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Solution-Focused Family Weekends in an Addictions Treatment Facility: An Action Treatment-and-Research Study

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Solution-Focused Family Weekends in an Addictions Treatment Facility:
An Action Treatment-and-Research Study

by

Sandra Natasha DiMarco

A Dissertation Presented to the
College of Arts, Humanities, & Social Sciences
In Partial Fulfillment of the Requirements for the Degree of
Doctor of Philosophy

Nova Southeastern University

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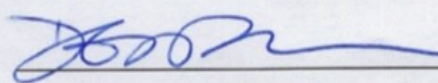
Nova Southeastern University
College of Arts, Humanities, & Social Sciences

This dissertation was submitted by Sandra Natasha DiMarco under the direction of the chair of the dissertation committee listed below. It was submitted to the Graduate School of Humanities and Social Sciences and approved in partial fulfillment of the requirements for the degree of Philosophy in the Department of Family Therapy at Nova Southeastern University.

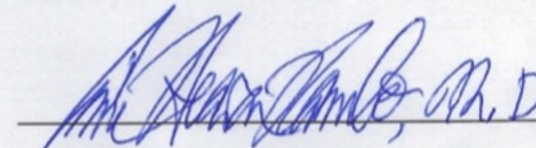
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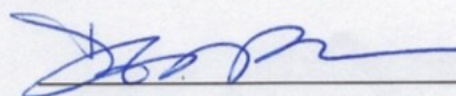
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Chair

This dissertation is dedicated to my friends and clients who have passed away from their struggles with addiction. Your time was cut too short. You all deserved another chance at life.

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Abstract

For the past 69 years, since the start of the addiction treatment system in the United States, treatment providers have been utilizing the same interventions in rehab centers, the majority of which are based on outdated ideas about substance misusers. Though the premise of such interventions has been questioned by researchers, treatment providers continue to utilize them. Family therapy, in particular, shows promising results for substance misusers and their families; it has been cited as the most powerful form of intervention in addiction treatment. Nevertheless, family therapy is underrepresented in the addiction literature and rehab centers. Furthermore, postmodern models of family therapy are even more scarce within these contexts.

The purpose of this study was twofold: to explore the viability of an underrepresented, alternative approach to treatment, and to explore the personal, organizational, and clinical processes occurring throughout the development of a systemic family program implemented in an adult inpatient rehab center with an individualistic approach. The researcher modified action research methodology to analyze archival data acquired from a completed clinical project, which was implemented over the course of three weekends. The researcher adapted categorizing and coding procedures from action research in order to analyze 34 personal journal entries and 11 supervision meetings, all of which illuminated the changes in the personal, organizational, and clinical processes that occurred throughout the clinical project. To illustrate the viability of a solution-focused, multiple family group (SFBT-MFG) approach for substance misusers and their families, the researcher collected and

analyzed a total of 79 client and family evaluation surveys, 19 pretreatment change questionnaires, and six staff evaluation surveys.

The results of this study support an SFBT-MFG approach for adult substance misusers and their families. The researcher identified enhanced communication, understanding, honesty, and support as key themes, along with nine other themes, in the evaluation surveys completed by the participants in the family weekends. The study can help other marriage and family therapists undergo their own processes of integration when practicing systemically in a culture guided by individualistic notions of mental health.

CHAPTER I: INTRODUCTION

“Every 3 weeks in the US, you have the equivalent of a 9/11. So that every year, at current rates, you have fourteen or fifteen 9/11s happening.”

– Dr. Gabor Maté, on the current opioid epidemic

The sun is always shining, and the beaches can always be found full of people embracing the serenity of the South Florida shoreline. Restaurants are packed with smiling people enjoying the company of families and friends in the warmth of the sun. The tropical climate can—both literally and metaphorically—warm a person’s soul; yet hidden behind the light is an unimaginable reality. For some families, the words *South Florida* invite tears, heartache, and devastation.

South Florida, known by many as “The Rehab Capital of America,” is failing in its delivery of addiction treatment (CASA, 2012; Seville, Schechter, & Rappleye, 2017). Although treatment centers—commonly referred to as *rehab*s—bring in billions of dollars, they can also cost patients their lives. Families from all over the United States send their daughters, wives, husbands, sons, brothers, and sisters to South Florida for addiction treatment. In fact, around 75% of individuals receiving treatment in Florida’s rehabs live in another state (Seville et al., 2017). Families place their trust in the addiction treatment industry to help their substance misusing loved ones, but these individuals are dying at accelerating rates. In Palm Beach county alone, there were approximately 600 overdoses reported in 2016 (Seville et al., 2017).

There are currently over 44,000 facilities offering addiction treatment services in the United States (HHS & SAMHSA, 2017), yet opioid abuse is at an all-time high. It is a

national epidemic, considered “the worst drug crisis in American history” (Bosman, 2017, para. 2). As a result of this epidemic, the life expectancy of working middle class individuals is decreasing (TheRealNews, 2017). The contrast between the abundance of treatment centers and the staggering rates of overdose does not make much sense. How can death rates increase when there are so many rehabs treating the very phenomenon responsible for killing people?

This issue becomes even more puzzling when considered in the context of a hypothetical example. Suppose this same dynamic occurred in the health field with chicken pox. Imagine there are 50 medical facilities in Lakewood County set up to treat chicken pox, and thousands of people flock from all over the United States to be treated. But in spite of being attended to by doctors, their chicken pox remains unchanged. They go back to the doctor asserting that the treatment is not helping, as they continue having outbreaks. The doctor insists that the patients are wrong and gives them the same shot as last time, since it has worked for other patients. The patients receive the same vaccine, only to stay sick. Now imagine that this same interaction continues to occur, and the problem continues to get worse. Eventually, the frustrated patients die from chicken pox.

Continuing with this example, suppose the same doctor-patient dynamic occurs in the other 49 medical facilities in Lakewood County. Patients keep receiving the same ineffective treatment, which leads them to desperately return to their doctors, explaining that the treatment is not benefiting them. The doctors continue to insist that the treatment works, and that the patients need only adhere to their suggestions. Eventually, an epidemic begins, and nothing is done differently to treat the problem. An abundance of medical facilities are set up to treat chicken pox, yet death rates are increasing rather than

decreasing. Would we blame these deaths on the patients themselves? Would we open more medical facilities offering the same type of chicken pox treatment? Certainly not. Instead, the medical facilities would be shut down, and doctors would be sued for malpractice.

Practices just like those described in this hypothetical scenario occur daily in the field of addiction, as treatment providers are not held to the same standards of treatment as those in other sectors of the health field (Szalavitz, 2014). Considering the escalating death rates in spite of established research on treatment approaches that can be utilized to treat addiction, the CASA (2012) suggests that “the low levels of care that addiction patients usually do receive constitutes a form of medical malpractice” (p. 200). Substance misusers deserve more than what they are receiving. Certainly, they do not deserve to die while trying to find the right treatment to meet their needs.

Statement of the Problem

While social scientists have yet to establish a cure for addiction, the existing literature has established certain approaches as effective in the treatment of substance misuse (CASA, 2012). For example, there are 565 evidence-based treatments listed in the Substance Abuse and Mental Health Services Administration (SAMHSA) National Registry of Evidence-Based Programs and Practices (HHS & SAMHSA, 2018a). However, only two are offered in addiction treatment facilities: Cognitive Behavioral Therapy (CBT) and Twelve-Step Facilitation Therapy (Fletcher, 2013; Kim, Brook, & Akin, 2018; Slaymaker & Sheehan, 2008; Szalavitz, 2016). This means there are 563 other treatment modalities to help end the opioid epidemic that are rarely offered to substance misusers. Traditional addiction treatment remains mired in the Twelve-Step

philosophy, and the same treatments have been offered since the early 1990s, despite the many scientific advances that have taken place over the last hundred years (CASA, 2012; Tatarsky & Kellogg, 2012; Wilson, Hayes, & Byrd, 2000). In the early 2000s, 90% of addiction treatment was based on the Twelve Steps (Fletcher, 2013). Since then, the percentage has decreased; however, not by much, as most addiction treatment facilities continue to incorporate some component of the Twelve Steps into their treatment programs.

The National Institute of Drug Abuse (NIDA) reports that 90% of individuals who enter addiction treatment return to using drugs within five years, and half go back to using after only one year (Shaw, 2017). Such high relapse rates raise concerns about the quality of care in modern-day rehabs, and it has been found that “the vast majority of people in need of addiction treatment do not receive anything that approximates evidence-based care” (CASA, 2012, p. i). Patel (2016) notes that “the insidious nature of addictive disorders coupled with less than successful treatment approaches (as evidenced by relapse rates) have prompted the research community to strive towards the reconceptualization of addiction with the goal of formulating more effective treatment interventions” (p. 1). However, the literature contains a vast array of treatment interventions, such as those appearing in SAMHSA’s National Registry of Evidence-Based Programs and Practices (HHS & SAMHSA, 2018a). The problem remains that the preponderance of studies conducted on addiction interventions have focused on a select few treatments (Heatherington, Friedlander, Diamond, Escudero, & Pinsof, 2015), while other treatments receive little to no attention. Furthermore, funding for addiction

treatment is primarily dedicated to interventions rooted in neurobiology; psychotherapy receives the least funding (Dingel, Karkazis, & Koenig, 2012).

Addiction treatments oriented toward neurology, which are individualistic in nature, have been the focus of scientific investigation and the main treatment approach since 1949 (Davidson & Chan, 2014). In current addiction treatment programs, the substance misuser is the only person who receives treatment (Orford, Templeton, Velleman, & Copello, 2010). However, there are many interpersonal addiction treatments available that focus on the family as the unit of treatment. Not only are these treatments available, they are also recognized in the scientific literature as one of the most effective alternatives to traditional treatment interventions (Rowe, 2012).

In the typical addiction treatment facility, family members are minimally involved, if at all (Patel, 2016; Smock, Froerer, & Blakeslee, 2011; Templeton, Velleman, & Russell, 2010). The family interventions that are offered do not reflect the practices utilized by marriage and family therapists; at most, they consist of psychoeducation for family members (SAMHSA, 2015). Furthermore, interventions that incorporate the family are problem-based and suggest that families and substance misusers should be separated during treatment (HHS & SAMHSA, 2015).

For over 25 years, research studies investigating family therapy in the treatment of substance misuse have produced astonishing outcomes. Yet these treatments remain non-existent in current treatment facilities and are underrepresented in the literature (Smock et al., 2011). For example, Solution-Focused Brief Therapy (SFBT), a family therapy approach, has been proven to be highly effective for an array of mental health

issues; however, it remains underutilized in the field of addiction treatment (HHS & SAMHSA, 2015).

Research Gap

Solution-focused practices present a contrast to the theoretical underpinnings of standard addiction treatment, which commonly utilizes problem-focused interventions (Berg & Reuss, 1998). Such interventions are mainly found in treatments based on the disease model of addiction, which assumes that addiction occurs primarily because of the effects substances have on the brain. Thus, the predominant etiology of addiction is grounded in an individualistic paradigm, which sees addiction as a problem located inside the substance misuser (Munro & Allan, 2011). Essentially, addiction is categorized as a medical disorder, and solutions are found in medicine (Lewis, 2017; Reiter, 2015).

Professionals providing addiction treatment are assumed to be experts who provide patients with remedies for their problems (Lewis, 2017). For example, clients enter therapy struggling with issues related to substance misuse. They report these issues to the therapist, who explores the causes of the problem. The therapist's job is to eliminate the problem and ultimately *fix* the substance misuser. Ultimately, the treatment is embedded in a cause-effect model. Seeing addiction as a medical disorder obliges substance misusers to follow the experts' treatment recommendations in order to alleviate their problems, just the same way that people with broken bones go see physicians to get them fixed (Lewis, 2017). Unlike broken bones, addiction does not yet have a cure, so treatment must be handled differently.

Problem-focused, cause-effect models work well in the treatment of physical problems, yet they are often unsuccessful when applied to mental health and relational

difficulties (Young, Edwards, Nikels, & Standefer, 2017). Human beings are unpredictable, complex creatures by nature. No single assessment or instrument can pinpoint the specific origins of mental health issues, and clinicians cannot surgically remove maladaptive thinking patterns and replace them with healthier cognitions. Medical models of human psychology fail to account for individual and cultural differences, the factors that help us understand each other (Young et al., 2017).

The most effective treatment for addiction is not a therapeutic intervention or prescription medication. In fact, according to the literature, empathy is the most curative treatment element; if this is so, clinicians informed by medical models of addiction are missing the biggest piece of the puzzle. According to Young et al. (2017):

The medical model ignores the most cost effective form of treatment available—individual strengths and resilience. Like the weather person on the news, we have been taught to believe that there is a 30% chance of rain (problems), rather than a 70% change of staying dry. (p. 5)

The addiction treatment system in the United States was founded on the theoretical assumption that addiction is a disease, and the culture of treatment has been guided by this notion since the 1950s (Fletcher, 2013; Slaymaker & Sheehan, 2008). The Minnesota model, the first formal addiction treatment to be established, remains the most commonly used approach (Anderson, McGovern, & Dupont, 1999; Fletcher, 2013; Miller & Rollnick, 2013; Szalavitz, 2016; White & Miller, 2007). It requires individuals seeking treatment to stay in a residential treatment facility, or rehab, for approximately 28 days. Within this model, individuals who have successfully completed the Twelve Steps and

are active in their own recovery are hired as counselors to work alongside doctors, nurses, and psychologists (Kingree, 2013; Slaymaker & Sheehan, 2008).

The Minnesota model was created based on the Twelve Steps of Alcoholics Anonymous (AA). To become a member of AA, individuals must accept an addict identity and introduce themselves as an alcoholic or drug addict at the beginning of each group session. Additionally, AA assumes that individuals can overcome their addictions only after accepting that they have faulty character traits and no power over their substance use. To rid themselves of their character defects, they must be confronted by others about their deficiencies, maladaptive cognitive skills, and lack of control. Additionally, they must complete the Twelve Steps, which specify what they need to do to abstain from substances and remain sober (McCaul & Petry, 2003). For example, they must admit that they are powerless over all chemicals and admit to all their wrongdoings. Within this model, change occurs when one follows all of the recommendations of the Twelve Steps and remains sober.

It is important to note that AA does not consist of professional treatment (Fletcher, 2013; Messina, Wish, & Nemes, 2000; Schenker, 2009; Szalavitz, 2016). Initially, the Twelve-Step philosophy was incorporated in rehabs as a suggestion for clients entering treatment. But over time, the Twelve Step philosophy has become an integral aspect of addiction treatment (McElrath, 1998; Szalavitz, 2016). It became so ingrained in the system that a therapeutic version of the Twelve Steps, Twelve Step Facilitation Therapy (TSF), was created (Kingree, 2013; Nowinski, 2002). The main distinction between TSF and Twelve-Step meetings is that TSF is led by a trained therapist who follows a strict agenda specifying step work to be completed during each

session (Kingree, 2013). During the therapeutic process, the therapist assists clients in completing the first five steps and creates a plan for continued step work upon the conclusion of treatment (Kingree, 2013).

The other treatment most commonly utilized in rehabs is Cognitive Behavioral Therapy (CBT). It has been established as an evidence-based treatment for addiction, but the long-term benefits are questionable (Vaillant, 2014). The CBT model is skill-based and consistent with behavioral theories about the nature of addiction (Granillo, Perron, Gutoswki, & Jarman, 2013). It aims to help substance misusers understand thought processes in connection with their emotions and behaviors (Fletcher, 2013). The focal point of therapy is acquiring new coping skills to combat the factors that contribute to and reinforce the abuse of substances. Additionally, CBT therapists work with their clients' thinking patterns and aim to restructure maladaptive thoughts into healthier ones (McHugh, Hearon, & Otto, 2010).

Motivational Interviewing (MI) is another individualized treatment found to be among the most effective in the treatment of addiction (Abo Hamza, 2012; Brown et al., 2009; Magill, Apodaca, Barnett, & Monti, 2010; Stotts, DiClemente, & Dolan-Mullen, 2002). The MI approach is based on a particular theory of change; it allows clients to choose what they want to work on during the therapeutic process (Miller & Rollnick, 2013). If clients are ambivalent about changing their substance use, they are encouraged by the therapist to explore the ambivalence, without having sobriety forced upon them. In this way, MI diverts from traditional medical models, as the therapist works like a collaborator rather than an expert.

The CBT and MI approaches are often advertised by rehabs as alternatives to the disease model (Fletcher, 2013). Theoretically, they offer alternative explanations of addiction, yet they are rarely implemented outside of a disease-based paradigm. Researchers have found a discrepancy between how these models are described and tested, and how they are actually implemented in rehabs (CASA, 2012; Fletcher, 2013; Miller, Sorensen, Selzer, & Brigham, 2006). For example, Fletcher (2013) visited rehabs all over the United States and found that in those centers implementing TSF, the treatment mainly consisted of clinicians trying to convince their clients that addiction was a disease and urging them to follow the Twelve Steps. Fletcher found that clinicians utilizing MI would allow clients to define their therapeutic goals, but simultaneously punish them for missing Twelve-Step meetings. Those incorporating CBT did so in the context of guiding clients to find a higher power (Fletcher, 2013).

Scientific studies may provide evidence for the efficacy of these models. However, when they are not implemented the way they were designed to be, disease-based assumptions about addiction wind up overpowering the models' inherent theoretical assumptions. This calls into question how effective these models really are, and whether they constitute legitimate Twelve-Step alternatives.

Interpersonal Approaches to Substance Abuse

Family therapy, an interpersonal approach to therapy that can incorporate families in substance misusers' treatment, has been found to produce better long-term treatment outcomes than individualistic models (Rowe, 2012; Steinglass, 2009). Though some interpersonal models of substance abuse hold vastly different theoretical assumptions,

others remain closely aligned with disease-based assumptions like those guiding individualistic approaches to treatment.

Family disease theory and the Al-Anon organization both view addiction as a family disease and assume that addiction manifests from dysfunctional family patterns (Smock et al., 2011). Family disease theory recognizes that other family members are affected by the addiction of one individual in the family and consequently organize their behavior in an attempt to stop that individual from using substances. According to this theory, in their attempts to stop their loved one's addictive behavior, families develop addictive behaviors themselves, such as codependency and enabling (Smock et al., 2011). Codependency and enabling are identified as unhealthy behaviors which allow the substance misuser to continue engaging in drug use. Treatment derived from the family disease model suggests that family members should attend psychoeducational groups, as well as individual therapy, in order to address their own behavior (Smock et al., 2011).

Al-Anon, which is similar to AA but for family members, serves as a mutual self-help group following the theoretical assumptions of family disease theory (Timko, Young, & Moos, 2012). While the Twelve Steps dominate treatment in rehabs, Al-Anon is the most commonly recommended support group for family members (Fletcher, 2013). Al-Anon is designed to be a supportive environment where families can learn about addiction as a family disease and identify ways to cope with their loved one's addiction (Timko et al., 2012). Al-Anon groups promote ideas about families engaging in their own recovery from codependency and enabling. While both family disease theory and Al-Anon share the perspective that addiction affects the entire family unit, they diverge from

family system models in their commitment to the belief that separating family members for their own individual treatment is necessary and beneficial.

Family therapists operating from family system models treat the whole family, as opposed to solely focusing on the substance misuser. A mutual relationship is assumed between the functioning of the family and an individual family member's use of substances (Smock et al., 2011). Essentially, the substance misuser's addiction serves as an expression of some other dysfunction occurring within the family (Reiter, 2015).

Systems theory suggests that family members organize their behaviors around the substance misuser's addiction. Therefore, addiction becomes the primary organizing principle of the family (Walters & Rotgers, 2012). Cybernetic theory, which is interwoven in the systems theory tradition, emphasizes the significance of context and suggests that behaviors cannot be understood without understanding the context in which they occur (Watzlawick, Bavelas, & Jackson, 1967). This theory also describes relationships in terms of circular causality, suggesting that individuals do not cause each other to behave in certain ways, but rather constantly influence each other's interactions in an ongoing, recursive fashion (Flemons, 1991). Embedded in both cybernetic and systems theory is the notion that treating substance misusers in isolation is illogical, as the phenomenon of addiction occurs within the realm of relationships, context, and larger systems.

An approach which originated from these theories, Structural Family Therapy, assumes that substance misuse is a reflection of dysfunctional family structures. The nature of the boundaries between parents and siblings provides the therapist with information about the structural make-up of the family. The therapist closely observes the

family structure during therapeutic sessions and makes assessments about dysfunctional hierarchies, family rules, and communication (Reiter, 2015). Change occurs when there is a structural shift within the family and individual symptoms dissipate accordingly.

Haley Strategic Family Therapy also asserts that individual symptomology is reflective of dysfunctional family structures that serve a function within the family. Both Structural Family Therapy and Haley Strategic Family Therapy assume that symptoms of addiction are manifested within the family, as opposed to only in the addicted individual; this presents a sharp contrast to disease-based assumptions (HHS & SAMHSA, 2012). Aside from focusing on the family structure, the therapist also examines each family member's perception about the problem and vision of ideal change. The goal is to create a concrete, identifiable problem formulated from the various perspectives of family members, which can lead to the dissipation of the problem.

The therapist and participating family members explore the family interactions maintaining the addiction, and the therapist utilizes strategic interventions such as directives, paradox, and metaphors to create spontaneous behavior changes and facilitate shifts in the family patterns perpetuating the addiction (HHS & SAMHSA, 2012). In the addiction literature, most efficacy studies focus on Structural Family Therapy and Haley Strategic Family Therapy as integrative models rather than stand-alone treatment approaches. The first studies of these models in the literature investigated the interpersonal treatment of addiction through a Structural-Strategic model; since then, these approaches have largely been integrated in combination with others (Stanton & Todd, 1982).

The first structural-strategic approach for addiction is known as the *Stanton and Todd Model*. This model first appeared in the literature in the late 1970s, when researchers established its efficacy in the treatment of male opiate users (Stanton & Todd, 1982). Prior to then, families were acknowledged as having an effect on substance misusers' addiction; however, just as in family disease theory and Al-Anon, they were seen as barriers to change and were often blamed for their loved one's addiction because of their own dysfunctional behavior (Munro & Allan, 2011). The perception of families in relation to substance misusers' addiction came a long way since the 1950s, when Al-anon first appeared as the only support groups for family members. While families were once viewed as the problem or, at least, as significant contributors to the problem of addiction, social scientists began recognizing the valuable influence families can have over substance misusers prior to and during the treatment process (Rowe, 2012). This led researchers to begin investigating family therapy in the context of addiction treatment.

Family therapy approaches grounded in systems theory and cybernetics were the first to be studied in the addiction literature. However, since then, the literature has included a focus on family behavioral models, which incorporate learning principles with systems theory. Behavioral Couples Therapy (BCT), for example, has been found to be efficacious in the treatment of couples consisting of an addicted partner and a non-addicted partner (Ruff, McComb, Coker, & Sprenkle, 2010). The primary goal of BCT is to encourage non-addicted partners to support their addicted partners in abstaining from all mood-altering drugs. The therapeutic process requires the couple to sign a sobriety contract specifying behavioral goals and vowing that the addicted partner will attend Twelve-Step meetings.

The BCT approach has been identified as the most effective interpersonal treatment for substance misusers and their partners; yet disease-based notions of addiction remain embedded within the standard treatment approach. One example of this is that most rehabs require their patients to attend daily AA meetings. Considering the fact that most researchers define addiction as a disease, it is not surprising that the one relational model incorporating the Twelve-Step philosophy has received the most attention in the addiction literature, compared to other interpersonal models of addiction (Des Jarlais, 2017). Nevertheless, though the popularity of this model is evident in the scientific community, it is not as evident in the clinical community, as only 5% of rehabs offer BCT (Fals-Stewart & Birchler, 2001; Fals-Stewart, O'Farrell, & Birchler, 2004).

Even more underrepresented in the addiction literature and addiction treatment field are family therapy models derived from a postmodern philosophy. Thus far, addiction has been discussed as an identifiable, objective phenomenon occurring within individuals or manifested within family systems. Drugs have been discussed in the context of having the power to take over an individual's brain, sense of self-control, and willpower. Whether individualistic or interpersonal, all treatments discussed strive to help substance misusers achieve abstinence or shift dysfunctional family structure and patterns into healthier ones, thereby removing symptoms of addiction from the family system.

Postmodernism posits that reality is subjective, defined differently by every individual, and that there is no one, universal truth. Viewing the phenomenon of addiction treatment from this perspective, it is the client, not the therapist, who functions as the expert in the therapeutic encounter; this stands in stark contrast to the medical model of addiction. Rather than aiming to eliminate the problem, therapy becomes a

creative, collaborative process (Neimeyer, 1993). Together, the therapist and client explore complex relationships and meanings related to the substance misusers' positioning in a larger social context (Burrell, 2002).

Focusing on strengths is a hallmark of SFBT, a postmodern model developed by Steve de Shazer and Insoo Kim Berg. Scott Miller and Insoo Kim Berg were the first to introduce SFBT into the field of addiction (HHS & SAMHSA, 2012). This approach assumes that substance misusers are better served by focusing on their abilities and strengths, rather than their inabilities and weaknesses. It is considered a brief therapy approach, because the standard therapeutic process consists of approximately five sessions (de Shazer, 1991). Therapy does not begin with the therapist directly addressing the substance use issues. Rather, the therapist and client collaborate to explore the problem together (HHS & SAMHSA, 2012). The therapist works within the client's perspective, assisting the client in identifying failed solution attempts. The goal is to help the client identify new, more effective solutions to deal with the problem. By allowing their clients to define the problem, SFBT therapists promote client motivation (Berg & Reuss, 1998). Therapists utilizing SFBT assume that addressing problems in any area of substance misusers' lives will reduce their substance use (HHS & SAMHSA, 2012).

In SFBT, the therapist works with the family unit, including both substance misusers and their family members in the treatment process (Berg & Reuss, 1998). These therapists believe that families know more about their strengths than any professional could (Berg & Reuss, 1998) and, thus, have beneficial information to share in the therapeutic process. The SFBT approach assumes that there is a reciprocal relationship of blame between families and substance misusers. Although symptoms of addiction are the

substance misuser's problem, the responsibility for generating solutions belongs to the entire family (Berg & Reuss, 1998). A core belief in the SFBT model is that change can only occur when the client feels empowered and confident; therefore, therapists avoid labeling clients in a way that could inhibit the change process. Instead, they highlight clients' strengths and abilities, helping to position both the clients and their families in a way that makes change possible (Berg & Reuss, 1998).

In the context of therapy for substance misusers and their families, the SFBT model concentrates on failed solution attempts and the building of new, more effective solutions. Once families recognize that previous attempts at solving the problem were ineffective, they can open up to attempting new solutions. In SFBT, therapists do not offer solutions to families; rather, they collaborate with them and ask questions to assist the families in discovering new solutions or forms of interaction. Change occurs through the process of families attempting new solutions that facilitate different interactions with the substance misuser. These new solutions do not necessarily stop the substance misuser from drinking or using drugs; however, the behavioral changes that occur in the family eventually influence reductions in that individual's substance use (Berg & Reuss, 1998).

Though SFBT has produced promising results when applied with other populations, more research is needed to determine the efficacy of SFBT in the field of addictions (Gingerich & Peterson, 2013; HHS & SAMHSA, 2012). Nevertheless, SFBT has been acknowledged in the literature as an appropriate addiction treatment intervention (Gingerich, Kim, Stams, & Macdonald, 2012; McCollum, Trepper, & Smock, 2004). Although SFBT is not considered evidence-based within the field of

addiction treatment, Solution-Focused Group Therapy (SFGT) is listed as an evidence-based treatment in the SAMHSA registry (HHS & SAMHSA, 2018b).

Solution-Focused Group Therapy (SFGT) is facilitated in a similar manner to SFBT. The process of building solutions can be even more advantageous in a group setting, as multiple people can contribute to different ideas (McCollum et al., 2004). Unlike the type of substance abuse group typically facilitated in rehabs, the SFGT approach is designed to avoid confrontation and respect all group members equally. Problems are discussed as a group, with an emphasis on change. Group facilitators ask solution-focused questions to the individual group members, which has a ripple effect on other groups members, influencing them to discover solutions for their problems. When SFGT was compared with traditional group treatment, it was found that group members improved more significantly in SFGT (Smock et al., 2008). Solution-focused groups have been recognized in the addiction literature as being effective, but the studies that have been conducted focused solely on substance misusers, without including their families in the therapeutic process.

Multiple Family Groups (MFG) is a therapeutic way of working with substance misusers and their families within the context of a group. Rehabs have facilitated MFG since the 1970s, around the same time when the model first began to be studied (Schaefer, 2008). But around the 1980s and 1990s, researchers lost interest in studying these groups (Garrido-Fernández, Marcos-Sierra, López-Jiménez, & de Alda, 2016). During the early 2000s, some scholars developed a renewed interest in MFG applied to individuals with severe mental health issues. Currently, researchers are interested in investigating MFG with individuals who have mood disorders, eating disorders, or

substance use problems (Heatherington et al., 2015). To date, few studies have examined MFG in the context of addiction treatment; however, those that have been conducted revealed positive outcomes (Anton, Hogan, Jalali, Riordan, & Kleber, 1981; Boylin, Doucette, & Jean, 1997; Garrido-Fernandez et al., 2016; Henggeler et al., 1991; La Belle, 2015; Schaefer, 2008; Springer & Orsbon, 2002).

