and Rebecca discussed family weekends, usually the family programs are in person and provide intense therapy. Psychoeducation is the bare minimum to supply to family members. Center for Substance Abuse Treatment (2004) said inpatient substance abuse treatment was “Limited to psychoeducation to teach the family about substance abuse, related behaviors, and the behavioral, medical, and psychological consequences of use” (p. 6).

Strengths Based/ Solution-Focused was another sub-theme established within the evidence-based models preferred theme. Only Rebecca mentioned Solution-Focused Therapy and stated “In our PHP level of care, we have a family program, which is a lot of like Cognitive Behavioral and Solution-Focused.” I am surprised Solution-Focused Brief Therapy was not discussed due to the similarity to Motivational Interviewing, which was utilized at the last treatment center I was employed. Also aspects of Solution-Focused Brief Therapy were options to use in our notes such as the miracle question or scaling questions. Jennifer discussed “More or less role plays, CBT, and Motivational Interviewing.” Motivational Interviewing is considered Strength-Based due to the client exploring and achieving inner strength. Rollnick and Miller (1995) describe Motivational Interviewing as “It is guided by the notion that motivation to change should not be imposed from without, in the form of counselor arguments for change, but elicited from within the client” (p. 105).

Only Jennifer discussed Structural Therapy as a preferred model to use at her treatment center and stated “In regards to Structural Therapy deciding a model we use, I would say it was integrated through clinical research, insurance, and just the clinical department overall.” Although this may be the evidence-based model preferred, Jennifer did not sound as if she was familiar with the characteristics of the model and what it entails due to even unsure of the name of the model. It may be appropriate if Structural Therapy pertains specifically to the LMFT who conducts the family program or the primary therapists who use this with the clients.

Conflict of Models

The participants were contacted after the interviews were conducted for another follow up question, “If any, how have you handled conflict with being told by owners or insurance what models to use?” Sue stated “the conflict was not so bad regarding models because many times, it was about the client's goals being accomplished. What bothered me was not being able to document if the client was making significant progress in their treatment because if you document that the client is improving, the insurance does not pay for the client to remain in treatment. To them, it means the client no longer needs treatment since they are making progress.”

Rebecca responded, “The owners have never dictated treatment to me. Insurance companies often make recommendations and we try our best to accommodate. They might request Medication-Assisted Treatment (MAT), which we don't provide but will try to get the client to agree to Vivatrol or Naltrexone after treatment.” To clarify, Johnson (2007) explained that “Vivitrex®/Vivitrol® and Naltrel® are injectable naltrexone depot formulations that have been tested as possible medications for treating alcohol dependence.” When Jennifer was asked the same question, she replied that “We haven't had much conflict to deal with, but when we do, we usually ensure we document to explain our reasoning for including the family and/or NOT including the family like if it's not appropriate to include the husband of one of our clients, we need to ensure we document and explain why so other people looking into the case can conceptualize why or why not we chose to do what we did.”

When I searched for literature about conflicts of models with owners or insurance, there were no conclusive results. The lack of literature on this specific topic may not exist due to substance abuse treatment centers are more popular and the demand has increased significantly. My perception was the participants who are Social Workers did not appear as conflicted as the participant who is a Marriage and Family Therapist.

Limitations of the Study

Although the perspectives of clinical directors were obtained, there are still several aspects to question related to family therapy and substance abuse that indicate the limits of this study. One of the most obvious limitations is that this study took place in a very specific region in South Florida, and even though the themes and sub-themes discovered through the study are valid, they cannot be extrapolated to a nationwide population. I would be interested in exploring decision making of family involvement throughout the country at inpatient substance abuse treatment centers. Since I worked at inpatient treatment centers in New York and Florida, I observed many differences in how family therapy was included and how often the family was involved in treatment. I think family involvement is difficult to obtain many times due to family members residing in different states while the sessions occur via phone calls. Many treatment centers are limited by the quantity of therapists as well. These are factors that could be explored more in future studies.

Another limitation may be non Marriage and Family Therapists may not be as familiar with family therapy based approaches. When I questioned Jennifer about specific models used at her treatment center, she had difficulty remembering Structural Therapy

was a model they used. I contacted Jennifer after the interview to follow up and inquire about her meaning of Structural Therapy and was aware of some characteristics.