Thus far, one study and one book have been published on an integrative model of MFG that incorporates solution-focused techniques (Schafer, 2008; Springer & Orsbon 2002). However, the theoretical assumptions of this integrative model of MFG are grounded in family pathology and dysfunction, which is inconsistent with the SFBT philosophy.

Research has established MFG as a promising treatment for substance misusers and their families, but more studies are needed to provide evidence for its effectiveness. Furthermore, studies of MFG for substance misusers have only been conducted using a model of MFG grounded in pathology-based assumptions about substance misusers and their families; no studies have been conducted to examine a purely SFBT format of MFG.

Researcher Relationship to the Topic of Study

“You care when you shouldn’t, but that is what makes you, you. You have this intensity flowing out of your eyes and you feel what you feel because you must. Because the human heart is the only art you understand.”

– Anonymous

Upon completing the coursework for my Ph.D. program in 2014, I began working in the field of addiction treatment. I took my first job as a Marriage and Family Therapist Intern at an adult inpatient rehab facility to work towards my state license. While

working in the rehab, I observed many dynamics that my graduate school experience did not prepare me to understand or handle. Therapists would often confront their clients and speak of them in a negative way, which differed vastly from the training I had received. I was trained to respect my clients and collaborate with them in addressing the goals they presented in therapy. Instead, I was surrounded by other therapists who would make goals for their clients, assuming they knew what was best for them after knowing them only a week. Counselors without credentials played a more powerful role in clients' treatment than the licensed therapist did, deriving their legitimacy not from their education but from having been in recovery for five or more years.

My background in systemic thinking led me to perceive clients' problems in a different way. I was not interested in exploring clients' triggers or coercing them to follow a Twelve-Step program. I could never bring myself to confront my clients about their weaknesses while telling them they would die or wind up in jail if they could not stay sober. Instead, I was interested in learning who they were; what was important to them; what kind of emotional pain they had endured throughout their lives; and, most of all, what I could do to help them shift their tremendous suffering into resilience. Where I saw pain, hurt, and agony, my co-workers saw manipulation, arrogance, and behavior that needed to be met with harsh consequences.

Meetings with co-workers often consisted of dialogues about how sick, dysfunctional, and unhealthy the clients were. "He's so Borderline. He's hopeless." "She's going to die; she's been here five times already." "If he doesn't start being grateful, he'll be on the streets." Following from these assumptions, the therapists would create behavioral contracts to punish noncompliant clients and dole out consequences. I

was the only one who could look past the clients' behaviors and see the agony they were in, which kept them from being able to trust other human beings. These individuals navigated their world according to the belief that other humans are distrustful and out to hurt them, so they must protect themselves. Heartache was the norm, and unconditional love was a completely unfamiliar idea.

When substance misusers enter the treatment system, they lose the only thing that eases their pain and makes them feel anything even close to happiness. It is no wonder, then, that they respond with anger, hesitation, and mistrust to the suggestions they hear in treatment about what needs to be done to improve their lives. They are stripped of the only thing that soothes them, then held to rigid expectations and judged for acting out on their pain. As a master's level clinician with a systemic background, none of this made sense to me.

I vividly remember a counselor suggesting that one of my clients needed to be changed to another case load, because I was not "tough enough" in "confronting" the client's "denial." What struck me most about this was that a counselor with no background in psychology, no training in therapy, no education in ethics, and no formal qualifications—someone whose primary credential was being sober for 20 years and working the Twelve Steps—was able to determine clients' needs and choose what would serve as the best therapeutic fit. From that moment, my passion for working in the addictions field only grew stronger.

While working in another position at a different rehab, I was asked to facilitate services within a newly created family program. My boss was aware of the scientific literature recommending family therapy as an integral aspect of addiction treatment,

which served to enhance treatment outcomes. He admitted, however, that family programs implemented within the rehab facility in the past had been unsuccessful.

The rehab was small, housing a maximum of 30 clients. Within its clinical model, addiction was defined as a disease, and most of the counselors were in recovery themselves. While there were other marriage and family therapists in the rehab who shared some of my theoretical assumptions about addiction treatment, they utilized pathology-based models of family therapy and regularly confronted their clients. While their style of confrontation was more respectful than the standard approach used in most rehabs, it was still an integral part of their clinical approach. Although there were two other clinicians on my team with family therapy backgrounds, I still felt a sense of isolation, which only grew stronger when I sat in clinical meetings and heard the treatment team discuss client cases in an exclusively pathology-oriented manner.

The Twelve-Step philosophy, with an emphasis on confrontation, was the core of my coworkers' treatment style. But I took pride in my ability to offer clients and families something therapeutically different. The challenge I faced was that those clients who had received treatment two, three, or five times prior and were well-versed in traditional addiction treatment did not always embrace my therapeutic flexibility.

Counselors and therapists in rehabs tend to be guided by the assumption that clients need to find the "root cause" of their addiction and deal with their underlying emotions in order to achieve and maintain sobriety. As a result, clients assume that all therapy takes place within an emotion-based paradigm. I became aware that my clients expected me to focus on the emotions they had regarding their underlying pathologies, while telling them what to do to change. It was also clear to me that I was expected to

challenge and confront my clients about their dysfunctional behaviors in the past and within the treatment process.

Clients' success in treatment was determined by their ability to process their emotions; if they had difficulty doing this, they were perceived as unmotivated and unable to put in the work needed for treatment to succeed. If they could express their pain, they were praised for their "personal self-growth," and for doing "good" work in therapy. Family work was viewed similarly, with the measure of success being emotional expression between family members and the confronting of dysfunctional family dynamics.

As an SFBT clinician, I could not help but think about how constraining it would be to work in such a way that my therapeutic success was determined solely by my ability to get clients to express their emotions and admit all the ways they caused pain to their family members. There were so many more aspects of clients and their families that I was curious to explore. I wanted to know about the families' strengths and understand how they overcame obstacles in the past and kept going despite years of seeing someone they love destroy themselves through addictive behaviors. I saw the resilience and strength these families demonstrated, and I wanted to learn more about them. They experienced many heartaches throughout their loved one's addiction, yet they still traveled thousands of miles to Florida to support them. They were willing to sit in a room with their loved one, who may have just stolen all of their belongings and robbed them of their sense of peace only a month prior, and be part of their treatment. I was astonished by the loyalty and unconditional love demonstrated by these families.

Substance misusers already know their families are hurt, and they often beat themselves up for the pain they caused. As a clinician, I recognized that it did not benefit my clients for me to reinforce negative feelings and experiences associated with their addiction and remind them how much they hurt the people around them. Instead, I could better serve them by making them aware of the unconditional love and support their families had for them.

At a time when the rehab I worked for was going through some financial difficulties, I was tasked with developing and implementing an SFBT and MFG based family program emphasizing the strength, loyalty, and resilience hidden beneath all the destruction that addiction causes in families. That program became the clinical project upon which the present study is based.

The family program I developed took place in the context of an intensive family weekend. From August 2017 to January 2018, I facilitated the family program during the last weekend of every month. I called the program *Regaining Connections* and added a tagline: *Because families recover, too*. The program ran consistently, with the exception of November and December of 2017 (as many families struggled to commit to travel plans around the Thanksgiving and Christmas holidays). The MFG sessions I conducted in this program lasted for seven and a half hours on each of two weekend days.

All of the group activities in the *Regaining Connections* program were strength-based. It is important to note that although these groups were strength-based, problems were still discussed; however, they were always addressed within the context of solutions. When I incorporated other techniques from different models, like experiential exercises that are uncommon in SFBT, I added an SFBT element to the activity. For

example, experiential exercises typically focused on relational problems in substance misusers' families. However, I facilitated solution-building throughout these exercises so that by the end, clients had a sense of what was needed to change in order for them to feel differently within their relationships.

I implemented the family program a total of three times and distributed surveys to clients, families, and co-workers at the end of each weekend to obtain feedback about ways I could improve it. Unfortunately, after the third weekend, the rehab faced major financial struggles and, in an effort to avoid bankruptcy, hired investors to save the company. The investors decided to lay off several employees, including me. Not surprisingly, considering the culture of the addiction treatment, they did not see the value of family work in an inpatient addiction rehab for adults, so my clinical project was cut short.

Purpose of the Study

I conducted this study in order to complete a post-hoc analysis of my family-weekend clinical project, utilizing modified action research methodologies. I explored the organizational and personal challenges, processes, and effects related to the implementation of an intensive SFBT-MFG program developed for an individually-focused inpatient rehab center. Although as a post-hoc investigation, this study cannot be considered a true action research project, I did utilize a modified action research methodology to guide my analysis.

During the development and implementation of the family program, I participated exclusively as a clinician. For the purposes of this study, I transitioned into the role of researcher. The clinical information I collected during the time of the clinical

project—which consists of journal logs, evaluation surveys, pre-treatment change questions, and transcripts of supervision meetings during the time of the clinical project—was considered archival data for the study. It was suitable for coding, categorizing, and interpreting. There were two major purposes of this study. The first was to investigate a different way of working with substance misusers and their families that departs from traditional practices. By utilizing a post-hoc analysis to analyze participant feedback, I aimed to give voice to those who are too often maligned by the providers of addiction treatment.

The second purpose of this study was to analyze the personal, organizational, and clinical processes that occurred throughout the development and implementation of the completed clinical project. As mentioned previously, there were major personal and organizational changes occurring within the rehab throughout the time that I implemented the program. At first, I questioned my ability to carry out this type of clinical work, and I felt unsure about how to work in an industry characterized by treatment approaches vastly different from my own. I did not know how to fit into a work culture dominated by individualistic notions of treatment when I was trained to work systemically. When I explained my theoretical framework to other co-workers, I was often met with blank stares and baffled expressions. But by the end of the project, I felt comfortable utilizing solution-focused MFG in the context of an individualistic paradigm of addiction treatment.

The fundamental goal in action research is change; and change was evident throughout the clinical project. However, I did not yet have a clear understanding of what processes contributed to those changes. I have designed this study to explore and describe

these processes in such a way that they will be capable of helping other marriage and family therapists to work systemically in contexts dominated by individualistic notions of treatment.

Significance of the Study

At present, the family disease, systems, and behavioral models dominate the field of addiction treatment (Walters & Rotgers, 2012), and postmodern approaches, such as SFBT, are underrepresented in the addiction literature (Heatherington et al., 2015). This study served to bridge the divide between under-researched and well-established interpersonal models by introducing an underrepresented model, SFBT, into the addiction literature.

According to Templeton et al. (2010), addiction research is dominated by studies grounded in quantitative methodologies. In this qualitative study, I explored the systemic treatment of addiction and aimed to fill the gap in the existing literature. Since addiction research and treatment focus predominantly on the individual substance misuser, this study offered significant new information by offering a view of the entire family unit as the focus of treatment. Furthermore, it added to the sparse literature on interpersonal addiction treatment for adults, as most of the existing literature on interpersonal interventions is based on adolescents in treatment (Munro & Allan, 2011).

The MFG approach, which I utilized through the duration of the clinical project, is another under-researched area in the literature, despite being recognized as being among the most effective treatments for severe mental health problems (Garrido-Fernández et al., 2016; Gelin, Cook-Darzens, & Hendrick, 2017). There is a need for qualitative research on MFG to explore the effects of group processes on individual

participants (Schaefer, 2008). Some studies have been conducted on the use of MFG with substance misusers and their families; however, none are embedded in a purely SFBT framework. Rather, two or three techniques from SFBT are borrowed and integrated, along with other pathology-based models.

The studies on MFG in the addiction literature are problem-focused with an emphasis on psychoeducation, endorsing conventional notions of addiction, and offering families nothing different from conventional addiction treatment. This study examined the integration of two underexplored modalities, MFG and SFBT, and contributed valuable qualitative research data to both the field of marriage and family therapy and the field of addiction treatment. Currently, there are no qualitative studies investigating an SFBT and MFG format for substance misusers and their families in the context of an inpatient rehab.

Conclusion

Mortality rates among individuals suffering from addiction are at a record high in South Florida and all over the nation. While hundreds of evidence-based addiction interventions appear in the literature, addiction treatment continues to consist of the same outdated, individualistic treatment paradigms. Funding for treatment continues to be determined based on the medicalization of addiction, and the power of talk therapy remains neglected. Treatment in the field of addiction diverges from treatment in other sectors of the health field, and providers are held to different ethical standards; this allows addiction treatment providers to get away with less than standard practices.

Alcoholics Anonymous (AA), which is built upon the Twelve Steps, is the major organization credited with establishing the foundation for modern-day rehabs. Since the

Twelve Steps do not constitute professional treatment, the Twelve Step Facilitation (TSF) approach was created for research purposes. Currently, TSF and Cognitive Behavioral Therapy (CBT) are two of the most commonly practiced therapeutic models in addiction treatment.

Family therapy, which works with the entire family unit as the focus of treatment, has been shown to be as effective, or even more so, than individual therapy in the treatment of addiction. Considering the high mortality rates of substance misusers, it would appear logical to utilize family therapy in addiction treatment. However, it is rarely practiced in rehabs, and when it is, does not reflect the standard practices of marriage and family therapists. Interpersonal models of substance abuse consist of a multitude of approaches stemming from various theoretical assumptions. While the family disease, system, and behavioral theories dominate the addiction literature, strength-based practices derived from postmodernism are nearly non-existent.

Postmodern approaches, such as SFBT and Narrative Therapy, are even more scarce in the addiction treatment literature. Collaborative and respectful in nature, the SFBT approach focuses on client strengths rather than problems. It works well in the context of groups, because multiple people can contribute to the solution-building process. However, a purely SFBT model implemented with MFG has never been explored in the literature. Although MFG has previously been incorporated in rehab centers, scholars only recently resumed exploring the processes of MFG in the context of rehabs. Considering the call for more research on SFBT and MFG in addiction treatment, the significance of this study was evident.

I conducted this study to explore the personal, organizational, and clinical processes involved in the development and implementation of an SFBT-based MFG for adult substance misusers and their families within an inpatient context. The clinical project was inspired by the assumptions guiding action research. I utilized a modified version of action research to study the processes inherent in the clinical project I completed.

In this chapter, I explained the problem relevant to the investigation of this study and provided contextual information about the phenomenon of addiction and the industry of addiction treatment. I provided an overview of individualistic and interpersonal addiction research, revealing a gap in the literature. Additionally, I provided the context of my experience as a systemic clinician working in an individually-focused rehab, where the completed clinical project took place. This chapter also included an explanation of the purpose and significance of this study.

In Chapter II, I will present an in-depth review of the relevant literature, chronicling the history of the addiction treatment industry. Additionally, I will explore individualistic and interpersonal philosophies and treatment modalities of addiction treatment. In Chapter III, I will discuss common methodologies used in traditional action research projects and explain the modifications I made in my post-hoc analysis of the completed clinical project.

CHAPTER II: REVIEW OF THE LITERATURE

“Beyond actual fatalities, severe addiction can become a kind of living death, supplanting the full lives that addicted people had hoped to live and that their society had anticipated for them.”

– Bruce K. Alexander

America has been confused about the phenomenon of addiction for centuries (Flanagan, 2017). To understand that confusion, it is useful to examine several theories. It is also important for health providers to understand different etiologies of addiction, as these determine the types of treatments they implement in their practices. Thinking of addiction as a disease requires medicine, since diseases are typically treated by doctors through the use of medications. When seen as a choice, addiction is addressed through the implementation of punishments; defined as an escape from trauma and pain, it calls for the services of compassionate mental health providers.

The meaning of the word *addiction* has changed considerably over time. According to Alexander (2011), 1984 was the first time addiction was defined not only in negative terms, but also in positive: “1. Rom. Law. A formal giving over or delivery by sentence of court. Hence, a surrender, or dedication, of any one to a master. 2. The state of being (self-) addicted or given to a habit or pursuit; devotion” (p. 28). In its positive connotation, addiction implies a strong commitment to a merited cause, such as the work of Gandhi (Alexander, 2011; Szalavitz, 2016). Toward the end of the 19th Century and beginning of the 20th Century, excessive drinking became a social problem, and the notion of addiction turned into a medical and moral problem. As a result, the word

addiction became synonymous with *alcoholism*, constricting its original meaning (Alexander, 2011).

Anti-drug movements began around the same time, and the notion of addiction became associated with the use of other drugs aside from alcohol. Labels such as *junkie* and *drug fiend* became part of the common language of a drug/alcohol user, and the phenomenon of addiction became extremely stigmatized (Alexander, 2011). Drug users were considered irreparably damaged unless they sought out medical treatment, and they were commonly lumped together into one homogenous category. Since drug users failed to prioritize personal relationships marked by honesty and trust, the larger society began to think there was something inherently wrong with their personalities (Alexander, 2011).

According to Szalavitz (2016), the earliest research on addiction characterizes it as the result of an antisocial or psychopathic personality disorder. The author points out that this is likely because most of the early research on addiction was conducted in prisons with a population already characterized by lawbreaking activity, which is associated with Antisocial Personality Disorder. Therefore, skewed beliefs about the phenomenon of addiction were produced due to misconceptions reported in initial studies of addiction.

Another false belief accepted during this time included the idea that anyone who uses drugs, socially or chronically, will develop a serious drug addiction. But in reality, most social drug users will not go on to develop a problem (Alexander, 2011). As Alexander (2011) explains,

The imagery of the temperance and anti-drug movement was powerfully visual.

Fearsome pictures of addicts were engraved in public consciousness, by the new

photographic newspapers of the 19th century and electronic media of the 20th. The images of the ruined alcoholic and the diseased junkie became the cultural archetypes, known throughout the world. (p. 32)

Although the stigmatization of addiction persists in our current society, an important social institution began to recognize the shame associated with the addiction label (Alexander, 2011). The American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders* (DSM), now in its fifth edition, has officially eliminated the term *addiction* and replaced it with other language (Flanagan, 2017).

Flanagan (2017) explains that an earlier version of the manual, the DSM-III, contained the terms *addiction* and *alcoholism*. In its next revision, the DSM-IV replaced these terms with *substance abuse* and *substance dependence*. Then, in the most recent revision, the DSM-V, The term *substance use disorder*, which ranges from mild to severe in nature, is offered. Mild substance use disorder is classified as the presence of two or three symptoms; moderate, as four or five symptoms; and severe, as six or more. The DSM-V does not provide a specific definition of addiction, only clusters of symptomologies (Reiter, 2015). Another term currently used in the professional community, intended to result in less shaming and stigmatization, is *substance misuser* (Alexander, 2011).

The National Institute on Drug Abuse (NIDA) defines addiction as “a chronic, relapsing brain disease that is characterized by compulsive drug seeking and use, despite harmful consequences. . . . It is considered a brain disease because drugs change the brain—they change its structure and how it works” (Volkow, 2014, p. 5). However, Lewis (2017) points out that the principle of neuroplasticity, which refers to the brain's

ability to change in response to new learning experiences, reveals that our brains are constantly in a state of change. In light of this, he argues that contrary to what NIDA reports, the structure of our brains does not necessarily result in permanent pathology or even a disease. As Lewis makes clear, the brain is one of many variables to consider in the understanding of addiction. Neurobiological processes should not be the defining feature of addiction; rather, it should be “seen through a multidimensional lens composed of social, emotional, cognitive, familial, developmental and contextual factors” (Flanagan, 2017, p. 6). The treatment of addiction needs to be a multifaceted approach utilizing the expertise of different professionals from many different backgrounds to address the multitude of variables involved in this complex phenomenon.

Individual-Oriented Models of Substance Abuse: Etiologies and Treatments

Despite the need for a variety of professionals in the treatment of addiction, nurses and doctors are the primary treatment providers. This is mainly because addiction is widely understood in an individualistic paradigm rooted in the medical model, which endorses traditional, individualist approaches to treatment (Munro & Allan, 2011). When a patient reports a problem, a treatment provider’s job is to act as the expert and locate the root causes of that problem within the patient. Within this paradigm, treatment providers are expected to offer a cure through the use of medication or psychoanalysis to surface repressed material from childhood. Though the healing process may look different depending on whether you’re a medical doctor or psychologist, the one aspect all individually-focused treatments of addiction have in common is the failure to incorporate other support systems within substance misusers’ treatment.

Some individually-oriented treatment modalities view relationships as being the result of independent individuals coming together (Gergen, 2009). Since this perspective treats relationships as a derivative of individual minds, other people are often viewed as disruptive to an individual's treatment process. The predominant theory in the addiction field, which places the greatest amount of responsibility on the substance abusing individual, is commonly referred to as the Moral Model.

The Moral Model

The Moral Model, the first major model of addiction developed in the early 20th century, views substance misusers as devoid of willpower and psychologically weak, choosing not to do things differently even though they could. If individuals who use drugs or alcohol have difficulty stopping, they are viewed within this model as lacking strength. Proponents of the Moral Model assert that punishing substance misusers is the only way to rid them of their character defects and treat their addiction (Reiter, 2015).

Basic principles of human behavior suggest that a person who has been punished for a certain behavior is more likely to learn how to avoid punishment than to correct the behavior (Szalavitz, 2016). Additionally, when someone is threatened through punishment, certain areas of the brain—specifically those responsible for abstract reasoning and self-control—shut down. If you are trying to help an individual modify substance use behavior, utilizing methods that shut down areas of the brain vital to behavior change is counterproductive. Nevertheless, criminalization is the most common response to substance misuse; and despite evidence of their ineffectiveness, jail time, prison sentences, and strict drug laws continue to be the most predominant solutions attempted to address the problem of addiction (Szalavitz, 2016).

If jail or punishment were an effective cure for addiction, it would no longer exist (Szalavitz, 2016). Substance misusers would finish their prison sentences free from their addictions, never to touch alcohol or drugs again. But, of course, this is not the case. Nearly half of the individuals serving prison sentences are there on drug-related charges (Roeder, 2015). As Bosman (2017) states, “Public health officials have called the current opioid epidemic the worst drug crisis in America history, killing more than 33,000 people in 2015” (para. 2). We have been punishing people through the criminal justice system since the 20th century, yet the problem has escalated (Szalavitz, 2016).

Some believe that law enforcement should only be utilized to connect those struggling with addiction to resources, such as employment and housing. Studies have been conducted on a program called *Lead*, which helps inmates struggling with addiction to access services that can help them become productive members of society upon their release from prison. These efforts have been successful, and re-arrest rates for those inmates participating in the program have declined compared to other inmates (Collins, Lonczak, & Clifasefi, 2015; Szalavitz, 2016).

Another theory of addiction commonly discussed in combination with the moral model is the disease model. Whereas the moral model views individuals’ personalities as the cause of addiction, the disease model views certain individuals as being inherently at risk for the formation of an addiction. The disease model shifted the conversation about addiction’s etiology from choosing to live a depraved lifestyle to something more complex and biological in nature. Holding the views of addiction as a moral problem and a disease simultaneous presents a troublesome paradox; yet this is how many Americans continue to conceptualize addiction (Szalavitz, 2016).

The Disease Model

The disease model, which categorizes addiction as a medical disorder, is currently the accepted theory of addiction in the United States (Lewis, 2015; Reiter, 2015). The disease model was developed by E. M. Jellinek, who, in the 1950s, initially presented his theory only within the context of alcoholism. Since his time, however, the model has also been applied to drug addiction and other behavioral addictions (Jellinek, 1952; Reiter, 2015). Jellinek (1960) conceptualizes alcoholism as a four-phase progression, depending on the particular function alcohol serves for the individual (e.g., using substances for social reasons or to feel happy). The categories include *alpha alcoholism*, *beta alcoholism*, *gamma alcoholism*, and *delta alcoholism*. Jellinek's model categorizes substance misusers according to their level of psychological or physical dependence (Reiter, 2015). Research on this conceptualization was designed to support the disease model of addiction and provide scientific evidence for this theory. However, Jellinek's original study ". . . consisted of a meager sample size of only 98 male Alcoholic Anonymous (AA) members" (Young, 2017, p. 55), causing scholars to question its methodological credibility.

Jellinek's (1952) study paved the way for another era of research conducted in the 1980s and 1990s, which was based on the notion that drugs interfere with brain wiring. Researchers began to focus on synaptic differences in laboratory animals who were given various types of drugs. Based on this research, nationally recognized TV news commentator Bill Moyers hypothesized that drugs "hijack the brain" (Lewis, 2017, p. 8). The next major wave of research contributing to the disease model, conducted in the early 2000s, classified addiction as a chronic mental illness. McLellan, Lewis, O'Brien,

and Kleber (2000) compared drug dependence to diabetes, asthma, and other health conditions, suggesting that the course of treatment for drug addiction must be long-term.

Due to the chronic, long-term care needed to treat addiction, the disease model promotes the idea that once individuals become addicted to drugs, they will be addicted for life. Addiction can be in remission, but never cured, even if the individual maintains sobriety and abstains from the use of substances forever. From this perspective, individuals who fail to seek treatment will inevitably die (Reiter, 2015), so failure to comply with treatment protocols is tantamount to certain death.

Limiting the complex nature of addiction to an incurable disease with only one outcome reduces the complexity of human beings. Accordingly, Gergen (2009) cautions against the choice “of certain languages of descriptions and explanation opposed to others” (p. 22). Humans are the stories they tell themselves, and they behave in ways according to those stories (Parry, 1997). Individuals struggling with addiction who are immersed in a belief system that says they suffer from an incurable disease may see limited possibilities for themselves and their futures.

The disease model has also been critiqued for its excessive focus on the medical aspects of addiction, at the exclusion of important social and cultural variables. Focusing exclusively on biological aspects neglects to account for the social context in which the process of addiction occurs. Additionally, concentrating on the brain processes involved in a disease limits the focus of research to the field of neurobiology while minimizing the significance of biopsychosocial processes (Dingel et al., 2012). This is evidenced when examining the funding sources supporting NIDA. Dingel et al. (2012) found that NIDA drives most of its research funding toward neuroscience, which aims to investigate

neurobiological and genetic factors. Approaches examining relational interactions between individuals and their environment receive the least funding (Dingel et al., 2012). This disparity reveals how influential institutions like NIDA are in shaping our collective understanding of addiction. As Gergen (2009) explains, referring to the influence of large social institutions on our belief systems, “Such organizations come to have authority over matters of reality, reason and right. . . . In effect, institutions such as these are enormously important in determining the constructions by which we live” (p. 47).

Along with NIDA, two other major social organizations endorse the disease model of addiction and profit considerably for promoting this belief: these are the rehab industries and pharmaceutical companies (Lewis, 2017). Taking into consideration the dynamics of power within the larger social systems in which the disease model is embedded, it becomes easy to understand how this particular model maintains its dominance in the United States, despite researchers questioning its concepts (Carroll, 2016; Ford, 1996; Lewis, 2017; Miller, 2012). In addition to its support from social institutions and research funding, the disease theory is promoted through another major social system associated with addiction: AA.

Alcoholics Anonymous

Commonly referenced alongside the disease model is AA, a well-recognized self-help group for individuals who struggle with alcohol problems. Though the AA approach originally avoided referring to alcoholism as a disease (Nowinski, 2002), instead using terms like *illness* or metaphors like *allergy*, it eventually came to adopt the disease concept (Irving, 2014; Kurtz, 2002). The emergence of addiction treatment centers during the 1940s promoted the disease theory within AA (Fletcher, 2014; White, 2014).

Currently, AA is the most common method of self-help for substance misuse and has over 2 million members across the globe (AA General Service Office, 2017; Slaymaker & Sheehan, 2008). It was founded in 1935 by Bill Wilson and Dr. Bob Smith, who met each other in a Christian social community called the *Oxford Group* (Irving, 2014). The Oxford group was founded on a combination of religious principles and self-help approaches; it informed the founding principles of AA, which include confessing wrongdoings, making peace with people you hurt in the past, living a life of honesty, and serving others (Irving, 2014).

Bill Wilson and Dr. Bob Smith had their own struggles with alcoholism. Prior to the establishment of the Oxford group, both men attempted to stop drinking and failed numerous times, resulting in multiple hospital stays and the loss of relationships and careers. Recognizing the importance of social support in the process of attempting to gain sobriety, and realizing that a singular focus on God would repel non-religious alcoholics, the two men created AA (Irving 2014; Szalavitz 2016).

The earliest members of AA were severe alcoholics practically on the verge of death. Prior to the inception of AA, individuals struggling with addiction were stigmatized and considered unresponsive to treatment, which at the time consisted of psychiatric hospitalization and various religious practices. There was no research on addiction treatment during this time, so individuals trying to cope with addiction were left to figure it out themselves. When AA meetings first began to be offered, they served as a gathering place for people struggling with alcoholism to come together, process their difficulties, and relate with one another (Slaymaker & Sheehan, 2008; Szalavitz, 2016).

According to the philosophy of AA, deeply rooted psychological transformations will occur if substance misusers accept that they have no control over their lives while under the influence of substances (Tonigan, 2008). Essentially, substance misusers are considered *powerless*, a common term used within the AA community. Powerlessness is defined as the substance taking complete control over an individual's physical and psychological well-being (Slaymaker & Sheehan, 2008). Accepting the idea of powerlessness requires individuals to conform to the idea that change can only occur once they accept that willpower alone cannot cure addiction.

According to the AA philosophy, until substance misusers accept their weakness and powerlessness over their addiction, recovery will be impossible (Slaymaker & Sheehan, 2008). Vaillant (2014) believes that for the "still suffering alcoholic" (p. 219) accepting powerlessness can lead to positive emotions, such as joy and love. Furthermore, Downing (1991) conducted a research study with 50 participants and concluded that the more a person surrenders to the idea of powerlessness, the less likely he or she is to relapse. However, it was found that the participants who did not relapse had previously engaged in psychotherapy for substance abuse issues. Additionally, those who avoided relapse had no serious trauma compared to those who did relapse. Another research study composed of 122 participants found the exact opposite of what Downing did; these researchers concluded that relapses are more frequent and severe the more firmly a substance misuser believes in the idea of powerlessness (Miller, Westerberg, Harris, & Tonigan, 1996). The results of these two studies show that the effect of the concept of powerlessness is hard to determine.

The existing literature on the cultural ramifications of conforming to the idea of powerlessness is clear. Women and minorities groups fail to benefit from this idea, because they already deal with a lack of power in the broader society (Berg & Reuss, 1998; Szalavitz, 2016; Timko, Young, & Moos, 2012). Additionally, individuals may interpret powerlessness as meaning they have no control over other aspects of their lives, thereby viewing themselves as victims of their addiction (Ford, 1996).

In general, AA has been criticized for its insensitivity to cultural differences. For example, the organization is based on Western ideas that apply to heterosexual Caucasian males. While AA's theories may be valid in the Western culture, they may not apply to the whole human spectrum, with its wide-ranging cultural and socio-political beliefs. For example, powerlessness may have an entirely different meaning for an individual living in Asia or Africa (Reiter, 2015). Nevertheless, the idea of powerlessness is embedded in AA's core philosophy. It is suggested that once substance misusers accept their powerlessness, they can turn their willpower over to a *higher power*, while beginning a journey toward spiritual awakening (Wilson, 1953).

The definition of a higher power is open to interpretation, depending on each substance misuser's personal beliefs. The overarching purpose of connecting with a higher power is that it gives substance misusers a meaningful sense of direction in their lives (Slaymaker & Sheehan, 2008). Some choose their God of choice, or the higher power associated with their religion. Other agnostic or atheist substance misusers may choose anything to be their higher power, such as the Universe.

The AA approach has been criticized for its definition of addiction as both a disease and a spiritual or moral failing. Szalavitz (2016) states that "while 12-steppers

claim that addiction is a disease, they don't treat it like one. Imagine a psychiatrist telling a depressed person to surrender to God and take a moral inventory—or better yet, imagine this being proposed to treat cancer or AIDS” (p. 184). Nevertheless, suggestions such as these are found in the *Big Book*, which outlines the underlying principles of AA.

Written by Bill Wilson and Dr. Bob Smith, the *Big Book* establishes the primary goals of AA, including complete abstinence from all mood-altering substances. Outlined in *the Big Book* are the Twelve Steps, “one of the most influential guidelines in the substance abuse field” (Reiter, 2015, p. 135). The Twelve Steps were developed as a set of guidelines and beliefs for those attempting to recover from substance misuse problems (McCaul & Petry, 2003). Every member of AA is expected to read through the *Big Book*, attend meetings—ideally 90 meetings in 90 days—complete the Twelve Steps, and obtain a sponsor (Reiter, 2015).

A sponsor is another member of AA who has been sober for some time and is active in the AA community. To be considered eligible, an individual must have successfully completed the Twelve Steps (Nowinski, 2002). Sponsors promote the idea of fellowship and take in new members as their sponsees, guiding them through each of the Twelve Steps and supporting them with any struggles they come across during their recovery (Irving, 2014). Members of AA participate in weekly meetings with their sponsors, while practicing and implementing the Twelve-Step philosophy into their lives; this is known as *working the program*. Individuals who are abstinent but fail to actively engage in the AA program and work the Twelve Steps are considered *dry alcoholics* who cannot consider themselves truly in recovery (Irving, 2014).

The Twelve Steps of AA are outlined below:

Step 1: We admitted we were powerless over alcohol—that our lives had become unmanageable. . . .

Step 2: Came to believe that a Power greater than ourselves could restore us to sanity. . . .

Step 3: Made a decision to turn our will and our lives over to the care of God as we understood Him. . . .

Step 4: Made a searching and fearless moral inventory of ourselves. . . .

Step 5: Admitted to God, to ourselves, and to another human being the exact nature of our wrongs. . . .

Step 6: Were entirely ready to have God remove all these defects of character. . . .

Step 7: Humbly asked Him to remove our shortcomings. . . .

Step 8: Made a list of all persons we had harmed, and became willing to make amends to them all. . . .

Step 9: Made direct amends to such people wherever possible, except when to do so would injure them or others. . . .

Step 10: Continued to take personal inventory and when we were wrong promptly admitted it. . . .

Step 11: Sought through prayer and meditation to improve our conscious contact with God, as we understood Him, praying only for knowledge of His will for us and the power to carry that out. . . .

Step 12: Having had a spiritual awakening as the result of these Steps, we tried to carry this message to alcoholics, and to practice these principles in all our affairs.

(Wilson, 1953, pp. 21-106)

There are three structures of AA meetings: *speaker meetings*, *step meetings*, and *discussion meetings*. In speaker meetings, a member is chosen to share his or her story related to the personal struggles he or she has faced with substance misuse. Step meetings are utilized to discuss one of the Twelve Steps in depth. Discussion meetings provide the space for members to process their own relationship with addiction related to a specific group topic (Reiter, 2015; Szalavitz, 2016).

Although AA consists of individuals who struggle with a common problem coming together for support, meetings are different from formal group psychotherapy, as they are not facilitated by a licensed clinician. Typically, AA meetings are recommended as an adjunct to professional treatment or as the main supportive outlet for individuals who are not involved in any kind of therapeutic services (Reiter, 2015).

History of the American Addiction Treatment System

In 1941, the Saturday Evening Post wrote an article about AA, which attracted many individuals to the program. As a result, its membership began to grow at a rapid rate (Reiter, 2015). Eventually, other self-help groups were created following the same Twelve-Step structure, specific to the problematic substance or behavior. All Twelve-Step self-help groups are collectively referred to as Twelve-Step Organizations (Kingree, 2013). Some examples of these include Cocaine Anonymous, Marijuana Anonymous, Crystal Meth Anonymous, Narcotics Anonymous, among others (National Council on Alcoholism and Drug Dependence, 2018).

In the early years of AA, individuals who engaged in the program began to successfully transition their lifestyles from problematic use of substances to complete abstinence. As a result, medical professionals took notice and started to incorporate AA philosophy into hospital treatment for addiction. Members of AA who had difficulty remaining abstinent by solely attending AA meetings were referred to residential treatment centers. This led to the creation of the American Addiction Treatment System, which sparked a revolutionary shift in the way alcoholism was treated (Szalavitz, 2016). Although the treatment of alcoholism was considered separate from narcotic treatment during this time, both fields implemented similar treatment methods and eventually merged into one (White & Miller, 2007).

Hiring recovering AA members and multi-disciplinary teams of professionals within treatment centers led to a revolutionary change in the way alcoholism was treated during the early 20th Century. Psychiatric practices grounded in psychoanalytic theory were replaced with group psychotherapy, psychoeducation, and referrals for long-term support through AA. Dan Anderson, a psychologist, and Nelson Bradley, a psychiatrist, both at Wilmar State Hospital in Minnesota, held a special interest in the most severe cases of substance misuse. Initially questioning the effectiveness of AA and eventually growing a deep appreciation for its philosophy, they began hiring recovering alcoholics to work in conjunction with teams of nurses, doctors, and psychologists. Recovering alcoholics who worked alongside these professionals eventually earned counselor positions within these residential centers (McElrath, 1998).

Around the same time, Pat Butler, founder of a treatment facility named Hazelden, developed a similar treatment philosophy as that adopted by Dan Anderson

and Nelson Bradely. As a result, he invited both men to assist in the development of his program. Eventually, Dan Anderson accepted a full-time position as Hazelden's Vice President and Executive Director. He continued to develop a treatment strategy firmly based on the concepts of AA, which was facilitated by multi-disciplinary teams. This eventually became known as the Minnesota Model (Kingree, 2013; Slaymaker & Sheehan, 2008).

The Minnesota Model

The Minnesota Model, which was founded in 1949 (Anderson et al., 1999), provided the space and time for residents to embrace and learn the AA philosophy within a 28-day treatment program (Kingree, 2013). Though this is considered a revolutionary time in the shift of alcoholism treatment, the Twelve Steps of AA were never intended to be imposed on substances misusers within the context of a treatment program. Rather, AA was only meant to provide a series of suggestions for individuals in recovery. With the birth of residential treatment centers based on the Minnesota model, AA stopped being suggested and instead became mandatory (Szalavitz, 2016; McElrath, 1998).

Some scholars suggest that substance misusers receiving professional treatment should be able to make their own choices regarding whether and how to engage with AA. They emphasize the harm that can be caused if the AA is forced upon individuals, especially minorities, women, and youth, advising that different treatment options be offered in addition to AA (Fletcher 2013; Szalavitz, 2016). Client-centered approaches, the antithesis of coercion, have been found to be more effective for treating substance misuse than those approaches involving confrontation (Miller et al., 1993; Project MATCH Research Group, 1997).

Confrontational approaches were initially utilized in the Hazelden Model and later incorporated into AA. This approach was developed at Hazelden to reach individuals who were deemed to have severe dysfunctional character defects and were unresponsive to treatment attempts. These clients were mainly young individuals who struggled with narcotic abuse (White & Miller, 2007). Confrontation-based interventions are based on the notion that when individuals repress their feelings, they will develop other psychological problems; therefore, the goal is to address and unlock those repressed emotions to prevent further psychological damage (White & Miller, 2007). According to Miller (2012), confrontation “was a common practice in the field at that time to get in people’s faces and yell at them. . . . Someone who broke a program rule might be required to wear a toilet seat around his neck for a day or two” (p. 3).

Confrontation techniques are also rooted in the assumption that substance misusers have rigid defense mechanisms that need to be torn down. The general assumption is that all substance misusers have defective and immature character traits; however, no scientific study has ever proven this. There are no specific personality traits attributable to individuals struggling with addiction. In fact, the range of personalities found within the addicted population is no different from what is found in the general population (Donovan, Hague, & O’Leary, 1975; Szalavitz, 2016; White & Miller, 2007).

Another assumption underlying confrontational methods is that individuals struggling with addiction are incapable of comprehending reality. The solution to this problem requires another professional or individual in recovery to correct their deviance and refute the illogical notions of their particular version of reality (Csiernik, 2016). As a result of this belief, therapeutic models grounded in compassion and empathy were

abased within the early addiction treatment community because of their passive nature (Miller, 2012). Instead, confrontational interventions were promoted because they served to, “tear down the masks that contained repressed emotions, allowing the individual to get ‘real’ with themselves and others” (White & Miller, 2007, p. 6).

Early claims promoting confrontation as effective relied mostly on opinion rather than scientific evidence (Padwa & Kaplan, 2017; White & Miller, 2007). As new research studies were facilitated over time, confrontational approaches were proven ineffective, as they increase client resistance and discourage change (Csiernik, 2016; Pomerleau, Pertschuk, Adkins, & Brady, 1978; Szalavitz, 2016; White & Miller 2007). Despite the lack of scientific evidence, confrontational methods remain an integral part of the American Addiction Treatment System (Forman, Bovasson, & Woody, 2001; White & Miller, 2007).

Synanon

The Synanon model was developed in 1958, around 10 years after the Minnesota Model was founded. It takes a confrontational approach and borrows ideas from AA. Synanon was developed by Charles Dederich, a former member of AA, and was intended to be an alternative recovery community for people struggling with addiction (White & Miller, 2007). It promoted a cure for addiction grounded in harsh treatment philosophies. A major concept utilized in Synanon, as well as in AA and the Minnesota Model, was known as *hitting bottom*, which asserts that individuals struggling with addiction have severe character defects and are unlikely to enter treatment unless they experience dramatic physical and emotional suffering (Robertson, 2012). Getting kicked out of one’s house or losing a job or important relationship as a result of substance use are all

examples of hitting bottom. This belief is embedded in American treatment centers and government policies more than in any other country (Robertson, 2012; Wilson et al., 2000).

If substance misusers fail to hit bottom, Synanon believes they should be pushed to that point through attack therapy, which is designed to destroy their dysfunctional character traits and ego through humiliation and embarrassment. This approach was commonly utilized in addiction treatment during the 1960s and 1970s to coerce individuals to reach their bottom and surrender to the ideas of the Synanon model (Miller, 2012; Szalavitz, 2016).

Like AA, Synanon gained its popularity through the media, despite evidence of a high drop-out rate, large occurrences of relapse, and lasting psychological damage (Szalavitz, 2016). Despite inefficient research reports, the approach had won national acclaim by the 1960s; by the mid-1970s, more than 500 addiction treatment centers based their philosophies on Synanon concepts (Szalavitz, 2016; White & Miller, 2007).

Initially, the Twelve Steps of AA were not affiliated with Synanon. However, by the 1980s and 1990s, a second generation of therapeutic communities based on Synanon reincorporated the Twelve Steps and encouraged its graduates to attend AA meetings upon graduating from treatment. Treatment lasted from three to 18 months, after which point patients would move into a residential addiction treatment center. Examples of second-generation Synanon communities are the Phoenix House, Walden House, and Daytop (Szalavitz, 2016). Eventually, the Synanon movement ended in the early 1990s, due to illegal activities that led to the arrest of Charles Dederich, who was drunk when arrested for conspiracy to commit murder (Szalavitz, 2016).

Although the interventions used in AA and the Minnesota model were not as harsh as those used in Synanon, all three models advocated the use of confrontational methods for the treatment of addiction. Whether the confrontations entailed demanding that a grown man dress up as a baby to break through his defense mechanisms, as in Synanon, or forcing individuals to admit to all their wrongdoings in the presence of strangers, as in AA and the Minnesota model, the practitioners viewed them as a necessary component of the treatment process.

The Current American Addiction Treatment System

The Minnesota Model, Synanon, and AA were all influential in the creation of residential addiction treatment facilities (Fletcher, 2013; Slaymaker & Sheehan, 2008). In the 1970s, an abundance of community and hospital-based treatment centers began to open, and addiction treatment centers became known as *rehab*s (Fletcher, 2013; Slaymaker & Sheehan, 2008). There are currently over 13,000 rehabs throughout the United States, the vast majority of which base their treatment on the Minnesota Model (Anderson et al., 1999; Fletcher, 2013; Miller & Rollnick, 2013; Szalavitz, 2016; White & Miller 2007).

Most rehabs based on the Minnesota Model advertise their facilities as *Twelve-Step-based*; treatment focuses primarily on Twelve-Step principles and beliefs, in combination with other therapeutic approaches (Fletcher, 2013). However, it is important to note that the Twelve Steps do not constitute suitable treatment (Fletcher, 2013; Messina, Wish, & Nemes, 2000; Schenker, 2009; Szalavitz, 2016). Twelve-Step-based treatment encourages Twelve-Step meetings, examines the Twelve Steps in depth, and welcomes Twelve-Step speakers into the treatment center. Although AA and other

Twelve-Step self-help groups do not associate themselves with professional treatment, it is common for members of these communities to speak at treatment centers (Fletcher, 2013; Humphreys, Huebsch, Finney, & Moos, 1999; Kingree, 2013; Slaymaker & Sheehan, 2008; Tonigan, 2008).

Treatment Structure

Within the structure of addiction treatment, there are various levels of care, which include inpatient, residential, intensive outpatient, and outpatient treatment. Inpatient treatment occurs in a medical facility or hospital, because medical services interventions are utilized. Inpatient services vary in their service delivery; some provide only detoxification, or *detox*, while others also incorporate treatment services. The underlying philosophy at this level of care is that “. . . recovery from addiction is the same, regardless of the drug involved” (Fletcher, 2013, p. 135). After completing detox and inpatient treatment, individuals have the option to transition to the residential level of care.

Residential treatment is considered a period of stabilization that lasts, on average, from 28 to 30 days. The cost of treatment ranges anywhere from \$27,000 to \$55,000 (Fletcher, 2013). Patients spend the day in residential treatment and, in the evening, receive a range of services particular to their particular treatment facility. Group therapy, individual therapy, psychoeducational groups, Twelve-Step meetings, acupuncture, chiropractic services, exercise classes, and nutritional counseling are just some examples of the wide array of services offered in residential treatment (Fletcher, 2013). Graduation ceremonies are often held once patients complete treatment. Graduates may give speeches, say good-bye to their peers, or receive a coin or another symbolic

representation of their completion of residential treatment. Typically, graduates of these programs are strongly encouraged to transition to an outpatient program and become involved with a self-help group in their community (Fletcher, 2013).

Individuals can choose to continue their care in intensive or standard outpatient treatment, which differ in terms of the number of hours required per week. The services offered at these levels of treatment are similar to those in residential treatment. However, individuals in intensive outpatient treatment must attend more hours of treatment in the daytime or evening. Progress made during intensive outpatient treatment determines when individuals can step down to standard outpatient; if they are unable to stay sober, they may be required to go back to residential treatment. In most programs, individuals who relapse are not offered a different treatment from what they previously received. Fletcher (2013) describes the transition back to residential treatment after a relapse like buying a car:

It's as if you want a car and there is only one model available, so you're forced to buy it, often literally forced. Then when the car you're sold doesn't work, you get the blame because you drove it incorrectly. (p. 19)

Individuals attending Twelve-Step-based treatment are often encouraged to see other treatments as less effective (Szalavitz, 2016). In her interviews with substance misusers attending treatment, Fletcher (2013) found that most individuals who do not adapt to the Twelve-Step approach are given the impression that this is the only way to recover and are not offered any other treatment options. Gergen (2009) cautions against becoming too certain about one idea, as it eliminates other possibilities. He explains, "In

this sense, what is most obvious to us—most fully compelling at any given time—is also the most limiting (p. 161).

When substance misusers relapse during the treatment process, they are automatically blamed; there is no systematic exploration of other factors contributing to the relapse, including the type of treatment delivered. It is not taken into consideration that perhaps the treatment was not a good fit for the individual. The existing literature reveals that most individuals relapse within a year or more of completing treatment; it is thus sensible to explore the various factors that could be contributing to such relapse rates (Fernández-Montalvo, López-Goñi, Illescas, Landa, & Lorea, 2008; Magor-Blatch, Bhullar, Thomson, & Thorsteinsson, 2014; Vanderplasschen et al., 2013).

Patients who avoid relapse usually transition from intensive outpatient to a standard outpatient program, which can last between 30 and 120 days. Services are usually delivered in the evening, making it possible for individuals to be employed while they complete their treatment. Patients live at their usual place of residence or reside in sober-living facilities while attending the outpatient program (Fletcher, 2013).

Sober-living facilities, also known as *halfway houses*, require individuals to maintain complete abstinence and submit to random drug tests or breathalyzers to ensure their sobriety. While a sober-living facility does not constitute treatment in itself, individuals can reside there while attending outpatient treatment if they require more structure while trying to remain sober (Fletcher, 2013).

Rehabs work from the assumption that the combination of a structured program and drug-free environment will foster social and coping skills that individuals can transfer to their environment outside of treatment. The idea is that the fewer distractions

individuals experience while in rehab, the more engaged they will be in the treatment process, allowing them to learn the coping skills necessary for dealing with their substance misuse struggles. However, some argue that such lack of connection to the outside world can be counterproductive to individuals' treatment process (Fletcher, 2013; White & Miller, 2007).

Professional Staff

Although medical professionals are the primary treatment providers in addiction treatment facilities, other professionals such as social workers, mental health professionals, marriage and family therapists, psychologists, addiction counselors, massage therapists, and acupuncture specialists are also typically part of the treatment team. Unfortunately, "staff and director turnover in these programs is higher than in fast-food restaurants" (Fletcher, 2013, p. 17).

In addition to medical professionals, addiction counselors are the other group most commonly found working in rehabs (CASA, 2012). There are typically no credentials required for these employees, other than personal experience with addiction. Currently, 14 states lack educational or licensing requirements for individuals to become an addiction counselor, and only one state requires a master's degree. In the state of New York, counselors are required to go through Credentialed Alcoholism and Substance training; however, they are not required to obtain a license to work in a rehab (Fletcher, 2013). In other states, a high school diploma is the only requirement to become a counselor at an addiction treatment center. Individuals usually receive informal training on the job through other recovering individuals who also lack credentials (Fletcher, 2013).

With the exception of only a few addiction treatment programs, experts are not the ones providing treatment in rehabs (CASA, 2012; Fletcher, 2013; Szalavitz, 2016). As Miller, Sorensen, Selzer, and Brigham (2006) explain, “Treatment practices thus continue to be guided by the folk wisdom of recovering people, particularly through the perspectives of AA and related 12-step programs” (p. 26). A similar sentiment is echoed by CASA (2012), which indicates that treatment offered in current rehabs is no different than what was offered in the 1950s.

Since the 1950s, research on addiction has advanced and established various evidence-based practices for substance misuse (Bricker, 2015). However, there is a gap between what is practiced in rehabs and what researchers report as effective (CASA, 2012; Miller et al., 2006). Although this is generally true in healthcare, it is more prevalent in the field of addictions (Fletcher, 2013). Additionally, The American addiction treatment system remains the most segregated and stigmatized of all healthcare sectors. Fletcher (2013) poses the relevant question, “In what other area of medicine can you go to a place for treatment and not have them be able to give you any idea of their outcome rates or point to the scientific basis for the treatments you might receive?” (p. 14). It only takes one or two positive trials for a treatment intervention to qualify as evidence-based. At present, there are over 300 treatments considered evidence-based in the field of substance misuse (Miller & Moyers, 2014).

Another variable separating the American addiction treatment system from the rest of healthcare is the financial element. Funding for treatment comes largely from government grant dollars rather than medical insurance (CASA, 2012; Fletcher, 2013). In fact, medical insurance is less likely to cover substance misuse treatment than that for

other health problems. When medical insurance does cover the costs of treatment, it does so only minimally, requiring the treatment recipient to pay a large sum out of pocket (Stewart & Horgan, 2011). For this reason, accessing treatment can be a challenge for individuals with limited finances and medical insurance. The American addiction treatment system has been criticized for offering pricey treatment that is no different from the Twelve-Step meetings offered for free in most communities (Szalavitz, 2016).

Efficacy of the American Addiction Treatment System

Financial barriers could be one of the reasons explaining the low numbers of people who seek treatment. Approximately 10% of individuals who struggle with addiction receive treatment. This number is particularly staggering when considering that over 33,000 people in America died from substance misuse disorder in 2015 (Bosman, 2017). Aside from financial reasons, individuals with the severest addiction problems are least likely to end up in treatment because they feel it isn't beneficial or effective (Kelly & Gates, 2017). Nevertheless, research indicates that rehabs are most effective for individuals with severe addictions (Darke, Campbell, & Popple, 2012; De Leon, Melnick, & Cleland, 2008; Magor-Blatch et al., 2014; Miller, 2012; Vanderplasschen et al., 2013). Cases categorized as severe include those involving escalated mental health issues, histories of incarceration, or homelessness.

A term often used interchangeably with rehab in the literature is *therapeutic community*, which is defined as:

. . . a miniature society in which residents, and staff in the role of facilitators, fulfil distinctive roles and adhere to clear rules, all designed to promote the transitional process of the residents. Self-help and mutual help are pillars of the

therapeutic process, in which the resident is the protagonist principally responsible for achieving personal growth, realizing a more meaningful and responsible life, and of upholding the welfare of the community. The program is voluntary in that the resident will not be held in the program by force or against his/her will (Dawson & Zandvoort, 2010, p. 97).

Research on therapeutic communities, which were initially based on the Hazeldon/Minnesota Model, first began in 1945 (Slaymaker & Sheehan, 2008). Abstinence was the only measured outcome, and the results were highly favorable (Slaymaker & Sheehan, 2008). Initial research studies about the efficacy of therapeutic communities reported positive outcomes; however, it was later discovered that the studies were full of methodological errors, critically limiting the generalizability of their findings (Vanderplasschen et al., 2013). The next era of research was conducted between 1989 and 2001, expanding outcome measures by analyzing other factors, such as the frequency and consequences of patients' drinking (Tonigan, 2008). The next era of research, which began in 2002 and is ongoing, continues to add and evolve outcome measures, including changes in behavior and attitudes (Tonigan, 2008).

Efficacy studies on therapeutic communities have identified short-term positive outcomes, such as reduced substance use and increased social skills (Inciardi, Martin, & Butzin, 2004; Magor-Blatch, et al., 2014; Nuttbrock, Rahav, Rivera, Ng-Mak, & Link, 1998). It is important to note, however, that most of these studies were conducted with the populations known to be the most likely to benefit from therapeutic communities: individuals with mental health problems, a history of incarceration, and homelessness.

Other studies attesting to the long-term effectiveness of therapeutic communities raise questions, as most of the participants eventually returned to the same behaviors after a year or more (Fernández-Montalvo et al., 2008; Malivert, Fatséas, Denis, Langlois, & Auriacombe, 2012; Van Stelle & Moberg, 2004).

Currently, research studies on therapeutic communities continue to be filled with methodological limitations, pointing to a need for strengthening research procedures (Magor-Blatch et al., 2014; Smith, Gates, & Foxcroft, 2006; Vanderplasschen, Vandeveld, & Broekaert, 2014). In spite of the inconclusive results, NIDA (2017) identifies therapeutic communities as being effective in reducing substance use, criminal behavior, and mental health symptoms; interestingly, it mentions nothing about the absence of long-term benefits associated with these kinds of communities.

Twelve-Step Facilitation Therapy

The existing addiction literature points to the efficacy of another therapeutic intervention: Twelve-Step Facilitation (TSF) (Kingree, 2013; Nowinski, 2002), a manualized therapy approach based on Twelve-Step ideology, which is facilitated in professional treatment settings and was specifically developed for research purposes (Kingree, 2013; Nowinski, 2002). Since AA does not allow researchers in their communities to conduct trials, a manualized approach reflective of AA principals and concepts was created to study AA-related processes (Nowinski, 2002).

Handbooks and curricula are used to guide facilitators in conducting each session (Nowinski, 2006; Nowinski & Baker, 2003; Slaymaker & Sheehan, 2008). Like AA, the goals of TSF are abstinence and active involvement in Twelve-Step organizations. A TSF facilitator connects clients to Twelve-Step self-help groups in their local community

and guides them into effectively utilizing these groups for guidance and resources (Kingree, 2013; Nowinski, 2002).

A TSF facilitator is a competent psychotherapist highly knowledgeable about Twelve-Step organizations. Although TSF facilitators are not required to be in recovery from substance misuse, they are required to attend a specified number of Twelve-Step meetings. Additionally, they are required to be knowledgeable about Twelve-Step resources so they can refer clients to various sponsors and meetings (Kingree, 2013; Nowinski, 2002). The facilitator's main role is to help clients work through the first five steps throughout a series of 12 therapeutic sessions while in the context of professional treatment. The remaining six steps are usually completed outside of treatment with a sponsor of the client's choosing (Kingree, 2013). Although certain expectations are outlined, there is no standard protocol specifying the number of steps that must be completed; clients set the pace for themselves (Slaymaker & Sheehan, 2008).

In general, TSF facilitators work from the assumption that addiction is a "cunning and clever illness" (Nowinski, 2002, p. 268). As such, they are trained to expect that denial and relapse will occur during the early stages of sobriety. Facilitators in the TSF approach are prepared to confront clients' denial during therapy sessions, while influencing them to accept and surrender to ideas about remaining abstinent from substances for the remainder of their lives. Within the TSF model, confrontation is called *care-frontation*, meaning that the act of confrontation is conducted with a warm, non-threatening demeanor (Nowinski, 2002). Additionally, the facilitator is expected to create

a context of collaboration; “he or she consistently strives to engage the client in a constructive collaboration towards the goal of achieving sobriety” (Nowinski, 2002, p. 267).

According to Nowinski (2002), TSF is a model requiring the facilitator to be both confrontational and collaborative. Confrontation implies that the facilitator’s viewpoint has more power than the client’s. But a facilitator who uses this approach exclusively and sees sobriety as the only possible outcome, fails to conduct a collaborative process. Collaboration considers all viewpoints equally, not only the one held by the facilitator. If a client disagrees with the goal of abstinence, the TSF facilitator does not collaborate on this goal, but rather tries to convince the client that sobriety is necessary for him or her to heal from addiction. This raises questions about how truly collaborative the model is. Kingree (2013) alludes to the lack of collaboration in Twelve-Step approaches: “Controlled use of alcohol is antithetical to AA and participants are discouraged from considering it as a viable possibility” (p. 143).

The TSF approach asserts that the fellowship of the Twelve-Step organization, rather than therapeutic processes or personal motivation, is primarily responsible for the shift in substance misusers’ behavior. A TSF facilitator practices mindfully ensuring that the therapeutic process remains separate from substance misusers’ recovery program (Nowinski, 2002).

The TSF model consists of three different program formats: core, elective, and conjoint. The elective program is designed for people who are already part of a fellowship but have relapsed after a consistent period of sobriety. The conjoint program is utilized to garner support from the partners of substance misusers and educate them about

the Twelve-Step organization. The core program is intended for individuals who are new to sobriety (Kingree, 2013).