Limitations to this study also included the demographics of participants and lack of previous research to support aspects of this study. The participants were all female, between the ages of 32 and 39, all Caucasian, and work in South Florida. Exclusion criteria were not necessary for participants in this study. However, the data may have been different if there were more variation among participants. In regards to my experiences working in the field of substance abuse, these demographics match the majority of clinical directors in South Florida.

I spent significant time searching for research and in my exploration, there seems to be a lack of research on conflicts of models, insurance reimbursement requirements for substance abuse treatment centers, demographics or culture of clinical directors, and evidence-based family therapy models utilized at inpatient substance abuse treatment centers. This study is the only research I found conducted on perspectives of clinical directors of inpatient substance abuse treatment centers. Actually, I could not locate any research on clinical directors in general.

Personal Reflections

Many of the themes concluded ideas I hypothesized prior to the study but there were also themes that I did not expect to find as well. Since I have worked in the substance abuse field for many years and have experienced substance abuse personally with family, I was confident many themes would surface. I was aware family therapy models are not required by health insurance and family involvement does not occur as

much as it should. I learned an abundance of information that I was unaware of prior to conducting this study. Some major factors I learned from this study include what models are utilized with families of clients from various substance abuse treatment centers. I was actually surprised Solution-Focused Therapy and Structural Therapy were reported to be used. When I went reconnected with the participants to inquire about their personal meanings of family therapy approaches and conflict of models with health insurance or owners, I was actually surprised the participants did not report conflict with factors that decide on utilizing those models. I also learned that owners of treatment centers make decisions regarding models preferred. The most surprisingly aspect I did not expect to learn was the lack of extensive literature and lack of research on clinical directors, health insurance reimbursement requirements, and evidence-based family therapy approaches.

As previously mentioned, I have worked professionally with some of the participants in the past. When I worked with these participants, they were primary therapists and not clinical directors at the time. The experience of interviewing these specific participants was casual due to our mutual understanding of working with clients and their families at inpatient substance abuse treatment centers. I did also recognize my personal perspective as an outsider and conducted the interviews appropriately by curiously inquiring about the position of clinical director since I have not held the position. I recognized these perspectives and assured to not allow bias influence the data provided by the participants.

The literature provided in Chapter I and II regarding evidence-based approaches and prevention programs exhibit positive results, yet it appears they are underused. I was

unaware of the excessive prevention programs available to parents and children until I conducted research for this study. Lochman and Van den Steenhoven (2002) suggested that in order to improve research on prevention, we need a better understanding of aspects that assist with retaining and recruiting families and high risk children in these preventative interventions. I am curious why these prevention programs are not mandatory since addiction has become an overwhelming epidemic in our society. The result of addiction may possibly be avoided if parents and children are willing to become involved in any, if not all resources available to avoid the devastation of addiction. Although utilizing resources may not completely guarantee the absolute prevention of substance abuse, utilizing the resources do not consist of risk, where not utilizing the resources may increase the risk factor of addiction.

It appears mental health disorders have severely increased with this population and the lack of healthy coping mechanisms are not common. Many individuals are prescribed narcotic psychotropic medications, which can be abused and addictive. The option for non-habit forming psychotropic medications are available and if these are prescribed instead, we may reduce the risk substance abuse being initiating.

Implications for Future Research

The goal of this study was to gain further insight of family involvement of inpatient substance abuse treatment centers from the perspectives of clinical directors. Those goals were obtained, however, there are many aspects still unanswered and this study could be the foundation for future research regarding evidence-based practices implemented into inpatient substance abuse treatment. Further research should be

conducted that could promote family involvement at the initiation of addiction in order to prevent future relapse. This may increase awareness of detailed factors that can be implemented into the family system to prevent the use of substances and also inform them about the detriments of addiction.

Family Therapy appears to be more acceptable with society, which provides more aspects to be studied. The foundations of Family Therapy have expanded with new approaches based on the current issues facing society. Robbins et al. (2009) explained that "thus, effectiveness research on family therapy is still in its infancy, and more studies are needed to examine the feasibility, acceptability, and effectiveness of family interventions in community settings" (p. 270). Although the field of Family Therapy has been established for almost a century, many are still unaware of the evidence-based family therapy approaches or have implemented these into therapeutic programming.