The core program begins with a detailed assessment in the first session to examine the severity of the individual's substance misuse. Based on this assessment, a treatment plan is created and the therapeutic process begins (Nowinski, 2002; Slaymaker & Sheehan, 2008). The objective of the first therapeutic task is to help clients understand that their lives are unmanageable under the influence of substances. The next therapeutic task, covered in the third session, is to cover steps two and three of the Twelve Steps (Kingree, 2013). The sessions build upon one another, continuing to emphasize the belief that individuals must surrender their efforts to control their substance use and turn it over to a higher power while welcoming a life of sobriety. Facilitators' main role during this part of the therapeutic process is to build trust so that their clients will disclose their struggles while practicing social and coping skills (Slaymaker & Sheehan, 2008).

Each session begins with a recap of the client's week in relation to Twelve-Step practices. For example, the facilitator inquires about the number of Twelve-Step meetings attended, new revelations acquired from step-work, and so on. At the end of each session, the therapist assigns a recovery task for the client to complete between sessions; this can include writing a goodbye letter to substances, journaling about the consequences of using substances, or identifying desirable traits for an ideal sponsor (Kingree, 2013).

The next six sessions center on recovery topics expected to help clients achieve a life of sobriety. For example, the seventh session requires facilitators to engage clients in conversation about potential threats to their sobriety. The recovery task is to create a lifestyle contract, a written document specifying actions that must be undertaken for a

successful recovery. Fundamental to the lifestyle contract is an agreement to stop associating with people and engaging in routines that will interfere with the recovery process (Kingree, 2013). The common slogan used to refer to this commitment to detach from people unsupportive of the recovery process is *People, Places, and Things* (Nowinski, 2002). Another recovery topic discussed in these sessions is the acronym *HALT*, which stands for *Hungry, Angry, Lonely, and Tired*, all seen as potential risks for relapse (Kingree, 2013, p. 141).

The ninth session examines Step 4 and Step 5, requiring clients to create a *moral inventory*, in which they identify everything they have done wrong in their relationships and then go out to interview those individuals to gain a greater understanding of their own behavior (Slaymaker & Sheehan, 2008). Facilitators act as a support system and help clients understand their feelings better. Additionally, they continue to help clients develop more recognition of maladaptive behaviors and a closer relationship to their higher power (Slaymaker & Sheehan, 2008). The tenth session explores lifestyle changes, and the eleventh encourages clients to elicit support from people in their relational systems to promote their new lifestyles changes. After 12 sessions, termination is marked by clients' committing to continued care in the fellowship of Twelve-Step meetings (Nowinski, 2002).

Efficacy of TSF and Other Twelve-Step Organizations

According to Slaymaker and Sheehan (2008), The American Psychiatric Association (APA) fully supports the recommendation of Twelve-Step meetings in conjunction with treatment. Although the APA (2018) indicates that Twelve-Step community groups can be helpful when combined with formal treatment, the efficacy of

such groups is inconclusive. This small but important detail is left out of Slaymaker and Sheehan (2008)'s article. While the APA (2018) asserts that "the focus and structure of groups can vary considerably, and there is a paucity of research on these modalities" (p. 23), other researchers show conclusive results, reporting that AA attendance leads to abstinence (Magura, Cleland, & Tonigan, 2013; Magura, McKean, Kosten, & Tonigan, 2013; Timko, Moos, Finney, & Lesar, 2000). Moreover, abstinence, the theoretical foundation upon which AA is based, is difficult to measure empirically. Ethical and practical considerations place considerable limitations on randomized clinical trials (Kingree, 2013).

Research on Twelve-Step community meetings is primarily conducted through self-report surveys or by studying participants in TSF therapy (Nowinski 2002). However, TSF therapy is not equivalent to the Twelve-Step meetings held in local communities, so the research results can be misleading. The AA organization is known to distribute its own surveys to members every couple of years, but for purposes unrelated to research (Gray, 2012; Irving, 2014).

Another methodological limitation raising questions about the legitimacy of TSF research is selection bias. Only participants who complete the full duration of the research studies are tested; results are not reported for those who drop out. Therefore, it is hard to determine whether positive outcomes are related to the Twelve-Step approach or to the fact that subjects are highly motivated for treatment, making them more likely to succeed (Szalavitz, 2016; Tonigan, 2008). Tonigan et al. (1996) found that positive outcomes in terms of participant abstinence resulting from Twelve-Step participation are amplified due to a lack of methodological rigor in research studies.

The Cochrane Group, known to have the highest standards for medical efficacy, reported in their most recent review of AA and TSF that “no experimental studies unequivocally demonstrated the effectiveness of AA or TSF approaches for reducing alcohol dependence or problems” (Ferri, Amato, & Davoli, 2009, para. 7). Outcome research on AA predominantly supports the notion that while AA is one way to achieve abstinence, it does not produce superior results for the population as a whole. Some people work the steps, obtain a sponsor, and attend meetings but are never able to completely abstain from mood-altering substances (Forman, Humphreys, & Tonigan, 2003).

Researchers have not yet been able to clarify the differences between those populations who benefit from AA and those who do not. The effectiveness of Twelve-Step interventions varies across sub-groups of people, and thus far, research has only accounted for half of the variance (Kelly, 2017). Some studies have been conducted in an attempt to correct methodological errors and produce more accurate research on AA, but outcomes continue to be affected by confounding variables (Humphreys, Blodgett, & Wagner, 2014).

Project MATCH

From 1990 to 1997, a largescale, randomized clinical trial known as Project MATCH was conducted to study interventions for alcoholism (Kingree, 2013). It compared TSF therapy with other therapeutic interventions, but its primary goal was to match treatments to client characteristics. Project MATCH was funded by The National Institute on Alcohol Abuse and is considered groundbreaking in alcoholism research because it was the largest randomized clinical trial ever completed. Project MATCH cost

over 20 million dollars and was conducted over the course of 10 years (DiClemente, 2011). Although the study's results were significant, it is important to note that it was conducted only on alcohol-dependent individuals, so its findings cannot be generalized to individuals who misuse other substances (Kingree, 2013).

The results of the study on TSF's effectiveness were unsurprising, considering the goals of the intervention: abstinence and attendance at AA meetings. Higher levels of AA engagement were found among participants in the TSF treatment group, the only treatment group emphasizing AA participation, compared to other treatment groups. As such, “. . . it is difficult to detect unique effects for TSF in relation to its primary goals” (Kingree, 2013, p. 146). A conclusive finding in Project MATCH was that individuals with minimal mental health issues and social networks unsupportive of abstinence did best with TSF compared to the other treatment modalities (Kingree, 2013).

Other randomized clinical trials have been completed since Project MATCH, studying TSF compared with other treatment modalities (Brown et al., 2006; Carroll, Nich, Shi, Eagan, & Ball, 2012; Hayes et al., 2004), but none have compared to Project MATCH. Furthermore, most of those studies demonstrated similar methodological errors as previous studies measuring abstinence-based outcomes (Kingree, 2013). Even though Project MATCH is known for its methodological rigor, errors related to selection bias, failure to control for placebo, and issues with internal and external validity were still present (Walters, 2002).

A critical finding from Project MATCH was that none of the three treatments studied—TSF, CBT, and Motivational Enhancement Therapy—was found to be superior to the others (Walters, 2002). This finding, which echoes what has been found in other

studies on the field of addictions as a whole, could have something to do with common factors in substance misuse.

Common Factors in Addiction Research

Common factors, which are sometimes called *contextual factors*, refer to unspecific factors related to a treatment modality; *specific factors*, on the other hand, are fundamental factors that are central to a treatment modality (Beregmark, 2015). Some examples of common factors in addiction research are client characteristics, such as motivation levels or level of social support for sobriety. Common factors can also include therapist characteristics, such as interpersonal skills or level of experience.

The research shows that there are few to no differences in research outcomes among evidence-based treatments (Bergmark, 2015; Miller & Moyers, 2014). Bricker (2015) states, “Forty years of clinical outcome research in addictions have shown us that treatment works, effects are small to moderate and one ‘bona fide’ intervention rarely works better than another” (p. 415). Researchers noting the lack of attention to common factors in addiction research argue that both specific and common factors should be given equal weight in the evaluation of addiction treatment outcomes (Bergmark, 2014; Miller & Moyers, 2014). The common factors debate is centered on the recognition of unspecified factors, which account for 30% of the variances in treatment outcome (Davidson & Chan, 2014; Lambert & Barley, 2001).

One of the most important common factors to consider in addiction research is the category of therapist characteristics, which are considered to account for the greatest differences among addiction treatment interventions. This same phenomenon is found in the field of mental health as a whole. However, this variable is found to be even more

significant among therapists working with the substance misuse population (Miller, Moyers, Arciniega, Ernst, & Forcehimes, 2005; White & Miller, 2007). Some addiction therapist characteristics associated with positive treatment outcomes include a sense of warmth, a fostering of client empowerment, optimism, humor, empathy, instillation of hope, non-judgment, acceptance, trust, and understanding (Davidson & Chan 2014; Steinglass, 2009).

Of all the therapist characteristics, empathy has been found to be the most effective in the treatment of addictions (Miller, 2012; Miller & Rollnick, 2013; Miller, Taylor, & West, 1980; Valle, 1981). Miller (2012) defines empathy as

. . . the therapeutic skill described by Carl Rogers, the ability to listen well to people, understand what they mean, and reflect it back to them in a way that helps them keep exploring. It is the opposite of an expert model, that “I’m going to fix you.” It is a respectful, hopeful, engaged kind of listening that brings out the best in people. It’s not an easy skill. (pp. 5-6)

Helping alliance is another characteristic predictive of positive outcomes in addiction treatment. However, if the therapeutic alliance is too strong, it can decrease treatment outcomes (Miller & Moyers, 2014). Research on this aspect of treatment is still in the beginning stages and needs further exploration (Miller & Moyers, 2014).

Common factors and methodological limitations should be considered when evaluating addiction research. Nevertheless, clinicians should still base their treatment practices on what works according to the literature. Although significant differences between treatments have not been found, there are still a great number of approaches demonstrating desirable treatment outcomes (Fletcher, 2013).

Individualistic Therapy Models Commonly Utilized in Rehabs Demonstrating Positive Research Outcomes

Cognitive Behavioral Therapy

Cognitive Behavioral Therapy (CBT) is well investigated in the literature and is considered an evidence-based therapy for the treatment of addictions (HHS & SAMHSA, 2018c). The theoretical foundation of CBT is derived from three different approaches: behavioral theory, cognitive theory, and social cognitive theory (Granillo, 2013). Although some techniques in CBT are more behavioral in nature, the model is adaptable, drawing from cognitive and behavioral principles depending on the client's needs (Granillo et al., 2013).

Despite CBT's theoretical assumptions drawing from three different approaches, its main emphasis is on the process of learning. Learning processes are examined to explore the creation and long-term effects of unfavorable behaviors, thoughts, and feelings (Granillo et al., 2013). The theoretical assumptions found in CBT are that individuals learn behaviors through their life experiences as they observe what others do. The beliefs they learn about themselves, others, and the world are identified as *schemas*; they can either promote or damage the person's development. A key idea in CBT is that what you think is how you feel, and how you feel is how you behave. When applied to addiction, CBT techniques are designed to modify and eliminate thoughts and behaviors maintaining the addiction (Granillo, et al., 2013).

Another fundamental theory in CBT classifies substances as reinforcers of behaviors. For example, the ability to express oneself better under the influence of drugs or alcohol serves as a reinforcer to use. After an individual develops a pattern of using substances for some time, reinforcers become connected to external or internal stimuli

connected to the substance use behavior. The target of intervention is to decrease reinforcers of substance misuse and increase reinforcers for abstinence or reduction of use (McHugh et al., 2010).

The CBT approach heavily emphasizes skill development for the altering of maladaptive coping skills and schemas. The main therapeutic goal is to help the client develop skills with the goal of decreasing the intensity of the problem (Granillo et al., 2013). One example of this is teaching refusal skills, a method for communicating to others the desire to no longer use drugs or alcohol. Other examples of CBT skills include coping mechanisms for managing cravings, or relaxation techniques for reducing stress (Mitcheson et al., 2010). Many scholars have criticized CBT for its heavy emphasis on skill development, which is believed to interfere with the therapist's ability to build a strong therapeutic relationship. Therefore, CBT therapists are encouraged to exercise caution, ensuring that a balance is established between the client-therapist relationship and the teaching of skills (Granillo et al., 2013).

During a client's first CBT session, a *functional analysis* is completed so that the therapist can gain insight into the client's thoughts and behaviors. Additionally, the therapist gathers information about the client's social supports, living environment, internal emotions, and triggers. Then, the therapist speculates about the function of the client's maladaptive behaviors, creating a unique plan based on that particular client's treatment needs (Granillo, et al., 2013).

The CBT model is considered strategic, structured, and present-focused. The entire therapeutic process lasts from 12 to 16 sessions, with each session divided into three different components. First, the therapist reviews the client's homework from the

previous session. In the second part of the session, the therapist assists the client in developing a new skill. Finally, the therapist and client discuss the client's application of the new skill outside of treatment. At the end of each session, the therapist assigns homework pertaining to the new skill. The process of assigning homework is done collaboratively, to address the client's unique concerns and enhance cooperation (Granillo et al., 2013).

In addition to skill development, CBT for addiction also consists of conversations about triggers and negative consequences associated with substance misuse (McCaul & Petry, 2003; Strickland, Reynolds, & Stoops, 2016). The client and therapist identify risky situations and people interfering with the client's progress and discuss alternative strategies for avoiding maladaptive behaviors. The therapist utilizes a technique known as *cognitive restructuring* to examine the client's distorted expectancies and beliefs, and alter them into adaptive ways of thinking that are conducive to the client's treatment goals (McHugh et al., 2010).

Another major goal of CBT is relapse prevention. If the client's goal is to abstain from all mood-altering substances, a relapse prevention plan is created and discussed, in order to help the client overcome challenges and avoid using drugs and alcohol. Therapy is concluded after clinical objectives are achieved and skill development is mastered (Granillo et al., 2013).

The highly-structured format of CBT has raised concerns for scholars when considering its implications outside of a research setting. Most research conducted on CBT has been facilitated in ideal conditions, failing to reflect the conditions in real-life treatment settings (McHugh et al., 2010). Follow-ups after three years did not show

promising results in terms of long-term abstinence (Vaillant, 2014). Additionally, individuals who have a hard time reading or writing may not be well-suited for this model, given the requirement to complete written homework assignments (McHugh et al., 2010). Nevertheless, CBT has been classified as the most empirically supported therapeutic intervention for the treatment of addictions (Granillo et al., 2013; McHugh et al., 2010). Another therapeutic modality strongly supported in addiction research is Motivational Interviewing (Miller & Rollnick, 2013).

Motivational Interviewing

In the 1980s, William Miller founded Motivational Interviewing (MI) as an alternative to traditional confrontational methods he often witnessed in rehabs (Miller & Rollnick, 2013). He questioned claims that substance misusers are liars who are in denial, unable to come to terms with reality due to pathological character traits. Drawing from his varied experiences working with this population, Miller began viewing substance misusers as “open, interesting, thoughtful people well aware of the chaos ensuing from their drinking” (Miller & Rollnick, 2013, p. 23). As a result, he began to question dominant viewpoints about individuals with substance misuse problems.

Miller became particularly interested in the language used in the therapeutic relationship and its effects on the client. He began to see that denial is often a product of the therapeutic relationship, rather than an innate defensive character structure inside the client. As a result, he created MI, based on the assumption that the way therapists talk to their clients determines the types of response the clients will give. For example, a therapist can experience two different outcomes: cooperation or denial. But the outcome

does not depend on the person so much as on the conversation. One type of therapeutic conversation promotes change, while the other promotes resistance.

Conversations promoting resistance can act as a self-fulfilling prophecy; if the therapist believes the client is in denial, for example, he or she will likely generate responses from the client that confirm this belief (Miller & Rollnick, 2013). Accordingly, denial in MI is defined as “. . .the expression of a dysfunctional relationship and damaged rapport and could be transformed in a positive direction by using a more collaborative style with clients” (Miller & Rollnick, 2013, p. 9).

The MI approach was designed as a way of helping therapists engage in effective conversations with clients; it was not intended to be a stand-alone therapeutic model. It is based on the logic of change mechanisms and the notion that conflicting feelings about change are a universal experience for human beings (Miller & Rollnick, 2013). In MI, contradictory feelings about change are classified as the first step toward change. Proponents of this approach assert that within the ambivalence about changing is the idea that change can happen. This is one of the fundamental philosophies of MI (Miller & Rollnick, 2013).

In the first stage of change within MI, known as precontemplation, the individual has little to no desire to change and has taken no serious actions towards change (Prochaska, DiClemente, & Norcross, 1992). In the next stage, contemplation, the individual is completely aware of the need to change but has not yet taken action. Next is the preparation stage, in which the individual has made unsuccessful attempts to change or plans to change in the future. The action stage is marked by a successful change in behavior. In the final stage, maintenance, the individual has successfully made changes,

demonstrates ongoing heightened awareness, and actively seeks out resources to maintain the changes already made (Prochaska et al., 1992).

The stages of change at the foundation of MI are known as the Transtheoretical Model of Change (TTM). Though commonly used interchangeably with MI, TTM is its own theoretical model. Although the MI approach does not consider TTM a vital component of the model, the TTM theory and MI practice are harmonious and can effectively be utilized together (Miller & Rollnick, 2013).

The MI approach is considered a form of client-centered counseling, which sees the client's perspective as the central focus of treatment (Wrenn, 1946). It is a guiding, collaborative way of helping others, and rather than acting as the expert who knows what the client needs, the MI therapist assists clients in making changes while allowing them to bring their own experiences and expertise about interpersonal and intrapersonal processes into the session. In MI, the therapist and client are both considered experts; the therapist is an expert in facilitating conversations about change, while the client is an expert in his or her own life. The therapist listens and elicits questions about the client's perspectives, without imposing change on the client based on his or her own perception of what the client needs to do (Miller & Rollnick, 2013).

Change in MI occurs through therapists facilitating conversations and allowing their clients to come to their own realization that they need to change. Miller and Rollnick (2013) assert that demanding clients to change is an ineffective way of facilitating therapy; in fact, this kind of intervention can actually prevent clients from changing, instead producing “. . . angry, defensive, uncomfortable and feelings of powerlessness” (Miller & Rollnick, 2013, p. 11).

The therapeutic process in MI consists of a recursive, chronological four-step approach. The first step is to establish a therapeutic alliance; this is known as engaging. The next step is called focusing; it occurs when the topic the client brought to therapy is explored. The third step, evoking, occurs when the therapist facilitates the client's own thought process about how change can take place. In the fourth step, planning, the therapist and client devise a plan for change, and the therapist emphasizes the client's strength and autonomy. The therapist utilizes four key skills to initiate this kind of therapeutic conversation: "asking open questions, affirming, reflecting and summarizing" (Miller & Rollnick, 2013, p. 62).

Unlike most therapeutic models used in addiction treatment, MI does not begin with an assessment, as this would be inconsistent with the underlying principles of MI, placing therapists in the position of interviewing clients according to their own goals, rather than eliciting information about clients' goals. However, for research purposes, the *Drinker's Check-up* was created as part of Project MATCH to function as an MI assessment that includes clients' voices alongside therapists' findings (Miller & Rollnick, 2013). In Project MATCH, MI demonstrated superior outcomes as compared to both CBT and TSF (Miller & Rollnick, 2013).

Overall, MI has been found to be particularly useful in the treatment of substance misusers, more so than with other populations (Abo Hamza, 2012; Brown et al., 2009; Magill, Apodaca, Barnett, & Monti, 2010; Stotts, DiClemente, & Dolan-Mullen, 2002). The most recent Cochrane review indicates, however, that "the evidence is mostly of low quality" (Smedslund et al., 2011, p. 2). This is likely because the therapeutic relationship in MI has a major influence on outcomes, making it hard to study under standard research

protocols. Therefore, a limitation of MI is that research findings about its effectiveness are not fully understood (Miller & Rollnick, 2013).

There is increasing evidence that MI is most efficacious when combined with other therapeutic models, such as CBT, but when compared with treatment as usual, fails to reflect differences in efficacy (Ball et al., 2007; Miller & Rollnick, 2013; Smedslund et al., 2011; Westerberg, Miller, & Tonigan, 2000). Researchers have also consistently found that MI is more effective for working with minority populations than with Caucasian clients (Hettema, Steele, & Miller, 2005; Miller & Rollnick). Most recently, MI has been tested specifically with African American clients with substance misuse issues, individuals with problematic cannabis use, and pregnant substance misusers (Burlew, Montgomery, Kosinski, & Forcehimes, 2013; Osterman, Lewis, & Winhusen, 2017). Although these results seem promising, the findings of these studies do not consistently show positive outcomes and warrant further research.

Inconsistency in the practice of MI is another limitation to consider when reviewing the results of research on this model. For example, Miller and Rollnick (2013) found a big gap between the theoretical assumptions of MI and the way the model is practiced in a standard addiction treatment facility. One example of this can be seen in the self-report of an MI therapist who participated in an interview with Fletcher (2013):

Everyone has a choice. If someone doesn't seem to want to be here, I reframe it and might say, "What would you like to work on?" Ultimately, it's meeting the client where he's at and seeing where we can be helpful." Inconsistent with MI philosophy, however, this counselor also told me that if a client resists twelve step meeting attendance, he might be suspended from the program for a week or the

counselor might say, “Try another program.” (p. 133-134)

Despite this limitation, therapists who work with substance misusers appear to be quite interested in the MI approach. Hartzler and Rabun (2014) conducted a mixed-method study using semistructured interviews to determine which empirically supported model therapists wanted to be trained in; MI was a top pick among them.

A final limitation of MI is that it has been found to be more effective with individuals who are more ambivalent about change, as compared to those who are certain. In fact, adverse outcomes have been reported with individuals who have already resolved their dilemmas about changing (Miller & Rollnick, 2013; Rohsenow et al., 2004; Stotts et al., 2001).

Although MI and CBT are grounded in different assumptions about the nature of change for substance misusers, both fall under the umbrella of Harm Reduction, which differs from abstinence-only approaches reflective of the moral model and disease-based notions of addiction (Granillo et al., 2013; Miller & Rollnick, 2013). Successful treatment in these models is not based on clients’ ability to remain sober. Rather, they promote healthier thinking patterns and behaviors (Granillo et al., 2013; Miller & Rollnick, 2013).

Harm Reduction

From the 1950s to the 1980s, researchers studying addiction were guided by the belief that successful treatment could only occur through clients’ complete abstinence from all mood-altering drugs (Des Jarlais, 2017). Since then, the field of addiction has grown to include harm reduction methods, which do not place the main emphasis of treatment on clients’ ability to abstain (Tatarsky & Kellogg, 2012). Carroll (2016) advocates for new standards pertaining to successful addiction treatment:

If we were to accept the old criterion for the “successful treatment,” that the person will permanently abstain and never relapse, then there is very little successful treatment going on anywhere, no matter what interventions are employed. This is not to disparage treatment, as people can and do learn how to alter their lifestyles and go on to have a good quality of life, one where they live a responsible, productive, and meaningful life without being “cured” of their addiction. (p. 253)

The harm reduction approach is defined as upholding a compassionate attitude towards high-risk behaviors and increasing the quality of life for human beings (Collins & Marlatt, 2012). The theoretical perspectives informing harm reduction including the humanistic tradition, social constructionist theory, and the doctrine of human rights. From a humanistic perspective, harm reduction acknowledges that humans are more likely to change when they feel empowered, respected, and safe. Social constructionist theory highlights the effect of individuals’ belief systems on their substance misuse. Lastly, the doctrine of human rights asserts that all individuals should have the right to decide on their own treatment (Collins et al., 2012).

Harm reduction interventions include safe injection facilities, preventive programs about driving under the influence, and a therapeutic approach known as Harm Reduction Psychotherapy, which is designed to address all levels of severity across the substance misuse continuum, from mild to severe (Tatarsky & Kellogg, 2012). Harm Reduction Psychotherapy combines addiction treatment and psychotherapy, addressing substance misuse issues and other problems simultaneously (Eaton, 2017).

Harm reduction views substance misuse from a biopsychosocial perspective, conceptualizing it as a complex interaction of biological, psychological, and social factors specific to each individual (Tatarsky & Kellogg, 2012). Psychological ideas underlying harm reduction psychotherapy come from psychodynamic, cognitive-behavioral, and relational theories. Based in the psychodynamic perspective, the harm reduction approach suggests that unconscious psychological processes can contribute to internal struggles and are strongly associated with perfectionist tendencies. The substance misuser holds simultaneous needs to please others and rebel against them. Consistent patterns of escalated use followed by abstinence are viewed as a form of self-punishment (Tatarsky & Kellogg, 2012).

Consistent with the assumptions of CBT, harm reduction psychotherapy is supported by the belief that substance misuse behavior serves a function—specifically, to self-medicate painful thoughts and emotions (Tatarsky & Kellogg, 2012). Relational theories in harm reduction psychotherapy derive from the idea that substances have relational significance for an individual. Substance misusers are in relationship with their drug of choice; and like romantic relationships, it ranges from healthy to unhealthy. The relational principles in harm reduction posit that most substance misusers have struggled in their personal relationships, so alcohol and drugs provide them with the soothing relationships they have yearned for their whole lives. Substance misusers do not place a high priority on human connection, because they primarily receive their sense of connection through substances. Relationally speaking, taking substances away means taking away substance users' whole world and identification with that world (Tatarsky & Kellogg, 2012). With this considered, harm reduction therapy serves to broaden

substance users' relational meanings, life skills, and coping mechanisms prior to taking away the one thing that serves to fulfill near needs and yearnings: their substance of choice.

In harm reduction psychotherapy, the therapeutic alliance is central to the treatment process, and the uniqueness of each client and clinical issue is considered. Unlike the Twelve-Step philosophy, which is grounded in the belief that all clients can be treated with the same approach, harm reduction psychotherapy meets clients where they are, even if they are not yet ready to give up using drugs or alcohol (Reiter 2015; Tatarsky & Kellogg, 2012). It is believed that substance misuse interferes with people's basic needs and values, becoming exaggerated and dangerous while effecting self-esteem; harm reduction psychotherapy, therefore, serves to minimize those harmful side effects without coercing individuals to stop behaviors they may not be ready to stop. The therapist's therapeutic goal is to be helpful and collaborate with clients on changes they would like to make, but only when clients are ready (Tatarsky & Kellogg, 2012).

The beginning of harm reduction therapy can be an experimental exploration of the positive and negative effects of substance misuse. For example, the therapist may assign a task for the client to complete outside of therapy, which limits the negative effects associated with drinking and using. Such tasks might include taking a taxi instead of driving while drunk, or using only three times per week instead of five. How successful or unsuccessful the client is during the experimental phase determines the next step in the therapeutic process.

Therapy begins differently when a client enters the process with a pre-determined goal. When this is the case, the therapist collaborates with the client in a pragmatic way,

co-constructing small goals to help the client reach longer-term goals. The harm reduction approach recognizes that the pathway to change requires small steps and periods of trial and error before successful implementation of new behaviors can occur. Lastly, therapy can also start by addressing other problems unrelated to substance misuse, such as depression, anxiety, or trauma (Tatarsky & Kellogg, 2012).

The therapeutic process consists of sensitive questioning. Harm reduction therapists recognize that most substance misusers are highly vulnerable, so they create a comfortable environment for this questioning to take place. The sensitive questioning process is designed to empower clients, and therapists create a collaborative relationship based on the belief that meaning is created through client-therapist interactions (Tatarsky & Kellogg, 2012). When therapists have concerns, they bring them to their clients' attention by saying something like, "I just had a wild thought; I could be wrong, I imagined that what you might have felt was . . ." (Tatarsky & Kellogg, 2012, p. 47).

The therapeutic process can include skill enhancement pertaining to safer drug or alcohol use, such as encouraging the use of clean syringes, having discussions about using less harmful drugs, or strategizing ways to decrease or stop using substances completely. Although there is no predetermined agenda in harm reduction psychotherapy, the overall format includes co-constructing negative consequences associated with use, discussing other lifestyle changes that support a shift in substance misuse, and developing a plan consisting of small goals aimed at minimizing harm to self and others (Tatarsky & Kellogg, 2012).

Sobriety can still be considered a viable goal in the harm reduction approach. The key difference between it and the abstinence-based approach is the way sobriety is

achieved. If a client does not desire sobriety as a therapeutic goal, a harm reduction therapist will not require the client to become abstinent. Instead, the therapist and client will collaborate to determine ways to reduce the harm associated with substance misuse. If the client chooses abstinence as the primary therapeutic goal, then the harm reduction therapist will respect this and tailor a treatment plan around the goal of abstinence. Overall, the harm reduction approach supports clients' efforts to improve their quality of life while minimizing harms associated with substance misuse. It is considered an alternative treatment for individuals who have had difficulty achieving complete abstinence from substances or are not willing to give them up entirely (Collins et al., 2012).

Contrary to common belief, it is more normal than not for individuals to be unready or unwilling to give up drugs and alcohol. Harm reduction therapists recognize that humans have and will always seek out mood-altering substances; it is part of the natural human condition (Collins et al., 2012; Madden, 2016; Marlatt, 1998; Szalavitz, 2016). As a result, they believe that time, money and energy are better utilized to decrease the harms associated with high-risk behaviors such as substance misuse, rather than trying to abolish these "intractable" human behaviors (Collins et al., 2012, p. 19).

Taking American history into consideration, harm reduction therapists recognize that any time humans have attempted to abolish behavior that is natural to human existence, they have been unsuccessful. For example, alcohol prohibition and the D.A.R.E program, which both promote complete abstinence from drugs or alcohol, were unsuccessful and actually resulted in increased rates of crime and risky behavior (Collins et al., 2012; Levine, 2003; Lynam et al., 1999). The original creators of harm reduction

psychotherapy observed the same phenomenon occurring in abstinence-based treatment programs, which left large numbers of clients without a form of treatment that met their needs. Harm reduction methods were created in response to this treatment gap, and researchers became interested in exploring the approach empirically (Tatarsky & Kellogg, 2012).

Efficacy of harm reduction approaches. Over the past 15 years, harm reduction has gained immense popularity in the research literature, and the findings seem promising (Collins et al., 2012). In the existing literature, harm reduction approaches are categorized by substance. Separate studies have been conducted on harm reduction methods for alcohol, opiates, amphetamines, cocaine, steroids, and cannabis.

There is controversy surrounding the effectiveness of harm reduction methods for alcoholics on the severe end of the addiction continuum. Some scholars report that harm reduction techniques are only effective for alcoholics on the low to mild end of the continuum (Charlet & Heinz, 2017; Guardia-Serecigni, 2011; Miller, 2012), while others report positive outcomes for individuals with varied levels of alcohol use (Charlet & Heinz, 2016; Witkiewitz, 2008; Young, 2017). In the first systemic review on harm reduction methods for alcoholics, a considerable number of benefits were found, specifically in the areas of physical and mental health (Borges et al., 2006; Charlet & Heinz, 2017; Xin Xue et al., 2018).

Another study found that practicing harm reduction methods eventually led alcoholics to abstinence. When compared to a control group of participants who completely abstained, those in the harm reduction group drank fewer days than those who tried not drinking at all (Saladin & Ana, 2004; Young, 2017). Overall, harm reduction

methods for alcoholics are supported in the research. However, since harm reduction psychotherapy is considered a newer form of treatment than abstinence-based approaches, more research studies are needed to evaluate the long-term effects (Charlet & Heinz, 2016; Larimer et al., 2012).

When comparing alcohol, opiates, and other drugs, cannabis is associated with the least amount of harm (Larimer et al., 2012). Nevertheless, a small population of substance misusers develop problems with cannabis, particularly those who use it persistently. Larimer et al. (2012) report that the most harm associated with cannabis has to do with “. . . laws and policies that unnecessarily and unfairly criminalize users” (p. 163). Researchers and clinicians utilize medication-assisted treatment (MAT) to reduce the harm associated with more dangerous substances, such as heroin (Azores-Gococo & Fridberg). As an adjunct to therapy, a harm reduction therapist may suggest the use of medication to subside symptoms of withdrawal and cravings. Some examples of medications utilized in MAT are methadone and Suboxone. The MAT approach is associated with superior research outcomes (Azores-Gococo & Fridberg, 2017; Miller, 2012); it has been found to decrease mortality rates for substance misusers by nearly 50% (Fletcher, 2013).

Despite promising outcomes in the literature, society continues to stigmatize the harm reduction approach. Furthermore, most of the public is unaware of other treatment options aside from abstinence-based approaches (Des Jarlais, 2017; Larimer et al., 2012). Some critics purport that harm reduction supports drug use (Christie, Groarke, & Sweet, 2008; Madden, 2016); however, quite the contrary is true. As Szalavitz (2016) explains,

Needle exchange and harm reduction don't say: Go on and kill yourself with drugs, no one cares. They tell people—both drug-users and non-users—that everyone deserves life and dignity and that being addicted shouldn't be a sentence of death or exile from humanity. (p. 236)

Harm reduction techniques recognize the stigma associated with addiction and the corresponding low numbers of people who seek help for themselves because they believe abstinence-based approaches are the only form of treatment available to them. Just as different healthcare options are available for the general population, various forms of addiction treatment should be made available to substance users. Following the harm reduction philosophy, some form of help is better than no help.

Currently, there is a lack of research on the effectiveness of harm-reduction methods with female and adolescent injection drug users. More research also needs to be conducted on harm reduction within rural areas. At this time, a considerable amount of work needs to be done to garner support for harm reduction from the public and policymakers, so that the stigma surrounding this treatment approach can be reduced (Azores-Gococo & Fridberg, 2017; Des Jarlais, 2017).

Summary

Prior to E. M. Jellinek's breakthrough research on alcoholism in the 1960s, most research on addiction was conducted in prisons, and treatment was left in the hands of individuals struggling with addiction themselves. Addiction was viewed as a moral problem, and substance misusers were perceived as weak and devoid of willpower.

The AA community was established as a place where individuals could meet to talk about their addictions and not feel so isolated. The principle guidelines of AA are the

Twelve Steps, and the *Big Book* was created to explain the steps through a series of other alcoholics' struggles with addiction and sobriety. When AA was first established, addiction was viewed as an illness or allergy; after Jellinek's research, addiction was seen within AA circles as a disease. The AA approach gained popularity, influencing the creation of other self-help groups, such as Narcotics Anonymous, which utilizes the Twelve Steps as its guiding philosophy. Due to the positive impact AA had upon substance misusers, Twelve-Step philosophies began to enter hospitals, leading to the creation of the Minnesota Model.

The Minnesota model was created in 1949 and is a 28-day long residential addiction treatment program providing clients the opportunity to learn Twelve-Step principles and implement them within their lives. The Minnesota Model is considered a major shift in addiction treatment. Until its inception, substance misusers were placed in jails and psychiatric hospitals. A distinguishing feature of the model is the hiring of individuals in recovery, in addition to other professionals.

Although AA was never meant to be involved in the realm of professional treatment, the Minnesota Model central to addiction treatment is based on the AA philosophy. Synanon, another recovery community created by a former member of AA, is centered on the belief that confrontation is the best way to help substance misusers. Synanon gained popularity in the 1960s and 1970s, around the time that an abundance of residential addiction treatment programs began to crop up throughout the United States, including 500 residential addiction treatment programs based on Synanon concepts. This took place in spite of the psychological damage Synanon was known to cause substance

misusers. It was also around this time that residential addiction treatment programs became known as rehabs.

Rehabs were primarily influenced by AA, the Minnesota Model, and Synanon; all three approaches view confrontation as a necessary component of working with substance misusers. Currently, there are thousands of rehabs all over the United States, a majority of which still follow the Minnesota Model. Standard addiction treatment in rehabs consists of a 28-day program embedded in Twelve-Step philosophy with medical staff, mental health professionals, and other recovering individuals providing treatment. Standard addiction treatment believes the only way to recover is complete abstinence.

Abstinent-based approaches, such as TSF, are based on the belief that the cure for addiction is lifelong abstinence, and anything less constitutes unsuccessful treatment. Substance users are blamed for their denial or resistance during the treatment process and are made responsible for engaging in therapy and Twelve-Step meetings or being more compliant with their therapists and sponsors. Abstinence-based approaches believe that the people who have been able to maintain sobriety for a length of time are experts who know what is best for substance misusers seeking help.

Therapeutic models such as MI and CBT focus on other treatment goals aside from complete abstinence; in this way, they can be considered harm-reduction approaches. However, these models are most often implemented in addiction treatment facilities requiring abstinence as the goal. Harm reduction methods are an alternative to abstinence-based approaches; they allow substance misusers to explore other therapeutic possibilities for change aside from abstinence. Research outcomes for harm reduction methods seem encouraging, demonstrating decreased rates of overdose among substance

misusers. However, the approach remains highly stigmatized and inaccessible for some substance misusers, depending on where they live.

The common assumption in all individual-oriented models of addiction treatment is that the substance misuser is the prime candidate for treatment. However, family members are also highly affected by addiction. They can feel defeated, detached, and desperate. Furthermore, high rates of mental health problems are found among individuals with addicted family members (McCrary, Ladd, & Hallgren, 2012; Miller, 2012; Moss, Mezzich, Yao, Gavalier, & Martin, 1995; Ray, Mertens, & Weisner, 2007; Rowe, 2012; Schaefer, 2008; Stanton & Shadish, 1997; Steinglass, 1987). The concept of drug addiction as a family problem is well supported in the literature and has led to interpersonal interventions that include families in substance misusers' treatment.

Interpersonal Models of Substance Abuse: Etiology and Treatment

“We’ve done a tremendous disservice to families in this field. . . . Long ago, Joan Jackson (1954) pointed out that what is interpreted as spouse or family pathology is an understandable adaptation to the course of addiction, normal survival responses. Yet we have pathologized it.”

– Dr. William Miller

Interpersonal Therapy in Addiction Treatment

From the 1930s to the early 1960s, families were recognized in the field of addiction primarily within disease-based theories. Though families were largely perceived negatively, as either the cause of the addiction or significant contributors to it, marital therapy was commonly included in the treatment of alcoholism, based on the results of studies pointing to its effectiveness (Stanton, 1979). Research studies on family

therapy and drug misusers remained non-existent until the late 1960s and early 1970s, when addiction treatment centers began incorporating interpersonal interventions (Stanton 1979; Stanton & Todd, 1982).

In 1975, the first Family and Drug Abuse Symposium convened; it consisted of researchers and clinicians actively producing studies on family therapy for drug misusers. Following the symposium, researchers distributed surveys to treatment facilities throughout the United States and found that 69% of them incorporated family therapy with substance misusers and their family members. The majority (75%) of the surveyed clinicians indicated that it is “highly important” (Stanton & Todd, 1982, p. 1) for substance misusers to receive family therapy. To the symposium researchers’ surprise, family therapy practices were being implemented at an accelerated rate. Nevertheless, this stands in sharp contrast with current-day rehabs which rarely include interpersonal therapy practices (HHS & SAMHSA, 2015).

Interpersonal practices in the treatment of addiction is defined by a broad spectrum of therapeutic configurations (Heatherington et al., 2015). Family therapists may work only with individuals, or with couples and families; nevertheless, they utilize interpersonal principles in employing their therapeutic model. When solely working with individuals, family therapists relationally conceptualize problems while facilitating change at the systemic level (Rambo & Hibel, 2013). Family therapists may work in a rehab and only provide therapeutic services to individuals, but their conversations with clients will be oriented around interpersonal topics.

An interpersonal approach known as MFG is a means of working with various groups of families in the same room (Schaefer, 2008). Interpersonal therapy in addiction

treatment can also entail working with family members without the substance misuser present, using psychoeducation as the central intervention (Heatherington et al., 2015). Family psychoeducation is considered an interpersonal approach, as family dynamics are evaluated while individualist characteristics are explored to promote change in the family (Heatherington et al., 2015).

Interpersonal therapies are organized in the addiction literature according to the degree to which the family is involved. Two main categories classifying family treatment are *family-involved* and *full-inclusion* (Smock et al., 2011). Family-involved treatment consists of a therapist or counselor utilizing psychoeducation techniques to teach family members different ways to cope with the substance misuser's behavior. Typically, families are encouraged to seek their own treatment while the substance misuser engages in treatment in isolation from the family. Family-inclusion treatments utilize family therapy models to intervene with substance misuse problems and treat addiction interpersonally (Smock et al., 2011). Together, the family and substance misuser engage in the therapy process to examine family patterns and interactions connected with substance misuse (Armstrong, 2004).

Efficacy of interpersonal therapy in addiction treatment. In general, the research literature indicates that family therapy is effective for treating a multitude of problems, including and beyond addiction (Friedlander & Diamond, 2011; Heatherington et al., 2015; Sexton, Datchi, Evans, LaFollette, & Wright, 2013; Shadish & Baldwin, 2005). For example, Rowe (2012) reports that family therapy is effective and essential in the treatment of addictions. Other researchers have found that failing to include family members in the treatment process can jeopardize substance misusers' ability to maintain

long-term sobriety (Carroll & Onken, 2005; HHS & SAMHSA, 2015; Rowe, 2012; Steinglass, 2009). Including families in addiction treatment has been described in the literature as “the most powerful” (Rowe, 2012, p. 66) form of intervention and “a key ingredient in treatment success” (Steinglass, 2009, p. 156).

It has been found that working with families prior to and during the substance user’s treatment increases treatment engagement, retention, and better long-term treatment outcomes (Edwards & Steinglass, 1995; Miller et al., 1999; O’Farrell & Fals-Stewart, 2003; Rowe & Liddle, 2003; Smock et al., 2011; Steinglass, 2009; Thomas & Corcoran, 2001). Furthermore, many studies indicate that family therapies are more effective than individualistic therapies in the treatment of addiction (Fals-Stewart, Yates, & Klostermann, 2005; McCrady & Epstein, 1999; Patel, 2016; Stanton & Shadish, 1997; Templeton et al., 2010), despite the fact, as mentioned earlier, that the overall approach to addiction treatment in the United States is based on individualistic treatments (Fals-Stewart et al., 2009; Morgan & Crane, 2010; Orford et al., 2009; Patel, 2016; Rowe, 2012).

In spite of the favorable perceptions of interpersonal addiction treatment in the literature, several barriers stand in the way of incorporating families into standard addiction treatment. First, the addiction treatment culture is largely based on individualistic paradigms, which can create complexity during the therapeutic process. Furthermore, since treatment is dominated by individual models of therapy, many professionals working in the field lack the skills and training needed to practice family therapy approaches (Heylighen et al., 1999).

The effectiveness of family therapy in addiction treatment may have something to do with its underlying foundational principles. Although the therapeutic models vary in their techniques and interventions, the qualities of the therapeutic relationship are consistent throughout family therapy models (Hammond & Nichols, 2008). The first step in all family therapy modalities, as well as in effective addiction treatment interventions, is to acknowledge clients' perspectives about their problems (Hammond & Nichols, 2008). Doing this requires therapists to have the ability to listen, understand, and provide curious and reflective feedback; these essential therapeutic skills can also be considered a means of demonstrating empathy (Miller, 2012). Several researchers have found that empathy is the most effective therapeutic quality in the treatment of addiction (Miller, 2012; Miller & Rollnick, 2013; Miller, Taylor, & West, 1980; Valle, 1981). It appears that the commitment of family therapists to valuing and understanding their clients puts them in alignment with what has been found to be most effective in the treatment of addiction. The following sections will cover the array of interpersonally oriented addiction treatment modalities, some of which predate the creation of family therapy. Among the family therapy models, there is a range of ideas and approaches to working with substance misusers and their families.

Psychodynamic Addiction Treatment

Interpersonal paradigms for treating addiction were formed in the 1930s through the melding of psychodynamic theories about alcoholic husbands and their wives (Heatherington et al., 2015; Smock et al., 2011). The presence of adverse mental health symptoms in the wives of alcoholics influenced researchers to investigate relational

factors in the treatment of alcoholism and conclude that wives were responsible for their husbands' addiction problems (Lewis, 1937; Smock et al., 2011).

Psychodynamic modalities were the first therapeutic approaches to introduce interpersonal epistemologies into addiction treatment (Smock et al., 2011); however, research on interpersonal addiction treatment remained absent from the literature until the late 1970s (Smock et al., 2011). Until then, individualistic ideas notions of addiction dominated the field, and researchers primarily sought out and explored causal explanations of addiction (Velleman, 2010). When families were mentioned, it was with negative connotations; consistent with psychodynamic theory, researchers saw families as a barrier to substance misusers' ability to overcome their addiction (Munro & Allan, 2011). As a result, families were pathologized, commonly labeled as abnormal and unhealthy (Velleman, 2010).

The blaming of wives for husbands' addictions was rooted in psychodynamic theory, which assumes that either the non-substance misuser in a couple is the truly dysfunctional individual, or both individuals are equally sick. This theory purports that non-substance misusers project their "sickness" (Wanlass & Scharff, 2016, p. 148) onto their substance misusing spouses, who then manifest the sickness as symptoms of addiction. According to this theory, it is also possible for both partners to project dysfunction onto each other; the essential view is that problems in couples or families are not directly related to the couple or family, but are rather the result of distorted perceptions that one individual formulated as an infant from interactions with his or her mother and later projected onto the couple relationship (Wanlass & Scharff, 2016).

In essence, psychodynamic models focus on the mother-infant relationship or, when the mother was absent, on the infant's relationship with the primary caregiver (Juhnke & Hagedorn, 2006). Since the mother is the primary person interacting with the infant, the infant forms its closest attachment with her (Juhnke & Hagedorn, 2006). Throughout mother-infant interactions, the infant internalizes and stores experiences with the mother into its unconscious mind. Interactions with the mother are defined by how the infant perceives them. For example, a controlling mother can produce a submissive child, because the infant or toddler learns that expressing independence receives negative attention and, therefore, comes to perceive independence as a bad behavior. This perception becomes internalized and goes on to characterize the individual's adult relationships (Juhnke & Hagedorn, 2006).

In psychodynamic family therapy, the therapist's goal is to identify unhealthy family members and "free them from their internalized, unconscious false lenses" (Juhnke & Hagedorn, 2006, p. 223) through re-parenting techniques. Re-parenting is defined as the client attaching to a new caretaker, the therapist (Juhnke & Hagedorn, 2006), in a holding environment characterized by safety and respect. Clients can behave freely without worry the therapist will react in the same ways their mothers or caregivers did, which caused distortions in their thinking. When clients feel safe to think and act freely, they become capable of forming healthier relationships with themselves and others (Wanlass & Scharff, 2016).

The attachment formed between the client and therapist in psychodynamic family therapy is where change begins. Therapists correct faulty emotional experiences from clients' earlier pathologic experiences, beginning in infancy. For example, they

encourage their clients to express negative feelings toward them—a phenomenon known as transference—demonstrating that adverse feelings can be processed without consequences. According to the theory supporting this therapeutic approach, corrected emotional experiences occurring in the therapy room will eventually translate into clients' relationships with others (Wanlass & Scharff, 2016).

Maladaptive communications occurring in session are believed to be reflective of clients' attempting to hold on to unhealthy personality characteristics formed in infancy. When this occurs, psychodynamic therapists confront their clients, in order to provide ongoing corrective emotional experiences and bring clients' unconscious faulty perceptions into their conscious awareness. Without conscious awareness, pathology remains. Psychodynamic family therapists use gentle confrontation, which consists of following confrontation with support so that clients feel safe and non-abandoned, unlike how they felt in the relationship with their primary caregivers. In this approach, the therapist is the driver of change (Juhnke & Hagedorn, 2006).

Psychodynamic family therapists prefer for all family members to be present in the therapeutic process so they can analyze family members' body language, unconscious facial expressions, and tones of voice and hypothesize about underlying problematic family dynamics (Wanlass & Scharff, 2016). Bringing these hypotheses to the family's conscious awareness is believed to diminish automatic defenses and unconscious projections within the family. Therapists in this model also correlate their hypotheses of family conflict to experiences in the family's past, or to the parents' families of origin (Wanlass & Scharff, 2016).

With increased understanding of the processes underlying their behaviors, family members can express their defenses and projections vocally, instead of acting out automatically (Wanlass & Scharff, 2016). This allows them to limit unhelpful family interactions, increase empathy, and develop more effective communication. When individual family members stop projecting unconscious distortions onto each other, they can give and receive love more freely (Wanlass & Scharff, 2016).

Chronic symptoms in the family, such as addiction, present an additional set of challenges in therapy. Therapists must attend to unconscious processes, meanings, and interpersonal impacts of addiction, while also addressing concrete issues, such as recommending a detox facility or Twelve-Step meetings (Wanlass & Scharff, 2016). The idea is that when individual family members seek out additional help, they lessen immediate symptoms in the family, which allows the therapist to place a greater emphasis on underlying processes.

Psychodynamic family therapy also acknowledges that families with addiction problems have greater chronic stress and underlying feelings of resentment, as a result of avoiding negative feelings and interactions so as not to worsen the substance misuser's behavior. With this in mind, therapists encourage vocal expression among family members, in an effort to avoid the continuation of defense patterns (Wanlass & Scharff, 2016).

Change in the psychodynamic family therapy model is not solely defined by the vocalization of underlying feelings or the increase of insight. The combination of experiences in the therapy room, a shared understanding about family members' projection processes, re-parenting interventions, and shifts in conscious awareness about

interpersonal realities produce new understandings so that family relationships are viewed in a less hostile manner (Wanlass & Scharff, 2016).

Recent efficacy research on psychodynamic therapy in the treatment of addiction is scarce; especially lacking are studies utilizing psychodynamic treatments with families. Some scholars and clinicians consider psychodynamic treatments outdated and tend to favor other, more modern approaches (Curtis, 2014). Nevertheless, some studies on psychodynamic treatment were completed in the 1980s and 1990s, specifically on individuals with opiate or cocaine addiction. Two studies found psychodynamic treatment to be more effective than drug counseling alone. Another study found no significant differences between CBT, psychodynamic therapy, individual drug counseling, and group drug counseling (Crits-Christoph et al., 2001).

A major limitation of psychodynamic theory is the longevity of treatment. Managed care policies typically allow for three to six sessions of psychotherapy (Wheeler, 2014), but psychodynamic therapy consists of much more than this. Supportive Expressive Psychotherapy, a brief version of psychodynamic treatment, is often utilized in the research on psychodynamic treatments, due to its time-limited approach (Wheeler, 2014).

One study on Supportive Expressive Psychotherapy found positive outcomes, but participants evidenced symptom regression during the last treatment phase (Nof, Leibovich, & Zilcha-Mano, 2017). Some scholars advocate for the use of psychodynamic treatments, based on the reported efficacy of these approaches in the research literature (Curtis, 2014; Smock et al., 2011); however, Markin, McCarthy, and Barber (2013) found negative outcomes in a study utilizing interventions grounded in transference. Supportive

Expressive Psychotherapy has only recently been studied, with the goal of providing more evidence supporting the use of psychodynamic practices (Vinnars, Frydman-Dixon, & Barber, 2013).

Until interest in empirically validated treatments beyond behavioral interventions was sparked in 2005, psychodynamic treatments were neglected in the literature (Curtis, 2014). But currently, four of the 77 empirically validated therapies are psychodynamic in nature (Curtis, 2014). Despite psychodynamic treatments historically lacking popularity in research, the theoretical assumptions underlying this approach, which suggest that family members are as sick or sicker than their substance misusing loved one, have remained a common viewpoint throughout American history (Reiter, 2015).

Family Disease Theory

Family disease theory, the most popular American theory of addiction in families, originated when the concept of codependency was first established (Walters & Rotgers, 2012). Codependency is said to be a consistent set of personality characteristics found in the family members of individuals who struggle with addiction issues (Walters & Rotgers, 2012). Several behaviors fall under the codependency umbrella: (1) trying to change someone else at the expense of your own physical and mental health, (2) putting another's needs ahead of your own, (3) relying on others for personal identity and self-esteem, and (3) trying to fix consequences associated with another's irresponsible behavior (Dear, 2002; Timko et al., 2012). According to the family disease theory, placing the substance misuser's needs before one's own needs is considered pathological. Furthermore, it is assumed that there is something inherently wrong with family members

who are so pre-occupied with the wellbeing of the substance misuser that they struggle to care for themselves (Walters & Rotgers, 2012).

Codependency has been criticized for its over-pathologizing of ordinary human needs (Szalavitz, 2016). These detractors assert that it is normal to have pre-occupying thoughts about someone you care about, particularly when that person is struggling in life. For example, feeling pre-occupied about the other while losing focus on the self is a defining characteristic of parenting (Flemons, personal communication, July 12, 2017). Humans depend on each other to survive; without human connection, stress systems become dysregulated, and mental illness occurs (Szalavitz, 2016). Nevertheless, codependency—which is seen as consisting of a two-part progressive stage, beginning with enabling—is a concept that remains commonly endorsed in the world of addiction treatment (Reiter, 2015).

Enabling refers to relational interactions that prevent substance misusers from experiencing the full consequences of their addiction. An example of this would be a mother who bails her daughter out of jail every time she is caught with cocaine, who by doing so, prevents her daughter from receiving the punishment that other individuals would normally experience. Proponents of the codependency framework surmise that the daughter will be likely to repeat the same behavior, as she has been given the impression that she will always have the safety net held by her mother to rescue her (Johnson, 1986; Reiter, 2015).

The concepts of enabling and codependency have not been empirically validated and are not included in the DSM. Miller (2012), one of the world's leading experts in addiction treatment, explains that “all of these concepts of the spouse or family as the

source of pathology are based on anecdotes, not science” (p. 15). The term codependency was originally popularized through a 1975 bestseller by Stanton Peele and Archie Brodsky, titled *Love and Addiction*. The book endorses theories about addictive relationships, suggesting that individuals in love obsess over their love objects in the same way substance misusers obsess over drugs and alcohol. Another bestselling book, *Codependent No More* by Melody Beattie, further introduced the concept into popular American culture (Szalavitz, 2016).

In the late 1980s, codependency became misinterpreted, so that any relationship with an addicted person was highly pathologized, and acts of caring were overly labeled as enabling. As a result, family members who sought guidance from counselors endorsing the concept of codependency were advised to stop supporting their substance misusing loved ones and cut off all ties with them. This is commonly referred to as *tough love* (Szalavitz, 2016).

Tough love was another movement associated with codependency, which was popular from the early 1980s to late 1990s. Like codependency, the concept of tough love was popularized by a 1982 bestselling book (Szalavitz, 2016). Eventually, tough love support groups began to form, and a set of rules were established to prevent parents from engaging in enabling with their substance misusing children. An example of a tough love rule may be that parents are to keep their child in jail if they get arrested because of drugs or alcohol. Substance misusers were expected to complete treatment, maintain abstinence, and follow the rules established by their parents. If they failed to comply, family members were advised to stop associating with them (Szalavitz, 2016).

Despite the overall acceptance of tough love in the larger society, it has never been scientifically tested. Therefore, practicing tough love is unpredictable and can be either effective or damaging (Szalavitz, 2016). Despite the lack of validity for codependency and tough love, popular American culture discusses these concepts as if they are valid and scientifically based. Inherent in theories of codependency and tough love are the strict binary terms of *healthy* and *unhealthy*; families are seen as unhealthy if they act in codependent ways, and tough love is considered a healthy behavior.

Within this framework, healthy behaviors include expressing inner thoughts and feelings in one's relationships. It is believed that before individuals can have healthy relations with other people, they must first become healthy within themselves (Gorski, 1993). Healthy individuals recognize relationship principles that unhealthy individuals cannot identify. For example, healthy individuals can break off relationships and fail to "lose themselves" (Gorski, 1993, p. 28).

These ideas about families, which are commonplace in rehabs (Walters & Rotgers, 2012), contradict fundamental notions of the family described in interpersonal theories. For example, the concept of context is neglected in family disease theory; but interpersonal theories assert that individual behavior cannot be understood in its fullest capacity unless context is considered (Bateson, 2002). It is believed that context is established through the interactions that take place within the various systems in which an individual participates. Therefore, excluding the individuals who are involved in interactions that contribute to the substance misuser's behavior is believed to limit therapeutic possibilities. This is supported by Rowe (2012), who found that individual treatment can be unsuccessful if family functioning is not considered.

The family disease model can appear individualistic in nature due to ideas that contradict interpersonal concepts, as well as its strongly upheld belief that family members should be separated for treatment. However, the model does acknowledge that permanent change in individuals is most effective when the entire family receives help. The recovery organization most closely associated with the family disease model is Al-Anon.

Al-Anon

Al-Anon is a non-professional support group for families of substance misusers that, like AA, is held in local communities. It was founded in 1951 by Lois Wilson, the wife of AA founder Bob Wilson (Keinz, Schwartz, Trench, & Houlihan, 1995). By attending AA meetings with her husband, Lois came to recognize the value of talking with other wives who had also been impacted by addiction. As a result of her insights, families began meeting while their loved ones attended AA meetings, and eventually, they began practicing principles of the Twelve Steps (Reiter, 2015; Timko et al., 2012).

Currently, Al-Anon is the most utilized support group for relatives of substance misusers (Reiter, 2015). Family members are typically encouraged to attend Al-Anon meetings while their loved one engages in AA or another form of Twelve-Step meeting. Al-Anon has expanded into other kinds of support groups, such as Alateen, which was created specifically for adolescents of substance misusers, and Nar-Anon, which was established for families of substance misusers who use drugs other than alcohol (Short, Cronkite, Moos, & Timko, 2015; Timko et al., 2012).

The theoretical ideas underlying the Al-Anon approach are derived from family disease theory (Timko et al., 2012), and the structure and organization of meetings

mirrors that of AA. Whoever is leading the meeting chooses a group topic, which relates to Al-Anon writings, Twelve-Step principles, and spirituality. Some of the topics commonly discussed in Al-Anon meetings include codependency, enabling, and coping skills for dealing with substance misusers. Some meetings are closed, only permitting loved ones of substance misusers to attend, while others are open to the public. Al-Anon borrows the concept of sponsorship from AA; family members who need additional support can seek a sponsor to help them work through the Twelve Steps. Al-Anon adopts the Twelve Steps of AA, using slightly adapted language to apply to family members (Timko et al., 2012):

1. Our common welfare should come first; personal progress for the greatest number depends upon unity.
2. For our group purpose there is but one authority—a loving God as He may express Himself in our group conscience. Our leaders are but trusted servants—they do not govern.
3. The relatives of alcoholics, when gathered together for mutual aid, may call themselves an Al-Anon Family Group, provided that, as a group, they have no other affiliation. The only requirement for membership is that there be a problem of alcoholism in a relative or friend.
4. Each group should be autonomous, except in matters affecting another group or Al-Anon or AA as a whole.
5. Each Al-Anon Family Group has but one purpose: to help families of alcoholics. We do this by practicing the Twelve Steps of AA *ourselves*, by encouraging and

understanding our alcoholic relatives, and by welcoming and giving comfort to families of alcoholics.