An aspect to explore in the future would be to question what models and interventions clinical directors would choose to use if health insurance did not have limitations. I believe clinical directors would still choose evidence-based models and I would like to believe they would also want to include family therapy based models. Since clinical directors and therapists work clinically with clients, there is an abundance of risk factors and Family Therapy can help. Every study elicits new idea and questions. This study created many ideas and questions, which will be more appropriate for future studies. This study focused on the perspectives of clinical directors at inpatient substance abuse treatment centers regarding decision making of family involvement. Future

research could focus on the themes discovered in this study and increase attention to the areas that are severely lacking in research.

Implications for the Field of Marriage and Family Therapy

By detailing individual's experiences and the themes and subthemes that arose, this dissertation will be able to serve Marriage and Family Therapists who are interested in working at inpatient substance abuse treatment centers. This may be able to increase awareness of how limited the use of family therapy approaches are in the field of substance abuse and especially since the abundance of research supports families are the major entity that influences substance abuse within the adolescent population.

Through interviews of clinical directors at inpatient substance abuse treatment centers, three themes were discovered with several sub-themes. Participants provided the data based on first hand experiences as holding the position of clinical director. The thematic analysis conducted was able to highlight the factors that are concerned with decision making of family involvement with substance abuse clients. Although the participants all discussed evidence-based models are preferred by health insurance for reimbursement, there was no mention of evidence-based family therapy approaches, specifically the approaches reviewed in Chapter II.

I have utilized some family therapy approaches when I had the opportunity to conduct a family session in person and those families reported some sort of change that was initiated after that session. This study focuses on the perspectives of clinical directors, who were not all Marriage and Family Therapists but were still aware of family therapy approaches. Although the field of substance abuse was the population of this

study's focus, these ideas can be applied to other specialties since family involvement may be helpful with other identified issues.

This study introduced many unique factors that lead to possible studies in the future to be conducted. A variable to consider for the Marriage and Family Therapy field are the approaches we are educated and trained on. Considering substance abuse continues to increase in individuals affected by the issue, Marriage and Family Therapists should also be educated on the approaches that are utilized at inpatient substance abuse treatment centers, as discovered by themes from the data in this study.

Psychoeducation provided for families of clients at inpatient substance abuse treatment centers tends to be learned as you continue working and there is no formal training. There is no formal training on psychoeducation and how to execute it. Psychoeducation presents the opportunity to introduce supplemental training to family therapy approaches so a therapist attempting to obtain employment in substance abuse will be knowledgeable in other approaches besides family therapy models. Other approaches used frequently in the substance abuse field should also be implemented like Motivational Interviewing and training on substance abuse documentation, considering the language and interventions required by health insurance carriers are vital.

The implementation of education and training external to Marriage and Family Therapy is important for several reasons. One reason this is essential is for lack of background and experience when attempting to obtain a position at a substance abuse treatment center. An applicant who is familiar with substance abuse interventions will more likely be hired as opposed to an individual who is only aware of marriage and

family therapy models. Another reason this should be considered is for funding. Insurance is a major factor when individuals seek therapy. Most therapists or treatment facilities accept insurance due to many individuals not able to afford out of pocket expenses to pay for therapy.

Unique Conclusions

This study provides several unique characteristics. There is an extensive deficit of research and studies that focuses on many factors discussed in this chapter. This is the first study, to my knowledge, that extracts data from clinical directors through interviews. Not only is there a lack of research on clinical directors specifically of inpatient substance abuse centers, there is a lack of research on clinical directors at all. Although clinical directors are the sample purposefully selected for this study, similar data may be provided by individuals in other positions.

The literature on evidence-based family therapy approaches provides a plethora of research but lack of literature on these evidence-based family therapy approaches implemented into inpatient substance abuse treatment existed in my research attempts. There is plenty of research supporting evidence-based family therapy approaches exhibiting positive results, yet they are not utilized. Another unique finding when conducting this study was a lack of literature exists regarding health insurance reimbursement requirements. There is the possibility health insurance requirements for funding may be a new concern or not an issue of studies in need of the information.