6. Our Family Groups ought never endorse, finance or lend our name to any outside enterprise, lest problems of money, property and prestige divert us from our primary spiritual aim. Although a separate entity, we should always co-operate with Alcoholics Anonymous.
7. Every group ought to be fully self-supporting, declining outside contributions.
8. Al-Anon Twelfth Step work should remain forever non-professional, but our service centers may employ special workers.
9. Our groups, as such, ought never be organized; but we may create service boards or committees directly responsible to those they serve.
10. The Al-Anon Family Groups have no opinion on outside issues; hence our name ought never be drawn into public controversy.
11. Our public relations policy is based on attraction rather than promotion; we need always maintain personal anonymity at the level of press, radio, films, and TV.
We need guard with special care the anonymity of all AA members.
12. Anonymity is the spiritual foundation of all our Traditions, ever reminding us to place principles above personalities. (Al-Anon Family Groups, 1996)

Al-Anon endorses the concepts of tough love, enabling, and codependency; it advocates for family recovery through detachment. From the Al-Anon perspective, family members can only begin recovering when they detach from their substance misusing loved one (Ferguson, 2009). When substance misusers exhibit the same

problematic behavior, family members are advised to go on with their recovery and focus on themselves.

In Al-Anon, family members need to engage in their own recovery to prevent the repetitive cycle of “worrying, reacting, and obsessively trying to control” (Ferguson, 2009, p. 1), which causes their lives to become unmanageable. Healthy detachment is the solution to this repetitive cycle and is facilitated through the ceasing of all efforts to change the substance misuser. Healthy detachment also means implementing boundaries by creating physical and emotional separation (Ferguson, 2009).

Flemons (1991) points out that while separation creates a boundary, it also concurrently establishes a connection. Furthermore, he explains that “symptoms are haunting reminders that attempts to eradicate pieces of our lived experience, to banish parts of our minds, can unwittingly create and entrench the very problems we most dread. The parted mind does not, indeed cannot, depart” (p. 29). Applying these ideas to the Al-Anon concept of detachment, it becomes clear that the more family members tell themselves to detach, the more amplified their attachment becomes. Family members who follow Al-Anon’s suggestion can indeed facilitate detachment from their substance misusing loved one, but they will simultaneously intensify that relationship by doing so. Seen this way, it becomes apparent that commanding a family member to detach is as effective as trying to teach a fish to climb a tree. Nevertheless, since the 1950s, Al-Anon meetings have provided families a place to go when they feel hopeless. As a result, researchers have investigated individual gains received by family members who participate in meetings.

On the surface, the outcomes of research on Al-Anon seem favorable; however, some limitations are important to consider. Many of the studies were conducted by researchers who are themselves advocates of Al-Anon support groups. For example, Chistine Timko, the main researcher on all current Al-Anon studies, has worked to legalize guidelines that mandate health professionals to recommend abstinence-based self-help groups in the field of addiction treatment (U.S Department of Veterans Affairs, 2014). Another researcher, Jeffrey Roth, is the featured addiction psychiatrist on the Al-Anon Family Groups website (Roth, 2011).

Timko, Laudet, and Moos (2016) conducted a longitudinal study to compare active Al-Anon members with drop-out non-members. The Al-Anon members in the study reported an increased ability to handle problems related to the substance misuser, improved sense of well-being, and fewer verbal or physical altercations. The researchers concluded that Al-Anon participation may initiate better relationships between its members and their substance misusing loved ones. Other outcomes associated with Al-Anon membership identified in this study included higher self-esteem and increased hopefulness (Timko, Halvorson, Kong, & Moos, 2015).

Another study found high drop-out rates after six months of Al-Anon attendance. Though improved quality of life was associated with Al-Anon attendance, physical and psychological health remained unchanged (Timko, Cronkite, Kaskutas, Laudet, & Roth, 2013; Timko, Laudet, & Moos, 2014). Another study investigated gender differences within the Al-Anon community; it found that 84% of members are women, so it remains unclear how study outcomes relate to men (Short et al., 2015). Considering women

dominate the Al-Anon community, some critics have raised questions about the utility of telling women to admit they are powerless.

Other critics have suggested that labeling oneself codependent, as is customary in Al-Anon, is questionable, as it reinforces a permanent, sick-identity role. The emotional intensity of some Al-Anon groups has also been criticized, as it has been found to be detrimental to some family members (Timko et al., 2012). In general, emotional intensity can be high within approaches based on the family disease model, because the notion of disease implies mortality. The core belief in this model is that if individuals fail to seek support for their addiction, they will die. Accordingly, family members who participate in approaches based on this model can experience a desperate, urgent need to get their loved one into treatment (Reiter, 2015). Trying to get a substance misuser into treatment can be challenging if the individual is unmotivated to change. Therefore, *The Johnson Model* was developed to help families encourage their substance misusing loved one to enter treatment.

The Johnson Model

The Johnson Model was derived from family disease theory. Like AA and Al-Anon, it pervades popular thinking about addiction (Reiter, 2015), largely due to the influence of a popular television show based on Johnson Model philosophy called *Intervention* (Reiter, 2015). Vernon Johnson first developed the intervention in the 1960s, for alcoholics, but it is currently utilized with all types of substance misusers. Vernon began working with family members and intimate partner of substance misusers who were unwilling to enter treatment (Reiter, 2015). He instructed the family members to write honest letters to the substance misuser, detailing the negative impacts his or her

addiction has had upon their relationship. Once everyone has written their personal letters, they gather in one room; then, the substance misuser—who is completely unaware of what is about to occur—is brought into the room.

The family members take turns confronting the substance misuser with their letters of concern. Prior to doing this, they had a few rehearsal sessions led by an interventionist and received advice about how to gently confront their loved one. They were advised to act kind and supportive while delivering their personal messages, making sure they include encouraging comments about entering inpatient treatment. During the intervention, treatment-related resources are on-hand so that if the substance misuser complies, he or she is immediately transported to inpatient treatment (Rowe, 2012). If the substance misuser does not comply, there are consequences: the family members do as they have been instructed and cut the substance misuser out of their lives (Reiter, 2015).

The intervention is embedded in the notion of hitting rock bottom, which suggests that when substance misusers no longer have emotional, physical, or financial resources to rely on, they hit a low point that renders them willing to consider a lifestyle shift. Essentially, the goal in the Johnson Model is for family members to force the substance misuser to reach rock bottom (Szalavitz, 2016). While the process is depicted as supportive and loving, it is not always that way. The Johnson Model has been critiqued for making substance misusers feel as if everyone they care about is against them (Reiter, 2015; Szalavitz, 2016).

Although family members are encouraged to confront the substance misuser in a loving way, they often feel very angry about interactions that occurred when the substance misuser was drunk or high. When given the opportunity to express negative

feelings about these interactions, they can easily allow their anger and resentment to guide their words, causing them to come across in an attacking manner. It is likely, therefore, that interventions can have the opposite effect from what is intended. The aftermath of an intervention gone wrong could be so devastating as to result in the substance misuser's suicide; perhaps the most popular example of this is the death of rock star Kurt Cobain, who ended his life following an intervention (Szalavitz, 2016).

While there has been considerable dispute about the overall effectiveness of the Johnson Model, some scholars support its use. For example, Smock et al. (2011) deem the Johnson Model the biggest paradigm shift that has taken place within the field of addictions, as it allows professionals to recognize what is "necessary" (p. 181) in order to promote successful outcomes. In spite of this, research shows that families are unlikely to follow through with the intervention (Edwards & Steinglass, 1995; Miller, Meyers, & Tonigan, 1999), and some researchers have raised questions about the model's ability to keep individuals in treatment (Reiter, 2015). Once the intervention is complete, the family remains minimally involved in the substance misuser's treatment (Rowe, 2012).

Family Behavioral Models

Unlike family disease theories, family behavioral models are grounded in the belief that addiction is a multifaceted phenomenon consisting of biological, psychological, and environmental influences. These models rest on the assumption that addiction is hereditary; however, they also acknowledge that the etiology of addiction is not solely a matter of genetics, as children become socialized by adult behaviors, including substance misuse (O'Farrell & Fals-Stewart, 1999).

Family behavioral models follow the basic tenants of learning theory, which asserts that behaviors are more influenced by learning than by genetics; that learning processes can create and change behaviors; that contextual and environmental variables influence behavior; that actual application of new behaviors is necessary for change; and that humans are unique and, therefore, must be considered in context (Carroll, 1999). Family behavioral models also identify the vicious cycles within family interactions that are difficult for family members to escape (Birchler, Fals-Stewart, & O'Farrell, 2008). According to the family behavioral approach, behaviors that take place within family interactions serve as negative and positive reinforcements, which serve to develop and maintain substance misuse.

Reinforcements can be either positive or negative. Positive reinforcements are “events that increase the frequency of a response when they follow a behavior” (Guise, 2015, p. 154). For example, a wife’s compliments about how well her husband cut the grass when he was sober could boost the frequency of his sober grass-cutting behavior.

Hersen, Miller, and Eisler (1973) identified positive reinforcements for husbands’ alcohol use within wives’ non-verbal cues. To study this, the researchers assigned a task to couples and observed increased eye contact between the spouses when the subject of conversation was the husband’s alcohol use; based on this, they determined that increased non-verbal cues during couples’ conversations about alcohol positively reinforce one spouse’s alcohol use (O'Farrell & Fals-Stewart, 1999).

Difficulties in family communication, inability to compromise, high conflict, financial strains, and nagging all serve as reinforcements of substance misuse (O'Farrell & Fals-Stewart, 1999). Negative reinforcements occur when a behavior is performed in

order to decrease the frequency and occurrence of a certain response. For example, a mother stops calling her son every half-hour because he came home sober every night for the past two weeks after hanging out with friends; this negative reinforcement can increase the frequency of the son coming home sober in the future (Guise, 2015). Another example of negative reinforcement is an argumentative husband who stops interacting with his wife while she is under the influence, thereby decreasing the frequency of the arguments between them.

Another principle of operant conditioning is the importance of attending to consequences, which can be categorized as either beneficial or detrimental, positive or negative (Guise, 2015; O'Farrell & Fals-Stewart, 1999). As mentioned previously, the detrimental consequences of a substance misuser's behavior on family members are obvious; not as obvious are the beneficial consequences these families experience. The literature on this subject primarily consists of studies conducted with couples. These studies have demonstrated that alcohol consumption by one partner in a couple is reinforced by positive consequences in the couple's relationship (Billings, Kessler, Gomberg, & Weinder, 1979; Frankenstrein, Hay, & Nathan, 1985; Gurman, Lebow, & Synder, 2015; Jacob & Leonard, 1988). Some of the findings of these studies include that husbands claim to solve problems better under the influence of alcohol, and wives who drink feel more assertive and able to deal with their husbands' sexual requests after consuming alcohol (Gurman et al., 1988; Jacob & Leonard, 1988). Feeling less anxious, more sociable, and more assertive are all beneficial consequences associated with alcohol consumption and its impact on individuals and couples (Gurman et al., 2015; Jacob & Leonard, 1988).

Family behavioral models incorporate theories about classical conditioning in their approach. The principle of classical conditional asserts that a *conditioned stimulus* or *neutral stimulus*, when paired simultaneously with an *unconditioned stimulus*, will trigger an *unconditioned response* over a span of time (Guise, 2015). The most well-known example of classical conditioning comes from Ivan Pavlov's famous experiment in which he used a bell to cause dogs to salivate by pairing the bell with food over a period of time and eventually getting the dogs to salivate without the presence of food (Guise, 2015). Barbara McCrady and Elizabeth Epstein developed a theoretical model of alcohol use—and, later, other substance use—grounded in classical conditioning principles. This approach, known as the S-O-R-C model, asserts the following:

Drinking is conceptualized as a *response (R)* elicited by environmental *stimuli (S)*, such as time of the day or the smell of alcoholic beverages, that occur prior to drinking and are mediated by *organismic (O)* factors, such as craving, withdrawal symptoms, or negative affective states (e.g., anger, depression, anxiety) and maintained by [the] positive *consequence (C)* of drinking[,], including cessation of withdrawal symptoms and alleviation of negative effect. (O'Farrell & Fals-Stewart, 1999, p. 292-293)

Classical conditioning was the first model from the behavioral therapy tradition to be applied in the family context to explain difficulties related to anxiety and sex (Masters & Johnson, 1970). Family behavioral models have evolved over time and are now utilized in the treatment of addiction as well. The overall treatment approach in family behavioral models is to target patterns in family interactions that serve to trigger substance misuse or relapse after a period of abstinence. Additionally, these models focus

on enhancing families' communication and coping skills to reinforce abstinence (O'Farrell & Fals-Stewart, 1999). Treatment occurs over a specific number of sessions and begins with a thorough assessment of the frequency of problematic behavior. Involving the whole family in the therapeutic process is unnecessary; only family members directly related to the problem are part of the process. The therapist formulates behavioral goals to shift the contingencies of reinforcement—i.e., consequences that control the frequency of a particular behavior—within the family. Therapy ends once the problematic behavior is no longer present (Crisp & Knox, 2009).

One particular strength of the family behavioral models is its focused attention on assessment and evaluation. Since behaviors are defined in concrete terms, progress throughout therapy is easily measurable. However, only focusing on the cessation of behavior, without considering other possible problems within the family, limits therapeutic possibilities and can leave families unsatisfied. For example, Joe may no longer drink after he completes therapy, but his wife cannot understand why he continues to isolate himself from the rest of the family. Despite some limitations, family behavioral models—such as Behavioral Couples Therapy (BCT), an evidenced-based treatment developed specifically for substance misusers and their non-substance-misusing partners, are considered by some authors to be the most effective treatment for alcohol and drug misuse (Carroll & Onken, 2005; Moregenstern & McKay, 2007; Rowe, 2012).

Behavioral couples therapy. Over 20 years ago, the National Institute on Alcohol Abuse and Alcoholism (NIAAA) identified couples' therapy as the most superior advancement in the treatment of alcoholism and called for empirical studies to be conducted on its effectiveness (Fals-Stewart & Birchler, 2001). Since the initial call

for clinical trials from the NIAAA, several decades' worth of research has been conducted on BCT to determine whether it is an effective treatment for both alcohol and drug misuse (Carroll & Onken, 2005; HHS & SAMHSA, 2015; Moregenstern & McKay, 2007; Rowe, 2012). However, Ruff et al. (2010) note that in spite of this, "few couple and family therapists may be aware of BCT" (pp. 439-440).

Despite efficacy studies recommending couples' therapy for addiction treatment, it is only incorporated in approximately 27% of treatment centers; of those that have integrated therapy for couples, only 5% have utilized behavioral models of couples' therapy (Fals-Stewart & Birchler, 2001; Fals-Stewart et al., 2004).

The BCT approach was derived in the 1980s from the Harvard Counseling for Alcoholics Marriages Project, which served to create the first manualized behavioral therapy for couples affected by alcohol misuse. Two prime goals in BCT are to enhance support for abstinence and to resume stability in the relationship (Ruff et al., 2010).

The theories supporting BCT share the general assumptions informing behavioral family therapy models—in particular, that a circular relationship exists between substance misuse and couple relationships. According to BCT philosophy, there is a debilitating cycle of interaction between partners in a relationship that is affected by addiction. Typically, such couples report high levels of relationship dissatisfaction, make frequent threats of separation, and engage in verbal and physical aggression. These behaviors serve to increase the chance of relapse or intensify the substance misuse. Accordingly, BCT aims to reverse these debilitating cycles, utilizing the same elements that started the cycle in the first place. In essence, the BCT therapist aims to transform the

cycle into a *constructive cycle* (Fals-Stewart et al., 2004), addressing abstinence and relationship functioning simultaneously.

The BCT model is typically implemented in addiction treatment facilities, where the BCT therapists works in collaboration with the substance misusers' primary therapist to maximize the effectiveness of treatment. Since some problems are best addressed individually and others in the context of couples therapy (Fals-Stewart et al., 2004), individual therapy is seen as an adjunctive asset to the couples therapy process. Additionally, BCT therapists recommend other support services, such as Twelve-Step facilitation programs. Therapy typically consists of 12 to 20 weekly sessions (Ruff et al., 2010).

Once a substance misuser agrees to involve his or her partner in the BCT process, the first session takes place in the form of an interview, as there are certain specifications couples must abide by in order to receive this kind of treatment. For example, the non-substance-misuser must agree to avoid mentioning separation or divorce during the duration of treatment, and the substance misuser must remain abstinent and attend Twelve-Step meetings (Ruff et al., 2010). In addition to getting these commitments from the couple, the BCT therapist also ensures that the couple does not present with characteristics that would exclude them as candidates for BCT.

The BCT approach is specifically designed for married couples or unmarried couples who have been living together for at least one year. If the couple is married but separated, they must share the intention to reunify in the future. Since skills such as communication, problem-solving, and negotiating techniques are taught in the context of therapy, the couple must possess a certain level of intellectual capability to receive the

full benefits of therapy. If domestic violence is present in the relationship, couples are excluded from BCT and recommended to individual therapy.

Couples in which both partners abuse substances are not considered candidates for BCT, on the basis of behavioral principles that suggest that (Fals-Stewart et al., 2004) it is difficult to break the cycle of addiction when both partners are using. Accordingly, BCT therapists view addiction as a *shared reward activity* that creates higher levels of satisfaction in the relationship, because partners enjoy a common activity (Fals-Stewart et al., 2004). Since BCT operates from an abstinence-only approach and views relationships between dually-addicted couples as being primarily built upon intoxication, such relationships are seen as a barrier to the goals of BCT. Substantiating this assumption, researchers have found that BCT is not effective in treating couples who misuse substances together (Fals-Stewart et al., 2004).

After ensuring that a couple meets inclusion criteria for the BCT process, the therapist provides the couple with a sobriety contract, which specifies behavioral goals to be completed daily. These goals include the substance misuser attending Twelve-Step meetings and asserting a commitment to abstinence to the non-substance-misusing partner, who is instructed to be supportive (Ruff et al., 2010). The couple is instructed to avoid discussions about past substance misuse or fears about future substance misuse, as they might reinforce relapse; such concerns are to be addressed in the safety of the therapeutic environment. The couple is also instructed to avoid interactions embedded in blame and instead focus on the present, as this serves to counter highly emotional discussions about the past (Fals-Stewart et al., 2004).

Therapy serves to enhance positive regard, increase shared activities together, and establish effective means of communication between partners, all of which are seen as necessary for the substance misuser to maintain sobriety (Fals-Stewart et al., 2004). Therapy sessions consist of conversations about topics such as the management of cravings, designed to ensure that abstinence has been maintained. The therapist provides behavioral homework assignments in every session to help the couple learn new skills; a review of the previous assignment occurs at the start of each new session. If conflict arises, the therapist creates strategies and behavioral plans to help the couple resolve it. Therapy sessions have specific directions, and therapeutic conversations focus exclusively on the specific behavioral goals covered each week (Fals-Stewart et al., 2004).

Toward the end of therapy, the BCT therapist emphasizes relapse prevention strategies, consistent with the idea that non-substance-misusing partners perceive relapse as a betrayal, which prompts feelings of hopelessness. To avoid the effects that relapse can have on the relationship, the BCT therapist works to frame relapse as a common but not necessary part of the process from which both partners can learn. In the final session, the couple and therapist collaborate to create a recovery plan, specifying activities to maintain sobriety and improve the functioning of the relationship (Fals-Stewart et al., 2004).

Fals-Stewart et al. (2004) report that the highly structured nature of BCT is a strength, as it offers couples stability during chaotic times; however, this degree of structure can also serve as a weakness, limiting the focus of therapy to only reflect the therapist's agenda and increasing the likelihood of client resistance. The approach is

further limited by its inability to treat all couples in which substance misuse is present. Furthermore, since abstinence is the only marker of success in BCT, the approach fails to consider couples' unique needs and processes.

The BCT approach may be most effective for couples in which the substance misuser has already made a commitment to remain abstinent prior to the start of therapy; it is not a good fit for those still contemplating change. Although the approach only applies to a small subset of the population, it demonstrates long-term success compared to no therapy for those couples that qualify (Munro & Allan, 2011).

Community Reinforcement Approach and Family Training (CRAFT) is another family intervention derived from family behavioral theories, which utilizes the family as a resource to motivate a substance-misusing family member to enter treatment. The approach promotes positive interactions among family members, rather than harsh confrontational methods, to influence change (Smith & Meyers, 2004; Steinglass, 2009).

Community reinforcement approach and family training. Robert Meyers designed CRAFT based on the theoretical assumption that punishment does not work to motivate substance misusers, as adding on more negative feelings for individuals who already experience tremendous guilt is ineffective in influencing change. The approach utilizes positive reinforcement for sober activities and other behavioral techniques to shift positive consequences of using. The first step involves teaching families new ways to motivate their loved one to enter treatment. Families also learn about self-care and effective ways to reduce violence within the family. Therapists using the CRAFT approach also guide families in using positive reinforcement techniques designed to limit

the substance misuser's intake of drugs or alcohol during these times (Kinney, 2008; Smock et al., 2011).

Families in CRAFT learn to develop forms of positive reinforcement, such as only inviting the substance misuser to participate in social activities when he or she is sober, and to avoid such activities when the substance misuser is intoxicated. Substance misusers who participate in the CRAFT program may receive assistance with job training to enhance their confidence about being able to function within society. The entire family may be coached on communication skills to avoid hostile arguments and enhance their ability to express thoughts and feelings. Everything occurring during CRAFT is facilitated in a way that increases the likelihood of the substance misuser agreeing to receive further treatment (HHS & SAMHSA, 2012).

The CRAFT approach is often compared to those of Al-Anon and The Johnson Institute. Randomized trials conducted to compare outcomes from all three models reveal that CRAFT is associated with higher rates of retention and engagement for substance misusers compared to Al-Anon and the Johnson Intervention (Meyers, Miller, Smith, & Tonigam, 2002; Miller, 2012; Rowe, 2012). In all clinical trials, CRAFT has demonstrated consistent positive outcomes and shown to be an effective way to utilize family members as resources for getting their loved one into treatment (Miller & Moyers, 2014).

Family System Models

Family system models are different from family behavioral models, as they originate from systems theory rather than learning theories. Systems theory (Walters & Rotgers, 2012) informs all models of family therapy to varying degrees (Rambo & Hibel,

2013). Its basic premise is that “the whole is more than a sum of its parts” (Bertalanffy, 1969, p. 18). A system is defined by nonsummativity, “a set of objects together with relationships between the objects and between their attributes” (Watzlawick, Bavelas, & Jackson, 1967, p. 101).

In systems theory, systems are considered either open or closed. Families are considered open systems because “. . . they exchange materials, energies, or information with their environments (Watzlawick et al., 1967, p. 103). According to Watzlawick et al., a “system is closed if there is no import or export of energies in any of its forms[,] such as information, heat, physical materials, etc.” (p. 103). Human systems are made up of the interactions among their members (Watzlawick et al.). Thus, family system models of addiction treatment are concerned with the interconnectedness of the individuals composing the system, rather than with the individuals themselves. It is understood that when one member of the system behaves, the other parts of the system are affected (Watzlawick et al.).

Rat park. The structure of a system refers to the way the system is organized. Levels create hierarchies, as explained by Heylighen, Joslyn, & Turchin (1999):

At the higher level, you get a more abstract, encompassing view of the whole, without attention to the details of the components or parts. At the lower level, you see a multitude of interacting parts but without understanding how they are organized to form a whole. (para. 6)

An example of a sole focus on lower levels of organization without consideration for higher levels comes from the Skinner box rat studies. In the 1970s, researchers became curious about the effects of heroin, often called the *demon-drug* (Alexander,

2011). Their assumption was that when individuals take heroin, something is set off in their brains, causing them to become permanently addicted for the rest of their lives; this notion was based on the disease model of addiction. To prove their theory, these researchers began conducting experiments with rats. They placed rats in Skinner boxes—which contained a device that could administer heroin, food, or water—and implanted needles in their veins, allowing them to self-administer the heroin by pressing a lever.

The rats in the study continuously chose heroin over food until they eventually died. This study was replicated with other animals, such as mice and monkeys, and the same pattern was identified. Based on the results of these studies, researchers concluded that heroin is highly addictive, and people who use it will become addicted for the rest of their lives (Alexander, 2011). In the late 1970s, Bruce Alexander, a well-known addiction researcher, concluded something entirely different based on his review of these studies. His clarifying conclusion was that rats in *isolation* will continue using heroin to the point of death. Rats are a highly sociable species; thus, Alexander surmised, the researchers' confining them to small spaces without social interaction was no different than placing human beings in solitary confinement. He also posited that the rats' continuous usage of heroin could have been a reaction to their severely high stress levels, due to the needles surgically implanted in their veins. Alexander (2011) concluded, "The results of the self-injection experiments may show nothing more than that severely distressed animals, like severely distressed people, will seek pharmacological relief if they can find it" (p. 194).

To prove his hypothesis, Alexander conducted an experiment known as *Rat Park*. He built huge boxes, placed wood scraps down as flooring, and painted a scenic view of a forest on the walls. Inside the boxes, he placed large groups of female and male rats

together to play and mate with each other. There were plenty of rat toys, food, and water available for the rats; from a physical and social perspective, the rats had everything they needed. Alexander built a tunnel leading to a small isolated corner, which could contain only one rat at a time. Two bottles were placed in this corner; one was filled with water and the other with morphine. Levers allowed the rats to choose which liquid they wanted.

In addition to Rat Park, Alexander (2011) also set up another group of rats in the same isolation as the original Skinner box experiment. The Rat Park rats and Skinner box rats had equal access to morphine; however, Alexander found that the rats in Rat Park chose the water, while the rats in the Skinner box chose the morphine. Alexander replicated this experiment in various ways. He gave the rats morphine two weeks prior to placing them in either Rat Park or Skinner boxes, to ensure that they were equally physically dependent on the morphine and in active withdrawal. In another variation of the experiment, he made the morphine sweet and, therefore, more tempting. In all cases, the rats in the Rat Park condition still chose water over morphine (Alexander, 2011).

Alexander's (2011) Rat Park study disproves many of the theoretical assumptions found in disease-based notions of addiction and highlights many fundamental concepts of systems theory. The conclusions from the original Skinner box study failed to consider elements of organization, structure, and levels of hierarchy in systems. The researchers focused solely on lower levels of organization, without examining higher levels; this led them to generate inaccurate conclusions about rat behaviors. The individual rats in that experiment, which can be said to represent the parts and lower levels of organization in a system, literally drove themselves to death when the whole system was taken away. Once the system was factored into the experiment, the problematic rat behaviors diminished.

The same phenomenon occurs when substance misusers only receive individualistic treatment; higher levels of organizations in their system are neglected, which can lead to inaccurate interpretations of their behavior.

Organization is fundamental in understanding the phenomenon of addiction. The system organizes around the addiction, therefore providing a function for the addiction. Treatment for addiction from a general systems approach focuses on how individual family members become organized around the addiction of one member. The primary goal is to shift structures within the family so that addiction is no longer the organizing component of the system (Walters & Rotgers, 2012).

Cybernetics. Systems theory is intertwined with cybernetics, and both theories are considered “two facets of a single approach” (Heylighen et al., 1999, para. 4). Cybernetics is closely associated with Gregory Bateson, among other scholars, who began exploring ideas about cybernetics in 1940 (Rambo & Hibel, 2013). Systems and cybernetic theories are both concerned with the organization of a system; however, systems theory places a greater emphasis on structures as compared with cybernetics, which prioritizes functions within systems (Heylighen et al., 1999).

Applying cybernetics to the phenomenon of addiction requires a consideration of context. The theory of context suggests that an individual cannot be addicted in isolation, and their patterns of behavior cannot be determined by linear explanations of cause and effect (Watzlawick et al., 1967). Rather, the interactions among all family members establish an interrelated, influential relationship surrounding one individual’s substance misuse. The mutually influencing nature of relationships is defined as circular causality (Flemons, 1991). For example, every time John and his wife are at odds with one another,

he goes to the bar and drinks. When he comes home drunk, Jane gets upset and they fight. The day after the fight, Jane feels hopeless and unloved, and John feels angry at being blamed for the tension between them. They give each other the silent treatment. John goes to the bar and drinks. We cannot blame John's wife for his drinking. However, there is a mutual influence of interactions between John and his wife, which establish circularity within his patterns of drinking behavior.

The notion of circular causality is embedded in the idea of positive and negative feedback loops, another cybernetic principle. All systems are composed of such self-regulating feedback loops (Watzlawick et al., 1967). With positive feedback, there is a mutual escalation of behaviors: The more John drinks, the more critical Jane becomes; and the more critical Jane becomes, the more John drinks. With negative feedback, there is a deescalation, where the increase of one behavior encourages the decrease of some other behavior: The more understanding Jane becomes, the less John drinks; and the less John drinks, the more understanding Jane becomes. When substance misusers only receive individual treatment, their behaviors are not considered in the larger context of the interactional processes maintaining their substance misuse behavior. Failing to consider circular causality and feedback loops in substance misusers' relational systems risks creating problematic feedback loops that complicate treatment.