A very unique and exceptional factor of this study is the utilization of the software application Otter.ai. This study is the first study to conducted using Otter.ai to transcribe

the verbal interviews live. There is no prior research or study I found that has used Otter.ai as a tool to transcribe an interview while it is actively happening. The hope is these unique factors can guide future research in a new direction and build on the research that is severely lacking or nonexistent.

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Appendices

Appendix: A

General Informed Consent Form

NSU Consent to be in a Research Study Entitled

Perspectives of Inpatient Substance Abuse Facility Clinical Directors on Decision Making Regarding Family Involvement in Treatment

IRB #: 2019-361-Non-NSU

Who is doing this research study?

College: Nova Southeastern University College of Arts, Humanities, & Social Sciences

Principal Investigator: Lauren A. Serdencuk, MS

Faculty Advisor/Dissertation Chair: Anne Rambo, Ph.D.

Site Information: Various locations that provide privacy.

Funding: Unfunded

What is this study about?

This is a research study, designed to test and create new ideas that other people can use. The purpose of this study is explore the perspectives of inpatient substance abuse treatment center clinical directors about involving families in treatment. The interview data will be collected anonymously and explored for themes.

Why are you asking me to be in this research study?

You are being asked to be in this research study because you are a clinical director currently working with clients at an inpatient substance abuse treatment center or have in the past.

This study will include up to five people. It is expected that only 1 person will be from each location.

What will I be doing if I agree to be in this research study?

While you are taking part in this research study, it involves one session that will approximately be thirty to sixty minutes.

Research Study Procedures - as a participant, this is what you will be doing:

You will be interviewed in a private setting once, unless interview is not recorded properly. The interview will last between thirty to sixty minutes. Participants will be

invited through colleagues and referrals of researcher. The researcher will confirm all participants have held or currently hold the position of clinical director in substance abuse treatment centers. Once participants agree to be in this study, appointments will be scheduled to meet for the interview. I will be interviewing participants about their clinical director position in substance abuse treatment centers. The interviews will be audio recorded and later transcribed by the researcher. No identifying information of participants will be discussed (name, address, date of birth, etc.) during the audio recordings to assist in confidentiality.

Are there possible risks and discomforts to me?

This research study involves minimal risk to you. To the best of my knowledge, the questions you will be answering have no more risk of harm than you would have in everyday life. Your participation does not ensue risk to you or any aspect of your lifestyle.

You may find some questions I ask you (or some things I ask you to do) to be difficult or stressful. If so, we can refer you to someone who may be able to help you with these feelings.

What happens if I do not want to be in this research study?

You have the right to leave this research study at any time or refuse to be in it. If you decide to leave or you do not want to be in the study anymore, you will not get any penalty or lose any services you have a right to get. If you choose to stop being in the study before it is over, any information about you that was collected **before** the date you leave the study will be kept in the research records for 36 months from the end of the study and may be used as a part of the research.

What if there is new information learned during the study that may affect my decision to remain in the study?

If significant new information relating to the study becomes available, which may relate to whether you want to remain in this study, this information will be given to you by the investigators. You may be asked to sign a new Informed Consent Form, if the information is given to you after you have joined the study.

Are there any benefits for taking part in this research study?

There are no direct benefits from being in this research study. We hope the information learned from this study will gain perceptions of clinical directors regarding families of clients in substance abuse treatment centers.

Will I be paid or be given compensation for being in the study?

You will not be given any payments or compensation for being in this research study.

Will it cost me anything?

There are no costs to you for being in this research study.

Ask the researchers if you have any questions about what it will cost you to take part in this research study (for example bills, fees, or other costs related to the research).

How will you keep my information private?

Information we learn about you in this research study will be handled in a confidential manner, within the limits of the law and will be limited to people who have a need to review this information. Your name will be changed to protect privacy. This data will be available to the researcher, the Institutional Review Board and other representatives of this institution, and any regulatory and granting agencies (if applicable). If we publish the results of the study in a scientific journal or book, we will not identify you. All confidential data will be kept securely in a locked filing cabinet. All data will be kept for 36 months from the end of the study and destroyed after that time by shredding.

Will there be any Audio or Video Recording?