An interpersonal perspective of addiction represents a stark contrast to society's popular notion that addiction is fixed in an individual's makeup (Sprenkle, Davis, & Lebow, 2009). While there are internal processes that influence the phenomenon of addiction, neglecting the context in which behavior occurs contributes to misunderstandings of addictive behavior (Heatherington et al., 2015). Since the

phenomenon of addiction is highly stigmatized, seeing it as a process occurring within relationships rather than a function of faulty characteristics within the individual can lessen much of the guilt and shame substance misusers experience. Considering humans are more motivated to change when they feel good rather than bad, family therapists can serve to reduce negative feelings by helping substance misusers recognize that their difficulties are connected to something bigger than themselves (Armstrong, 2004; Kaplan & Girard, 1994; Saleebey, 1996).

Structural family therapy. The earliest form of family therapy in addiction treatment centers was derived from concepts of the Structural Family Therapy approach, which utilizes principles from cybernetics and systems theory. Structural family therapy is primarily associated with Salvador Minuchin, who prioritized organization within in the family (Stanton & Todd, 1982); his model includes concepts from systems theory about how families organize around one family member's addiction. Repeated family interactions distinctive to a family compose the structure of that family system. A dysfunctional family system continues to interact in repeated patterns that fail to fulfill the needs of the family unit and its individual members (Robbins, Szapocznik, & Perez, 2007).

The theory of structural family therapy implies that the problem lies within the structures (i.e., interactions) within families. Individual symptomology is seen as the expression of faulty family structures and dysfunctional boundaries (Stanton & Todd, 1982). The family member expressing symptoms is known as the identified client; in the world of addiction treatment, this is the substance misuser. Boundaries, which can be identified by observing family interactions, serve to divide systems and subsystems

(Reiter, 2015). Two examples of subsystems within a family are the spousal and sibling subsystems. According to the Structural Family Therapy approach, boundaries in families can be *clear*, *diffuse*, or *rigid*. Healthy families have clear boundaries that are firm but flexible, allowing the system to adapt. An appropriate amount of information can flow from inside to outside the system, and vice versa. When a family has diffuse boundaries, an overflow of information enters the family system. Relationships in families with diffuse boundaries are overly close, to the point of dysfunction; this is also referred to as *enmeshment* (Reiter, 2015).

Rigid boundaries, which often characterize the families of substance misusers, represent a lack of information shared among the family system, its constituent subsystems, and other systems. The lack of information flow limits the family's adaptability to change. Families with rigid boundaries are marked by secrecy and parental subsystems blocking input from child subsystems (Reiter, 2015). Children in these families have little effect over what their parents say, and they often feel restricted in who they are allowed to be. Hence, deceitfulness becomes the organizing principle of the family. Family rules in families with rigid boundaries might include that nobody is to discuss addiction with the substance misuser or other family members. Often, families safeguard the substance misuser to prevent the occurrence of greater problems (Reiter, 2015). The homeostatic state of addicted families with rigid structures is classified by a lack of communication. By maintaining rigid boundaries and abiding by family rules, family members preserve the functioning of the family system. Altering these patterns can threaten the family's functioning (Steinglass, 2009), so all family members cooperate to maintain the homeostatic balance—sometimes by becoming symptomatic themselves.

In addition to implementing interventions aimed at restructuring the family system, structural family therapists also question the family's certainty about the problem belonging only to the substance misuser, seen as the identified client (Minuchin et al., 2014). This technique is based on Minuchin's belief that "the enemy of change is certainty" (personal communication, September 30, 2011). The goal is for family members to accept the therapeutic process as a family affair, rather than demanding change from the substance user. Therapists do not challenge families' certainty about the problem through direct confrontation, as is the case within family-disease-based approaches; rather, they join with families to establish a relationship that allows those certainties to shift (Minuchin et al., 2014).

The structural therapist maintains an empathic but firm stance toward the family, to effectively facilitate the process of joining and challenging (HHS & SAMHSA, 2015). Joining occurs when the therapist provides a space for each family member to discuss his or her perspective about the problem. This minimizes resistance among family members and improves the odds that the therapist's efforts to shift certainties will be effective (Minuchin et al., 2014). The therapist ensures that everyone feels heard and respected so that trust is established. If family members are disengaged or express other negative feelings, the therapist makes a concerted effort to form an alliance that will counter their disengagement (HHS & SAMHSA, 2015).

Affiliation, coalition, and alliance are concepts from the Structural Family Therapy model used to describe hierarchies in families (Stanton & Todd, 1982). Affiliation refers to a close association between two people who exhibit minimal conflict in their relationship. An alliance is a relationship in which two people are loyal to each

other over other members of the system. A coalition exists when a strong sense of loyalty between two people leads them to gang up on another person (Reiter, 2015). Within this model, coalitions are seen as dysfunctional, and it is the therapist's job to disrupt them (Sprenkle et al., 2009).

Disrupting dysfunctional organizational patterns depends on the therapist's ability to appropriately join with the family. Joining also means becoming part of the system and being in relationship with family members the same way they are in relationship with each other (HHS & SAMHSA, 2015). At the same time, the therapist maintains sufficient distance from the family so as to resist the family's pull to maintain homeostasis. In essence, the therapist acts as the agent of change for the family, restructuring it from the inside out (Stanton & Todd, 1982). The therapist restructures the family system by intervening in the family's interactions and communications. A structural therapist is always aware of structural shifts that occur in the therapy room and sees all therapeutic communications among family members as an opportunity to restructure boundaries or hierarchical problems in the system (Stanton & Todd, 1982). For example, the therapist may form an alliance with one family member against the entire system to shift family patterns.

The structural therapist shifts dysfunctional boundaries within families using directives. If, for example, a father is closer to his daughter than to his wife, the structural therapist will direct his or her focus to the parents, in order to strengthen their alliance. The therapist might direct the husband to sit next to his wife, thereby physically shifting the structural arrangement of the family in the therapy room. Another well-known technique utilized in Structural Family Therapy is *enactment*. The therapist directs

families to act out specific problems and then observes the dysfunctional organizations that are revealed. Then, the therapist directs certain interactional changes designed to shift structures within the system (Minchin, 2006).

Changes in the structure of family systems take place during Structural Family Therapy sessions. Therapists assume that there are specific organizations in family systems' structures that allow them to function optimally. Their primary task in therapy then becomes creating changes in these structures so that family functioning is enhanced and freed of coalitions, enmeshment, diffusion, dysfunctional hierarchies, and so on.

In one study conducted in the 1990s comparing Structural Family Therapy and Psychodynamic Supportive Express Therapy, negative outcomes were identified for both models. However, many methodological errors were present, so the study's conclusions are questionable (HHS & SAMHSA, 2012). In a longitudinal study conducted outside the United States, Structural Family Therapy was conducted with adolescent substance misusers. Findings from this study were positive, showing complete dissipation of addiction symptoms at all follow-ups (Sim, 2007). It is important to note that most of the research on Structural Family Therapy for addiction is based on other models—most commonly Strategic Family Therapy—incorporating structural elements.

The notion that symptoms are “both system-maintained and system-maintaining” (Stanton & Todd, 1982, p. 110) is common to both Structural Family Therapy and Strategic Family Therapy. These models also share the idea that individual change is best achieved by directly intervening in the system, moving families from individual to family symptomology (Stanton & Todd, 1982). The most significant commonality between these

two models is the way they perceive developmental stages within the family life cycle (Stanton & Todd, 1982).

In both models, therapists identify the functions that symptoms serve within families, depending on where they are within their developmental process, and then they generate therapeutic interventions based on their hypotheses. Without understanding the crises families undergo throughout their life cycles, structural therapists cannot know which levels of family organization need restructuring, and strategic therapists lack understanding about how to intervene strategically. Although the interventions characteristic of each model differ, an understanding of the developmental stages in the family life cycle is common to both strategic and structural therapists.

The family life cycle. The family life cycle begins when a child grows old enough to seek a partner with whom to establish a new life; completion of this task is considered a sign of healthy development. From the family life cycle perspective, people who are unsuccessful at securing a mate, or who remain uninterested in a partner until later in life, may develop symptoms. One reason young adults have difficulties during this developmental stage is that their parents struggle to set them free from the family of origin (Haley, 1993).

Viewing addiction through the lens of the family life cycle perspective reveals that leaving the family of origin can result in a multitude of problems. As described earlier, addicted families tend to have rigid boundaries that prevent social interactions within and outside the system; often, such families display enmeshment within the system and rigid boundaries with outside systems. In either case, these dysfunctional boundaries lead the family to isolate, making separation for the young adult extremely

difficult (Reiter, 2015). Families can emotionally distance themselves, as is the case in families in which an adolescent misuses substances, while the rest of the family is abstinent. This adolescent would be left without support and would likely have difficulties socializing as an adult (Reiter, 2015).

The next stage of the family life cycle occurs when two individuals are at the beginning stages of their relationship preparing for marriage. The task at this stage in the family life cycle is for each individual in the couple to achieve “independence while simultaneously remaining emotionally involved with one’s relatives” (Haley, 1993, p. 52). However, if addiction is part of the new couple’s system, both partners are at risk of completely cutting off contact with their families of origin to protect their secrets about the addiction in their new relationship system (Reiter, 2015). In this case, the couple is negatively impacted by a lack of growth and intimacy. The typical dynamic within a couple like this is one partner taking on too much responsibility, and the other failing to take on any responsibility. Conflict is high, and the couple’s ability to compromise on difficulties is low. The system does not always survive, as it becomes too stressful to maintain the relationship; divorce is likely (Reiter, 2015).

After marriage, children usually follow, marking the next developmental stage in the family life cycle. For some couples, children introduce a significant amount of joy into the system; for others, parenting can lead to the arising of symptoms. By directing all their energy toward their children, couples avoid dealing with their personal struggles and marital conflicts. Overly focusing on the children thus becomes an indicator of a couple’s marriage quality.

Haley (1993) explains, “What is known as adolescent turmoil can be seen as a struggle within the family system to maintain the previous hierarchical arrangement” (p. 59). When children are ready to move out on their own, a system breakdown can occur. When addiction is present in one or both partners, the parenting system is altered, and neglect and abuse are more likely, since outside support systems are lacking due to the system’s isolation (Reiter, 2015). Non-substance-misusing children with substance misusing parents who enter young adulthood may completely separate themselves from their original family systems (Reiter, 2015).

The final stage of the family life cycle occurs when the children are out of the home and the couple is reaching retirement. Symptoms can develop at this stage to resolve dynamics associated with the transition into retirement. It is common for one spouse to develop symptoms when the other retires, and for both spouses to have difficulty finding a sense of purpose in retirement. Misuse of prescription pain killers is one way addiction symptomology can arise during this stage. If an individual is divorced or widowed, the sense of isolation can be another source of symptoms (Reiter, 2015).

Developmental changes in the family life cycle allow therapists to see patterns of interaction within the context of clients’ individual and family processes. Additionally, they lend themselves to theories of symptom formation and progression within the Structural Family Therapy and Strategic Family Therapy approaches (Reiter, 2015).

Strategic family therapy. The Strategic Family Therapy models consists of two therapeutic approaches: the Mental Research Institute (MRI) and the Haley-Madanes Model (Guise, 2015). The MRI approach, developed to represent strategic theories, was originated by Don Jackson, Jay Haley, Virginia Satir, John Weakland, Paul Watzlawick,

Arthur Bodin, and Janet Beavin (Guise, 2015). Jay Haley eventually left the MRI and collaborated with Cloe Madanes to create the second version of Strategic Family Therapy. Both models of Strategic Family Therapy are symptom-focused; however, the Haley-Madanes model emphasizes family structure as it relates to symptomology. In this way, it is similar to Structural Family Therapy; the two approaches are often combined within addiction treatment (Guise, 2015).

The Haley-Madanes Strategic Family Therapy model was also influenced by the work of Milton Erickson, a psychiatrist and hypnotist whose way of practicing therapy was deemed controversial during his time, but who was posthumously regarded highly by the professional therapy community (Haley, 1993). Inspired by Erickson's work, Jay Haley incorporated the Ericksonian concepts of directives and paradox into the Strategic Family Therapy approach (Guise, 2015).

The first session in the Haley-Madanes Model is crucial, because it follows the assumption that therapy ends in the way it begins. Therefore, the therapist follows a four-stage process during the first session. The first task of the therapist is to define the problem and consider the context in which the problem occurs (Guise, 2015). In addition to the immediate family, anyone who is involved with the problem is invited to attend the therapy session.

The first stage, known as the social stage, begins as soon as the family meets with the therapist. The therapist ensures that each participant feels welcome, and from the outset, begins to formulate a tentative hypothesis about family structures through observations of the client family's interactions. These hypotheses are considered temporary, as family interactions do not typically reflect real-life family dynamics due to

the presence of an unfamiliar professional (Guisse, 2015). The next part of the therapy process is known as the problem stage. In this stage, the therapist acquires an accurate description of the problem from each family member, gaining different perspectives on the problem within the system. In addition to asking about the problem, the therapist asks each family member to describe what ideal change would look like. By accepting the family's notion of problem and change, the therapist works within the family's framework and maintains motivation in the system. If the therapist presents the problem from his or her own viewpoint, without considering the family's notions about the problem, the therapeutic process becomes irrelevant for them.

As the therapist continues to interact with the family, he or she observes family structures to contribute or modify the tentative hypotheses. At this point, the therapist increases interaction with the clients by strategically preventing problematic interactions. This process mirrors the restructuring process in Structural Family Therapy. For example, it might include disrupting a parent who is speaking to one of the children, or it might entail moving two siblings who are in conflict so that they are next to each other (Guisse, 2015). Enactments are facilitated during the next therapeutic step, known as the interactional stage. The family's interactions with the therapist are limited, but the therapist encourages interactions among family members as the original hypotheses continue to be modified.

The final part of the process is the goal-setting stage, during which the therapist considers all observations and working hypotheses and identifies a concrete, observable, identifiable problem. Prior to ending the session, the therapist provides a directive relevant to the problem that the family no longer wants to experience. A directive serves

to implement difference within problematic family interactions outside the therapy session. Since the problem is defined concretely, it becomes easier to recognize the termination of therapy, as the problem will no longer be present (Guise, 2015).

Traditional notions of therapy suggest that change occurs through therapists providing insight to increase clients' awareness of their own behaviors. Therapists passively listen to information provided by their clients, analyzing the reasons behind their behavior and sharing their impressions with the client. In some approaches, therapists tell clients how to change by teaching them coping skills or breathing techniques. Clients are held responsible for creating change by increasing their awareness about problematic behavior and then changing it. The strategic model follows a different set of assumptions. In this approach, change is seen as occurring outside clients' awareness, and therapists take the lead to influence change in families' ways of relating by providing therapeutic directives (Haley, 1993).

Directives are strategically planned interventions designed to avoid family resistance. Therapists accept this resistance in a way that is based on a hypnotic orientation, as explained by Haley (1993):

The subject is thereby caught in a situation where his attempt to resist is defined by cooperative behavior. He finds himself following the hypnotist's directives no matter what he does, because what he does is defined as cooperation. Once he is cooperating, he can be diverted into new behavior. (p. 24)

Directives do not consist of therapists telling families what to do. Rather, therapists tell families to continue interacting as they normally do when the problem is present, but with a change in the context in which the problem occurs (Haley, 1993). For

example, a therapist working with a highly conflictual couple in therapy would direct them to keep fighting, but to do it in the mornings instead of the evenings. This change in context would induce a spontaneous change within the couple's interaction (Haley, 1993). Spontaneous changes like this one occur effortlessly, without the therapist having to convince or advise clients of what they need to do.

Spontaneous change can also occur through the use of metaphors, which work exceptionally well when dealing with resistant clients or families (Haley, 1993). Within this model, symptoms in families are believed to serve a function. By analyzing family organization surrounding communication and behaviors correlated with symptoms, the strategic therapist can develop a metaphoric understanding of the family's dysfunctional hierarchies. Observing communication patterns, such as who talks for whom, who interrupts whom, who initiates conversation first and with whom, who fails to initiate conversation, and so on, the therapist can develop a clearer picture of the distinct function certain symptoms serve within the family (HHS & SAMHSA, 2012).

Utilizing a guideline of family organization, the therapist communicates a metaphoric understanding of the family's framework as it pertains to symptoms within the system. For example, if a highly conflictual couple continually resists the therapist's attempts to incorporate a relational approach into a therapy session about the couple's substance misusing daughter, the therapist could use a metaphor to influence relational understandings. The therapist might say, "You're both on the frontlines of the battlefield, and your daughter's left hand is handcuffed to you, Frank, while her right hand is handcuffed to you, Sally." Such a metaphor would depict the way addiction causes individuals to feel stuck in an interpersonal context they cannot escape (Haley, 1993).

It is important to note that the strategic therapist would not go on to directly explain the meaning of the metaphor, as this would prevent spontaneous change from occurring.

Since the parents in the previous example entered the session resisting a relational explanation of addiction, the therapist discussed their conflict as one of being on the “frontlines of the battlefield.” The symptom, in this case, is the daughter being “handcuffed” to both of her parents. As Haley (1993) states, “The analogic, or metaphoric, approach to hypnosis is particularly effective with resistant subjects, since it is difficult to resist suggestion one does not know consciously that he is receiving” (p. 27).

Within the strategic approach, addictive behavior is seen as involuntary. The substance misuser is caught in a context created by other family members, who simultaneously increase stress about the symptom while interacting in the same manner that contributed to the problem in the first place. Strategic therapy is fitting for this type of dynamic, because that form of resistance is utilized to produce change.

Paradox, another common therapeutic technique from strategic therapy, allows directives to be spontaneous, “since a person cannot respond spontaneously if he is following a directive” (Haley, 1993, p. 22). Paradox is the communication of two different levels of a message; for example, saying, “Do as I say” (Haley, 1993, p. 22), while simultaneously communicating, “Don’t do as I say, behave spontaneously” (Haley, 1993, p. 22). The individual receiving this communication is left with no choice but to adapt to the conflicting directive, resulting in a spontaneous reaction that produces change.

In the 1990s, scholars began criticizing the Strategic Family Therapy model, arguing that it was manipulative, hyperbolizing the system's power to change immovable family structures. However, strategic therapy has been empirically tested with adolescents and demonstrated effectiveness with at-risk youth (HHS & SAMHSA, 2015). Duncan Stanton and Thomas Todd were the first scholars to integrate research-based family treatment into the field of addiction. Their approach, dubbed the Stanton and Todd Model, is based on a structural-strategic model for adolescent substance misusers and their families (HHS & SAMHSA, 2012).

Stanton and Todd model. Stanton and Todd's work was inspired by families and couples struggling with substance misuse issues during the Vietnam War (Stanton & Todd, 1982). Stanton applied for a NIDA grant in 1973, which was initially denied but eventually accepted in 1974; this led to the first posttreatment study on the intervention he and Todd had developed, known as the Addicts and Families Program (Stanton & Todd, 1982). Stanton and Todd became greatly interested in therapists finding what worked, rather than providing insight for families. They emphasized change within their model: “. . . too often we have seen others become so enamored of family dynamics that the means for effecting change escape them” (Stanton & Todd, 1982, p. xvi).

The overall approach in the Stanton and Todd Model is strategic; however, the techniques used in session reflect structural practices. Additionally, Structural Family Therapy provides the theoretical framework for this model, and therapists incorporate joining, boundaries, enactments, and restructuring in the therapeutic process. They also engage in strategic planning, providing directives between sessions, deliberately targeting symptoms, and incorporating anyone involved with the problem—all of which are

elements of the Strategic Family Therapy approach. The Stanton and Todd Model was initially implemented only with young substance misusers; however, it can be used with any other client population (Stanton & Todd, 1982).

Because of the Stanton and Todd Model's emphasis on developmental stages, family involvement in therapy is strongly encouraged. In therapy, the family essentially re-visits the developmental stage it unsuccessfully navigated previously. When this model was first developed, standard addiction treatment did not involve family members; its introduction reflected a shift in traditional addiction treatment paradigms (Stanton & Todd, 1982).

In Stanton and Todd Model therapy, the therapist must first work with the parental subsystem and the substance misuser, prior to incorporating other individuals involved with the problem. As mentioned previously, addicted families tend to be isolated, creating an overemphasis on the family of origin. Working with the parents and substance misuser serves to resolve the enmeshment of the substance misuser while promoting the parents' "readiness to release the addict" (Stanton & Todd, 1982, p. 121).

After the first task is accomplished, the members of the sibling subsystem are invited into the therapeutic process. While it is not necessary for all siblings to attend every session, their attendance is vital during the early part of the therapeutic process. Following the theory of homeostasis, in-session shifts are compromised if a sibling who is not active in the therapy continues interacting with the substance misuser in ways that maintain the family's homeostatic balance. Siblings can provide the therapist with additional information about family interaction patterns, coalitions, alliances, and other dynamics (Stanton & Todd, 1982).

Because an individual's addictive behavior is deeply ingrained in the interactions of other family members, the therapist is handicapped without including those individuals in the therapeutic process. When a family member is resistant to therapy, it is seen as an attempt to maintain homeostasis in the system. In such instances, the therapist takes charge and determines who and what needs to be incorporated in the therapeutic process.

Therapists working from the Stanton and Todd Model use *noble ascriptions* to describe interactions among family members (Stanton & Todd, 1982). They believe that family members' behaviors, even the most conflictual, are always based on good intentions. For example, a strategic therapist would avoid describing a mother's behavior as codependent, instead saying that she has a high sense of loyalty and eagerness for her child to get better. According to strategic philosophy, negative descriptions of behavior tend to promote resistance, so therapists strategically endorse noble ascriptions of family members' behavior (Stanton & Todd, 1982).

Noble ascriptions serve to reframe negative interactions among family members as forms of care, concern, and loyalty. Therapists are encouraged to maintain positive thoughts about the family, so that their ascriptions are authentic. Stanton and Todd (1982) found that it was rare for family members to deny therapists' noble ascriptions. The families of substance misusers tend to experience contradictory feelings; they believe their efforts to help the substance misuser are futile, yet they continue to interact with him the best way they know how. Feelings of both hope and hostility are common. When strategic therapists identify good intentions hidden beneath their negative feelings, family members feel understood and acknowledged, presenting new possibilities for how to

behave. This also enhances families' trust in the therapist, resulting in a strong joining process (Stanton & Todd, 1982).

Therapists' use of noble ascriptions is not an endorsement of detrimental patterns of behavior in the system. Instead, it serves as one of many ways in which therapists position themselves to effect the most change, without inciting resistance (Stanton & Todd, 1982). Noble ascriptions work well with families affected by addiction, as they tend to present with high levels of defensiveness. Confrontation, common in standard addiction treatment practices, is seen as ineffective in the Stanton and Todd approach, because it furthers defensiveness in families already known to exhibit resistance. Therefore, therapists who engage in confrontation lose their ability to influence (Stanton & Todd, 1982).

The therapeutic goals within the Stanton and Todd Model are dissipation of the symptom, or complete abstinence from all mood-altering substance. Abstinence is required, because if the substance misuser continues using, he is still classified as an addict, and change is blocked (Stanton & Todd, 1982). The second therapeutic goal is increased productivity by the substance misuser through employment or afterschool activities. The final therapeutic goal is, when relevant, separation of the substance misuser from the family home.

The therapeutic goals in this approach are set up strategically to promote the family's engagement in therapy, because these are the things they would like to see happen for the substance misuser. Nevertheless, establishing these goals with families at the beginning of therapy is not required, because one goal is adequate for the therapeutic process. Stanton and Todd (1982) found that the number of goals accomplished in

therapy depends on the family's readiness for change. Whether three goals or only one are reached, therapy is still considered successful, as any difference in the system establishes a change.

These goals serve as a guideline for the therapeutic process and are negotiated if they appear unfitting for the family. Incorporating family members' opinions about therapeutic goals allows them to feel engaged and encouraged (Stanton & Todd, 1982). Until the substance misuser becomes abstinent, the sessions remain dedicated to the subject of substance use (Stanton & Todd, 1982). Simultaneously, the therapist forms an alliance with the parental subsystem, encouraging both parents to establish rules that promote the substance misuser's continued abstinence.

The therapist continues orienting therapy sessions toward strengthening the parental subsystem. Although this could potentially elicit resistance from the substance misuser, Stanton and Todd (1982) found that, on the contrary, he or she is "secretly grateful for the fact that the parents' relationship is being attended to by the therapist" (p. 130). Once the substance misuser has been abstinent for at least a month and the parental subsystem is strong, the family addresses other therapeutic goals.

The next set of goals, securing employment and residing somewhere other than the family home, is based on the underlying intention of separation. When therapists work to restructure organization within the family to achieve separation, they are mindful of family members' struggles with the change, and they address those dynamics. Once the substance-misuser-related goals are completed, other issues can be addressed. Therapy is terminated after eight to 12 sessions, and a follow-up session is scheduled for two to four months after the final session to ensure that changes are maintained.

While efficacy research on the Stanton and Todd model points to its effectiveness with adult male opiate misusers, the model has not been further investigated since the time of its inception (Rowe, 2012). However, it has influenced other structural-strategic approaches that have been well-represented in the research literature over the last 30 years (Rowe, 2012). Recent outcome studies in the literature support the use of structural-strategic models for addiction treatment, especially with the adolescent population (HHS & SAMHSA, 2015). Since substance misuse begins in adolescence, research suggests that favorable outcomes are more likely when it is addressed early.

There is considerable support within the literature for the use of family interventions in the treatment of adolescent substance misusers (Rowe, 2012). Brief Strategic Family Therapy (BSFT), a structural-strategic family therapy approach for adolescent substance misusers, has especially high efficacy ratings and is considered an evidence-based treatment (HHS & SAMHSA, 2015; Reiter, 2015). Systemic explorations of BSFT have found positive outcomes for therapy with children and adolescents who present with behavioral, conduct, anti-social, and substance misuse problems (Robbins et al., 2007).

Brief strategic family therapy. The BSFT approach, a brief family therapy model consisting of 12 sessions, was developed in Miami in the 1970s by researchers who aimed to create a culturally appropriate treatment for young adolescents of Hispanic and African American heritage (Robbins et al., 2007; Szapocznik, Schwartz, Muir, & Brown, 2012). Initially, BSFT was oriented in purely structural terms, as the theoretical underpinnings of Structural Family Therapy were aligned with the values predominant in Hispanic culture; over time, strategic elements were incorporated. The approach shares

many theoretical assumptions with the Stanton and Todd Model: the family as a system, shifting patterns of interaction maintaining the symptom, utilization of family resistance, and strategic planning of interventions (Szapocznik et al., 2012).

In BSFT, multiple systems are considered in relation to the symptom, including the substance misuser's peer group, school, and neighborhood. The parental subsystem and outside systems it interacts with, such as the parents' places of employment, are also explored within this model. Culture is recognized as a fundamental contextual factor affecting problematic behaviors (Robbins et al., 2007).

The BSFT approach is based on research about family structures commonly associated with substance misuse and other delinquent behaviors, which serves as a guideline for intervening in family structures. Examples of faulty structures associated with addicted families are over-functioning and under-functioning in the parental subsystem, allowing of children to dominate the family system, lack of collaboration between parents, and poor relationship quality between parents (Robbins et al., 2007).

Family structures are divided into five categories: *organization*, *resonance*, *developmental stage*, *identified patienthood*, and *conflict resolution*. Organization consists of the family's communication and hierarchy. Resonance focuses on family boundaries. The developmental stage category is comprised of inappropriate developmental roles, such as children who act as parents—and, in this way, are said to be *parentified*—or children who are treated inappropriately, based on their developmental stage—or, in other words, who are *infantilized* (Robbins et al., 2007). The category of identified patienthood refers to the intensity of the family organization with respect to the adolescent's substance misuse. The conflict resolution category explores families' ability

to handle disagreements (Robbins et al., 2007). After a thorough exploration of family structure as it relates to symptomology, the therapist formulates a treatment plan.

Therapists investigate family structures to create change through the use of enactments and other therapeutic observations about families' in-session interactions (Robbins et al., 2007). Both the Stanton and Todd Model and BSFT emphasize problematic family structures as the prime target of intervention. Additionally, both models take advantage of enactments to shift family behavioral patterns. While the Stanton & Todd model focuses on out-of-session directives, the BSFT model does something similar with certain adaptations. Like directives, tasks in therapy are seen as possibilities for new, more positive family interaction patterns. However, directives in the Stanton and Todd Model tend to have a stronger paradoxical undertone, while tasks in the BSFT model are more straightforward. For example, a therapist might ask a parental subsystem lacking conflict resolution skills to negotiate a list of rules for the problematic child, then assign the parents homework targeting the same goal.

In BSFT, tasks can occur inside or outside a session. Those that occur outside are commonly known as homework assignments; these serve as the fundamental intervention in BSFT (Robbins et al., 2007). Therapists only assign homework when associated tasks have been completed successfully in session. For example, a therapist would not instruct a parental subsystem that has lost power over their child to create a curfew and set certain rules at home unless an in-session task oriented toward their resuming of power was successful.

Tasks are simplified during the initial phase of therapy and build up to more difficult assignments over time, depending on how families respond to their homework

assignments. When families are unsuccessful in completing their assigned homework, therapists utilize this information to determine what barriers are preventing them from finding new ways of interacting. They might process the homework with families in an upcoming session, identify barriers, and adapt the homework accordingly. Families that successfully complete the homework are seen as having established new patterns of behavior that will be maintained in other areas of their lives, positively influencing many aspects of family functioning (Robbins et al., 2007).