This research study involves audio recording. This recording will be available to the researcher, the Institutional Review Board and other representatives of this institution. The recording will be kept, stored, and destroyed as stated in the section above. Because what is in the recording could be used to find out that it is you, it is not possible to be sure that the recording will always be kept confidential. The researcher will try to keep anyone not working on the research from listening to or viewing the recording.

Whom can I contact if I have questions, concerns, comments, or complaints?

If you have questions now, feel free to ask us. If you have more questions about the research, your research rights, or have a research-related injury, please contact:

Primary contact:
Lauren A. Serdencuk can be reached at 917-902-5684.

If primary is not available, contact:
Anne Rambo, Ph.D. can be reached at 954-262-3002

Research Participants Rights
For questions/concerns regarding your research rights, please contact:
Institutional Review Board
Nova Southeastern University
(954) 262-5369 / Toll Free: 1-866-499-0790
IRB@nova.edu

You may also visit the NSU IRB website at www.nova.edu/irb/information-for-research-participants for further information regarding your rights as a research participant.

Research Consent & Authorization Signature Section

Voluntary Participation - You are not required to participate in this study. In the event you do participate, you may leave this research study at any time. If you leave this research study before it is completed, there will be no penalty to you, and you will not lose any benefits to which you are entitled.

If you agree to participate in this research study, sign this section. You will be given a signed copy of this form to keep. You do not waive any of your legal rights by signing this form.

SIGN THIS FORM ONLY IF THE STATEMENTS LISTED BELOW ARE TRUE:

- You have read the above information.
- Your questions have been answered to your satisfaction about the research.

Adult Signature Section

I have voluntarily decided to take part in this research study.

Printed Name of Participant	Signature of Participant	Date

Biographical Sketch

Lauren Serdencuk was born in Queens, New York 1982 and was raised by her father, from the former Czechoslovakia and her mother, born and raised in NY. She has one younger brother. Lauren grew up around many cultures and continues to thrive in variety. After graduating high school, Lauren started college as a theatre major and was an extra in several films. After being diagnosed with new health conditions, Lauren attempted to pursue nursing. Although the love for helping others was present, nursing was not the right fit. After receiving her Bachelors in Psychology, Lauren continued her education at Mercy College pursuing her Master's degree in Marriage and Family Therapy.

Marriage and Family Therapy was attractive to Lauren for many reasons. Lauren felt the therapy her family received when she was a child could have been different and more helpful. Marriage and Family Therapy offered a vast amount of ideas and eliminated the black and white idea. While Lauren was working as a manager at a gym, she interviewed, passed an exam, and was hired as a Child Protective Specialist (CPS) for New York City. Unfortunately, she could not attend the training due to conflicting hours of coursework in her Master's program and was given the opportunity once she completed her coursework.

While Lauren was completing her thesis and interning at an adolescent residential facility, she decided to apply to doctoral programs. Lauren relocated to Florida and started attending the doctoral program of Marriage and Family Therapy at Nova Southeastern University in August of 2010. Although Lauren grew up around many

family members and friends in active addiction and in recovery, working and gaining experience as a professional, gradually became a love for Lauren. Throughout Lauren's journey of completing her doctoral degree, she was able to utilize the resources and networks she gained in the substance abuse community in South Florida and helped her brother towards recovery.

Lauren became immediately attracted to Murray Bowen's model, especially the theory of sibling position. Lauren was also interested in Solution Focused Brief Therapy due to finding solutions instead of focusing on an individual's past and assisted Lauren's understanding of systemic thinking. During Lauren's journey, she became a Certified Addiction Professional (CAP) and is currently working on obtaining her MFT license. Lauren started working for Recovery First in 2015 and was provided many opportunities in the field. In the summer of 2016, Lauren was asked to discuss substance abuse within the family and the process of treatment on two different news stations, which introduced new possibilities. https://www.youtube.com/watch?v=46kdq0uW3wU&feature=youtu.be

Lauren currently resides in Davie, Florida with her husband Kenneth and Pembroke Welsh Corgi, Mila. Lauren's interests include traveling, music, hockey, animals, learning about new cultures, and trying new activities. Lauren's future goals include, but are not limited to, educating families on substance abuse, establishing foundations that assist individuals struggling with substance abuse that lack resources, implementing animals in therapy, and possibly private practice.