The creation and refinement of tasks is essential to BSFT, as tasks reflect treatment plan goals and objectives. Therapists process previously assigned homework with families at the start of each session and assign new ones at the end of the session. Each homework assignment is based on the specific needs of the system's structure and are derived from in-session enactments. Therapists should never assign tasks with ambiguous instructions that require big steps from families; instead, they believe homework should consist of small, clear-cut steps, so that families are more likely to follow through with the assignment (Robbins et al., 2007).

In addition to assigning tasks, BSFT therapists use interventions to manage in-session communication patterns. They may stop one family member from speaking while encouraging other, more quiet family members to speak up; this is similar to strategies used in the Stanton and Todd Model. But the focus on skill development within the system, such as conflict resolution and behavioral management, is the key factor distinguishing this model from Stanton and Todd's approach. Once healthy family interactions are established and the adolescent substance misuser's symptoms decrease or dissipate, therapy is concluded (Rowe, 2012).

Family systems and family behavioral models are different in their theoretical stance. However, they share in common their symptom-focused orientation and emphasis on a thorough assessment of family functioning at the outset of therapy, setting them apart from postmodern models of family therapy.

Postmodern Models

“Thus it becomes a real alternative to traditional diagnostic thinking in the sense that it helps us decided what to do, even though it does not help us decided what’s wrong with a certain person or a certain family system. It only helps us decided what might be helpful.”

– Harry J. Korman

In the 1980s and 1990s, a major reorientation took place in the field of family. Rather than focusing on problems in systems, postmodern therapists began emphasizing meanings and relationships to problems in the context of larger sociocultural systems (HHS & SAMHSA, 2012). Postmodern models, like family systems models, suggests that substance misuse cannot occur in isolation from its social context. However, unlike family system and behavioral models, postmodern models about addiction suggest the phenomenon of addiction makes sense to the substance misuser according to the unique ways they make sense of the world (Burrell, 2002). They have power over their lives and are considered active agents in creating their own social constructions and relationships to addiction. Addiction, from this perspective, is not a chemical phenomenon, but a relational one (Burrell, 2002).

In disease-based models, substance misusers are considered dysfunctional individuals with permanent brain deficiencies. They are passive; addiction is something

that happens to them. Once the pattern of using chemicals is established over time, these individuals lose control of their own lives (Burrell, 2002). Disease-based models assert to substance misusers that the chemical compounds of drugs and alcohol are so powerful, they take over their lives. Yet, simultaneously, disease-based models demand substance misusers take control and stop using drugs and alcohol.

Disease-based models are born from modernist traditions built upon “values of reason, objectivity, scientific truth, order, prediction, and control” (Gergen, 2009, p. 13). When applied to human relationships, modernism suggests that there is a singular truth behind individuals’ behaviors, which can be revealed through observation (Gergen, 2009). Modernism suggests that like machines, humans operate according to universal principles that guide their actions. Substances and substance misusers are defined by objective standards, and the phenomenon of addiction is believed to occur inside individuals or their family systems. Applying these modernist ideas to drugs and alcohol suggests that substances have inherent pharmaceutical properties that affect individuals and families in predictable ways. The only way to treat substance misusers, therefore, is through the promotion of abstinence, and the only way to control the general misuse of substances is with social sanctions like prisons and rehab (Burrell, 2002). Interestingly, though, many individuals who struggle with addiction are able to establish and maintain sobriety without going to rehab (Lewis 2015; Szalavitz 2016). This fact, bolstered by critiques of the disease model, opens up other perspectives.

Postmodernism is built upon notions of subjectivity, unpredictability, and multiple truths or realities. Postmodernism suggests that there is no such thing as a single universal truth; all we have access to are our interpretations about those truths (Gergen,

2009). Accordingly, there are no truths that can be observed about human behavior, only cognitive constructions we create (Gergen, 2009). Any description or explanation is just one of many ways to view the world; and furthermore, all we have access to are our own descriptions and interpretations about the world, not the actual world itself (von Glasersfeld, 1996).

Addiction does not occur within human beings' interactions, but rather within the meanings derived from those interactions. Addiction, therefore, is a subjective experience unique to each individual (Burrell, 2002). One treatment cannot possibly be generalized to the entire population of substance misusers, because addiction is embedded in the context of individuals' unique personal and social constructs of meaning and how they relate to the world (Burrell, 2002).

Postmodernism suggests that constructed perceptions about the world are not static throughout a lifetime, residing inside humans in a fixed and permanent way. Rather, models about the world are formulated through interpretation and fluctuate over time. If models constructed about the world are beneficial and in alignment with an individual's perceptions and meanings, he or she conceptualizes them as a true reality. However, true realities fluctuate, because something always occurs to illuminate another reality standing in contrast to the current constructed reality (von Glasersfeld, 1996).

To clarify the concept of constructed reality, von Glasersfeld (1996) uses the example of individual A claiming individual B has changed after that individual does an unexpected behavior. Modernist assumptions would claim that individual B showed his or her true personality to individual A through that behavior. But postmodern philosophies would suggest that individual B simply expressed a behavior that was not

part of the model individual A had of him or her. Therefore, the original model constructed by individual A about individual B no longer aligned with individual A's belief system. Because individual A could not understand the unexpected behavior of individual B, he or she interpreted the unexpected behavior based on his or her personal experiences with unexpected behavior in other contexts. From the postmodern perspective, any interpretation of individual B's behavior could be seen as true, depending on the way the person interpreting the behavior makes meaning out of it.

Although postmodernism recognizes all realities as equally valid, it also acknowledges that there are power imbalances among individuals whose unique construction of reality differs from socially accepted beliefs. Neimeyer (1993) states, "It is very hard, in a world with many realities, to maintain the position that satisfactory adjustment to one reality is equivalent to mental health, and that unsatisfactory adjustment is a form of illness" (p. 222).

Up to this point, all interpersonal models have been derived from modernist traditions. Modernist models such as Strategic and Structural therapy have certainly contributed to the addiction research literature. However, when it comes to postmodern models, such as Narrative Therapy or SFBT, only theoretical descriptions of the approaches appear in the literature. Few direct research studies of postmodern models can be found in the existing literature.

Narrative and solution-focused brief therapists come from a not-knowing stance and believe that change can be brought forth in clients' overlooked experiences. Essentially, both models bring significance to the insignificant. Narrative therapy differs

from SFBT in its greater focus on problems; SFBT, on the other hand, assumes that therapy sessions are best spent focusing on solutions.

Solution-focused brief therapy. The SFBT model is considered strength-based because it places a greater emphasis on strengths and resources, as opposed to problematic descriptions of behavior. Overall, strength-based approaches have made a compelling impression on the field of addiction (McCollum et al., 2004). As implied in its name, SFBT is categorized as a brief intervention, only requiring about five sessions (de Shazer, 1991; McCollum et al., 2004). The techniques, although brief, are designed to have lasting effects on treatment outcomes. Strength-based approaches assume that substance misusers, like all human-beings, have natural strengths that can be utilized to shift their struggles with addiction (McCollum et al., 2004).

The SFBT approach was developed by Steve de Shazer and Insoo Kim Berg in the 1980s at the Brief Family Therapy Center in Milwaukee, Wisconsin. It is practiced all over the world, including in countries throughout Europe and Asia (Gingerich & Peterson, 2013). It is more of a stance about the therapeutic process than a set of techniques, and it focuses on changing the problems clients bring into therapy (Hoyt, 2008). If clients focus on what they want rather than what they do not want, desirable change can occur (Hoyt, 2008). In SFBT, clients are treated as the experts on their own lives, as they are the ones with direct access to their perceptions, definitions of reality, and experiences. This is the fundamental assumption upon which the model was built (Berg & Miller 1992).

Solution-focused therapists are interested in what works for individuals and families. In individual therapy, families are included in the treatment process from the

outset, as they provide additional information that can contribute to the process of solution-building (Berg & Reuss, 1998). When working with issues of substance misuse, solution-focused therapists assume that the family is a necessary part of the treatment process (Berg & Reuss, 1998). This stands in stark contrast to dominant beliefs among clinicians who work in addiction treatment facilities, who see families as contributing to the substance misuser's addiction and, therefore, avoid involving them (Berg & Reuss, 1998). This dominant belief could have something to do with the cycle of blame that often takes place between substance misusers and their families.

Berg and Reuss (1998) describe the pattern of addiction in the family as family members blaming substance misusers, and substance misusers blaming their families. Individual treatment for substance misusers is not enough, because conflicts oriented in blame are left unaddressed, and upon returning back to the family, substance misusers can regress (Berg & Reuss, 1998). To prevent this from happening, solution-focused therapists who work with clients struggling with addiction will work with their families, too. Despite the amount of negativity, blame, and anger existing in families that struggle with addiction, solution-focused therapists give those families the benefit of the doubt. They follow the assumption that families are doing the best they can within the constraints from which they are operating. Even when families act toward the substance misuser with unhelpful behaviors, they are still acting from their own constructs about what they believe the individual needs to do to overcome the addiction.

In SFBT, it is assumed that "alcoholism is his problem but the solution belongs to all of us" (Berg & Reuss, 1998, p. 99). Berg and Reuss (1998) note that this idea runs contrary to most families' belief that the problem is happening to them, but the solution

lives somewhere else. Solution-focused therapists recognize that the solution belongs to all family members and, therefore, encourage families to see that they have the capability to do something about the problem of substance misuse. This increases their self-esteem and empowers them to make shifts in their actions toward their substance misusing loved one (Berg & Reuss, 1998).

Although it is common for solution-focused therapists to make Al-Anon referrals to increase family empowerment, ideas discussed in Al-Anon groups can be too far removed from their own constructs about what is helpful, which can overwhelm some family members and inhibit the change process (Berg & Reuss, 1998). For example, telling a mother who comes from a cultural orientation that defines good parenting as putting one's children before one's own needs that she needs to focus on herself would diminish her sense of self-esteem, making her feel there is something wrong with her. As a result, her caring attempts transform into agony. Not only is she being told she cannot be the good mother she knows how to be, her efforts are actually defined as dysfunctional. Berg and Reuss (1998) note, "She views her life from a relationship orientation; it is her identity, and to strip it away at the beginning of treatment is a disservice" (p. 154). The authors suggest that instead, the mother should be supported in working within her own competencies and strengths until she develops greater confidence in who she is. Then she can be in a better position to balance her own needs as an individual with the needs of her child.

When individuals feel confident and competent within themselves, they are in a better position to effectively help others. If the mother in the previous example feels like a failure, she will feel inadequate, which places her at a disadvantage in her efforts to

help. Telling families that they enable substance misusers is crude and ineffective (Berg & Reuss, 1998). Instead, solution-focused therapists compliment family members for all their efforts in trying to help and then facilitate conversations about times when they acted outside of enabling tendencies (Berg & Reuss, 1998). Rather than seeing family members as enablers, solution-focused therapists view them as having an “enormous capacity to tolerate frustration with unlimited patience and undying hope for the problem drinker” (Berg & Reuss, 1998, p. 27).

Solution-focused therapists elicit questions about family members’ perceptions regarding their solution attempts. Usually, family members’ solution attempts are unsuccessful; otherwise, the problem would not be a problem (Berg & Reuss, 1998). The SFBT approach allows families to recognize their own ineffective ways of helping through therapists’ use of specific questioning, rather than by telling them their solution attempts are unhelpful since they have not influenced change. For example, a solution-focused therapist might ask, “How have you tried to be helpful? Has it worked?” Once families recognize that their solutions have failed to work, they are able to do something different. Doing something different about unsuccessful solution attempts facilitates the potential for families to interact within different patterns of behaviors toward substance misusers. Although the recognition of failed solution attempts does not directly take away the substance misuse problem, it can create a shift in family members’ previous ineffective behaviors, allowing for a change in interactions and eventually influencing substance misuse behaviors (Berg & Reuss, 1998).

In SFBT, recovery is defined by the client, and abstinence is not required as the treatment goal. Goals are accomplished by adding new behaviors rather than taking old

ones away (Berg & Miller, 1992). For example, instead of formulating the goal as abstaining from substances for five days, the client would be asked, “What would be happening on the days you are abstaining?” Clients’ therapeutic goals are respected and divided into smaller goals to make achieving them more realistic. As a result, client motivation is enhanced, allowing clients to determine their own path to recovery (Berg & Reuss, 1998). If clients are trying to moderate and are unsuccessful, it is perceived as an unsuccessful solution attempt; this allows clients to revisit the goal of moderation on their own terms. Berg and Reuss (1998) suggest that solutions are only effective when they come from clients’ own voices. By allowing clients to create their own solutions, the therapeutic process remains collaborative, and the therapist does not need to beg, plead, or work harder than the client. As Berg and Reuss (1998) explain, “In our experience, clients will do what they want to do and say, ‘To hell with the experts’” (p. 41).

From the SFBT perspective, recovery occurs prior to treatment, in clients’ initial thoughts about change. This stands in sharp contrast to traditional treatment notions, which suggest that recovery begins when a client stops taking drugs and alcohol. In these models, the therapist is the expert who offers clients the “right” way to recover. For example, traditional addiction therapists might advise their clients to avoid people, places, and things associated with substances; change dysfunctional thoughts into healthy ones; and use cognitive skills they learned in therapy. In essence, a successful recovery requires clients to conform to professionals’ recommendations. If clients’ ideas about recovery fail to fit into the professionals’ constructs, the clients are said to be in denial. Berg and Miller (1992) find this uncondusive to change, because conformity does not necessarily entail change; rather, difference leads to change (Berg & Reuss, 1998).

Solution-focused therapists must be flexible and willing to look at clients' perspectives, rather than insisting on their own. As Berg and Reuss (1998) point out, "Prisons are full of people who comply but have not necessarily changed" (p. 137). Therapists and clients negotiate ideal outcomes for clients' lives, and the therapeutic relationship is collaborative in nature (Berg & Reuss, 1998). A collaborative therapeutic relationship entails a sense of trust; this contrasts with the therapeutic relationship commonly established in traditional addiction treatment, which is characterized by a mutual lack of trust.

As discussed previously, treatment approaches to addiction developed in the early half of 20th century were aggressive. Such models predominated in the addiction treatment field, leading client-centered practices to be viewed as impractical (Diamond, 2000). During the assessment phase and throughout the treatment process of traditional approaches, addiction professionals constantly question their clients. If they believe clients are reporting inaccurate information about their substance use, they label these clients liars. The SFBT model takes a different approach. Instead, therapists choose to trust their clients and accept them wherever they are within the process of change (Berg & Reuss, 1998).

Berg and Reuss (1999) suggest that telling clients they need to change puts them in a position of needing to defend themselves against change. As White and Miller (2007) note, "Here is the paradox: that in experiencing understanding and acceptance as they are, people are freed to change. Are human beings really wired in such a strange way?" (p. 20). Change is seen as a process of taking small, pragmatic steps to do something different; one small change can lead to other changes. Essentially, SFBT follows the

assumption that change constantly occurs, and avoiding change is nearly impossible (Berg & Miller, 1992; de Shazer, 1985).

In SFBT, change does not take place through uncovering unconscious motives or practicing healthy behaviors. Instead, SFBT therapists believe that all clients have the capacity to create functional patterns of living (Berg & Miller, 1992). The goal is to invite clients into *solution realities*, uncovering functional patterns of living, strengths, and resources that have been overlooked. By discovering their strengths and resources, clients gain the capacity to make useful changes they would like to see in their lives (Berg & Reuss, 1998). While solution-focused therapists recognize that there is more to the problem than substance misuse, they do not look for underlying causes of addiction. Once solutions to the problem are implemented, these underlying causes tend to dissipate (Berg & Reuss, 1998). If family members disagree with substance misusers' solution realities, SFBT therapists elicit their feedback and listen for an area of commonality between substance misusers and their families. Therapists avoid taking sides or determining who is right and wrong; rather, they view family disagreements as mere differences in perception (Berg & Miller, 1992).

In SFBT, the therapist's attitude is believed to influence change in the client's life (Berg & Reuss, 1998). Therefore, solution-focused therapists always demonstrate a sense of belief and hope in their clients' abilities (Berg & Reuss, 1998; Juhnke & Hagedorn, 2006). When clients believe their therapists have faith in their capacity to change, they remain more loyal to therapy and attentive to those experiences that support their ability to change (Juhnke & Hagedorn, 2006). Berg and Reuss (1998) explain, "We believe that unless we have absolute hope we cannot inspire hope in others" (p. 57). Similarly, Miller

and Rollnick (2002) assert that hope is crucial in the change process.

A hopeful therapeutic attitude is maintained throughout all client-therapist relationships. In SFBT, clients' readiness for treatment is categorized, and clients are seen as being either *customers* eager to change, or *visitors* who are curious but not yet ready (Berg & Reuss, 1998). Families are similarly categorized. Even if family members enter therapy only on behalf of their loved one, they are still considered customers, because they have an overall investment in change (Berg & Reuss, 1998). If the client's conception of change does not correspond with what the therapist anticipated, the therapist will accept the client's ideas, seeing them as a start to the therapeutic process (Berg & Reuss, 1998).

In the SFBT tradition, clients who are mandated for therapy or cannot define concrete therapeutic goals are not seen as being in denial, but rather are considered visitors within the therapeutic relationship. A visitor may not want to change entirely or may talk about change but not be prepared to act (Berg & Reuss, 1998). In SFBT, clients in denial are those who hold different constructs about change or therapeutic outcomes compared than their therapists do. Therefore, denial says more about the client-therapist relationship than about the client. Berg and Reuss (1998) expand on this by stating, "We learned from these situations that a client who is said to be in denial is simply noticing different things and weighing them differently than we do" (p. 38).

Research has found SFBT to be particularly beneficial for clients mandated to treatment (Smock et al., 2008). Identifying the type of therapeutic relationship is beneficial, because it allows the therapist to know the direction of therapy and what the client desires from the process. For example, in a customer-type relationship, the

therapist can establish goals from the outset of therapy and move at a quicker pace. In a visitor-type relationship, change is not prioritized, and the pace of therapy is more gradual and “gentle” (Berg & Reuss, 1998, p. 21).

Although theoretical assumptions of SFBT stand in contrast to dominant notions in contemporary models of addiction, they do not discount what works for a client. If Twelve-Step principles are useful, solution-focused therapists will endorse Twelve-Step recovery resources and explore how they can be helpful. Like Twelve-Step philosophies, SFBT follow beliefs about taking it one day at a time by focusing on small steps to produce change (Berg & Reuss, 1998). However, SFBT does not share the notion of rock bottom held by the Twelve-Step approach. Solution-focused therapists sit on the front lines with their clients while they are at their bottom, exploring the clients’ constructs about coping. For example, a solution-focused therapist might ask, “How have you only managed to drink five times this week instead of six?” Inherent in the question is a solution to the problem. Since a notable amount of energy is required to prevent problems from deteriorating, there are strengths to be explored even during times when traditional treatments models of addiction would label clients not invested (Berg & Reuss, 1998).

When clients who address their addiction problem through abstinence experience a relapse, it is defined as a *setback* in SFBT. In contemporary addiction treatment, relapse entails a sense of failure, and sobriety is seen as started over. In SFBT, a relapse is viewed as an opportunity to do something different (Berg & Miller, 1992). When clients decide to address their setbacks, it means they are no longer engaged in unhelpful behaviors and have a desire to resume their previous level of functioning. Therefore, progress has occurred. Solution-focused therapists explore relapses in a solution-focused,

rather than problem-focused, way. Rather than generating a list of triggers or designing relapse prevention plans, therapists ask their clients questions about what led up to the moment they decided to get back on track. Exploring circumstances, including even the smallest experiences that led clients to decide to regain sobriety, allows clients and therapists to know what worked and can work again in the future. Setbacks are openly discussed to allow clients to feel comfortable, so that if another setback occurs, they will openly discuss it in therapy again (Berg & Reuss, 1998).

Conversations oriented toward setbacks include discussions about times when the problem did not occur; in SFBT, these are known as *exceptions* (Berg & Reuss, 1998). Exceptions are explored in the context of clients having the potential to engage in problematic behaviors with a different outcome (Berg & Reuss, 1998). Exceptions include a broad range of possibilities and relate to any aspect of changed behaviors related to substances. For example, these might include times when the substance misuser could have driven past the liquor store but took an alternative route (Berg & Reuss, 1998).

The *miracle question*, another framework utilized by solution-focused therapists, is posed as follows:

Suppose when you go to sleep tonight (pause), a miracle happens and the problems that brought you here today are solved (pause). But since you are asleep you can't know this miracle has happened until you wake up tomorrow. What will be different tomorrow that will let you know this miracle has happened and the problem is solved? (Berg & Reuss, 1998, p. 30)

Some clients may answer the miracle question by describing the absence of the problem that brought them to therapy. For example, a substance misuser might say, “I wouldn’t have this addiction!” The therapist could respond in various ways by becoming curious about behaviors occurring on days when the addiction was not such a problem for the client, and emphasizing those behaviors in the present. The miracle question allows clients to envision change and possibilities (Berg & Reuss, 1998).

In SFBT, *scaling questions* are utilized to measure progress and define goals in concrete, observable terms (Berg & Reuss, 1998). A scaling question asked to a substance misuser might be, “On a scale of 1 to 10, where 1 represents you having a very slight idea of what has to happen, and 10 represents you being actively involved in your own recovery, where are you today?” In their best attempts, solution-focused therapists’ efforts to build toward solutions can become stagnant; when this occurs, they can pose another question to keep clients solution-focused. Nightmare questions apply when clients’ substance misuse is clearly detrimental, and they are unable to perceive other possibilities beyond their present circumstances. Berg and Reuss (1998) pose the nightmare question as follows:

Suppose that when you go to bed tonight (pause), some time in the middle of the night a nightmare occurs. In this nightmare all the problems that brought you here suddenly get as bad as they can possibly get. This would be a nightmare. But this nightmare comes true. What would you notice tomorrow morning that would let you know you were living in a nightmare life? (p. 36)

A solution fails to exist without a problem. Therefore, a nightmare question represents a reorientation from problem-talk to solution-talk. After the client answers this

question, other relational questions, the therapist asks about how the people around the client would be affected. The therapist and client then discuss preventative measures to keep the nightmare from occurring. Even if the client describes the nightmare situation as manageable, it is considered change, because there is a shift in the relationship to the problem constituting acceptance (Berg & Reuss, 1998). On some occasions, clients are unable to change anything. Solution-focused therapists perceive such situations as processes occurring prior to a reorientation to change. As Berg and Reuss (1998) note, “She has to go through what she is going through, right now, in order to get to her next place” (p. 155).

The SFBT approach has been criticized for its sole focus on solutions, without providing space for clients to talk about the problems (Hammond & Nichols, 2008). However, as noted earlier, SFBT would be non-existent without a discussion about problems. Essentially, the problem becomes part of the solution. Since 1993, many research studies have been conducted on the SFBT approach, mainly in the United States and Europe (Gingerich et al., 2012). Over the past 20 years, empirical evidence for SFBT has flourished (Kim et al., 2018). The first systematic review of SFBT was conducted in 2000 by Gingerich and Eisengart, whose findings established SFBT as a potentially efficacious treatment approach. However further research studies were needed, as methodological errors made it difficult to interpret their findings. Of the 15 studies conducted on SFBT, only two were tested with the substance misuse population, and one of those studies’ findings were inconclusive (Gingerich & Eisengart, 2000).

A less recent study contributing to an understanding of the efficacy of SFBT for substance misuse was conducted in an inpatient addiction facility in Belgium developed

from the *Bruges Model*, which is built upon assumptions of SFBT. The results of this study demonstrated an 84% efficacy rating four years after the time of the study. At the time of follow-up, half of the participants (50%) were sober, and 34% were successfully engaging in controlled drinking. The findings of this study were contrasted with the outcome of Polich, Armor, & Braiker's (1980) study, which found a 7% abstinence rate in traditional addiction treatment programs (de Shazer & Isebaert, 2004). However, Gingerich and Eisengart (2000) note that the outcomes of the Bruges Model should be considered within methodological limitations, because its results were based on individual and family self-reports without comparison groups or random assignments.

Franklin, Trepper, Gingerich, and McCollum (2012) created a handbook of SFBT evidence-based practices, which serves as the most current, comprehensive treatment outcome review on SFBT (Kim et al., 2018). The approach has been tested with many different populations, including domestic violence victims, adolescents, and children in school settings (Franklin et al., 2012). The chapter of the handbook devoted to the treatment of alcoholism reports positive outcomes from the use of SFBT with this population. Nevertheless, HHS & SAMHSA (2015) report, "As yet, however, little definitive research has confirmed the effectiveness of SFBT for substance abuse" (p. 101).

Clearly, research on SFBT and substance misuse is underrepresented in the research. Although results appear promising, further research is needed to continue establishing efficacy for this approach in the field of addiction. Nevertheless, Gingerich et al. (2012) identify SFBT as a well-suited model for working with substance misusers. Drop-out rates are high in addiction treatment, and instead of conducting lengthy

assessments prior to treatment, solution-focused therapists figure out what clients need from therapy so they can continue participating in it (Gingerich et al., 2012). When individuals seek support services and gain a sense of satisfaction from those services fulfilling their needs, they are more likely to come back. Solution-focused therapists discover what clients need from therapy during the very first session and begin working toward those goals right away, allowing the therapeutic process to move at a quicker pace. Therapeutic empathy, identified previously as one of the strongest predictors of positive outcomes in addiction treatment, is embedded in the SFBT model. In general, there are inherent characteristics of the model that naturally address some of the general problems clinicians can encounter when working with substance misusers (Gingerich et al., 2012).

Gingerich and Peterson (2013) conducted a more recent but less comprehensive review of SFBT than the one conducted by Franklin et al. (2012). These researchers conducted a systematic qualitative review of SFBT studies that utilized high standards in their experimental and quasi-experimental methods. They analyzed 43 studies and discovered that 74% of them reported significantly superior outcomes for treatments employing SFBT, while 23% reported positive outcomes (Franklin et al., 2012). The strongest support for SFBT was with a population of depressed adults. No studies were conducted on SFBT being used to address substance misuse issues. Nevertheless, SFBT was established as an effective treatment model for clients in a variety of populations with different behavioral and psychological problems. Additionally, it was found to be cost effective and less time consuming than other approaches (Gingerich & Peterson, 2013).

Another recent systematic review conducted by Franklin, Zhang, Froerer, and Johnson (2017) examined outcomes related to change processes in SFBT. Similarly to Gingerich and Peterson (2013), they found that 87.9% of studies received positive statistical support. Of 33 studies, only seven were negative. Eighteen studies reported on the outcomes on SFBT processes, while only 12 utilized experimental designs to test both process and outcome. The two therapeutic processes receiving the strongest support for positive outcomes in SFBT were linguistic/style and strength/resources. In other words, a shift from problem-talk to solution-talk, and the co-construction of conversations while emphasizing strengths and resources, are the two strongest variables contributing to this model's effectiveness. Additionally, these two variables are primary characteristics unique to SFBT, which separate this model from other client-centered approaches such as MI (Franklin et al., 2017). The limitation of this review is the quality of studies, which methodologically fail to meet the "gold standard for mechanism of change research" (Franklin et al., 2017, p. 23). However, Franklin et al. note that many therapeutic process studies fail to meet these standards.

The SFBT approach has a long history of being criticized for its lack of methodological rigor, due to the absences of reliable and valid measures to capture the essence of its primary elements (Gingerich & Eisengart, 2000; Kim et al., 2018). However, Gingerich et al. (2012) note that progress is beginning to be made within this area, and SFBT studies are starting to improve in methodological rigor.

A recent study conducted by Kim et al. (2018) reflects methodological progress and support for the inclusion of SFBT in addiction treatment. The researchers tested SFBT with substance misuse and trauma clients in a randomized controlled trial and

found that severity of use, trauma, and other related problems decreased. They concluded that SFBT is an effective alternative approach for treating addiction and trauma (Kim et al.).

Two other qualitative studies, both dissertations, have been conducted to explore the use of SFBT in the treatment of substance misuse. Bryson (2014) explored exceptions in the context of photography therapy, and Rodriguez (2017) integrated SFBT with mindfulness for co-occurring disorders. Both researchers found positive results utilizing SFBT approaches in addiction treatment.

According to Halbur and Nikels (2017), SFBT is considered a culturally competent approach that has proven efficacious within a diverse range of cultures. This is particularly beneficial for the field of substance misuse treatment, because accrediting bodies have produced guidelines to effectively address cultural issues in such contexts (Jordon, 2017). Although these guidelines include matters of cultural competence, they have also created a division between culturally diverse substance misusers and the rest of the substance misuse population. Jordon (2017) suggests that the best way to address cultural barriers is to develop better, more culturally competent treatment models. Overall, SFBT shows promising outcomes for treating adolescents and children, addressing violence in families, and facilitating hope among clients (Halbur & Nikels, 2017).

Despite SFBT being under-tested in the field of addiction, research supports the efficacy of Solution-Focused Group Therapy (SFGT) for substance misusers (Heatherington et al., 2015). This approach is listed under SAMHSA's National Registry of Evidence-Based Programs and Practices and demonstrates improved outcomes for

depression and overall psychosocial functioning among substance misusers (HHS & SAMHSA, 2018b).

Solution-focused group therapy. The most common way for rehabs to provide treatment is in the context of group therapy, and there are many advantages to group therapy in general (Berg & Reuss, 1998; McCollum et al., 2004). Clients in group therapy come together, establish connections, and feel understood by other individuals going through similar problems; all of these factors can serve to cultivate change. Clients receive a strong sense of social support for changes they desire to achieve in their lives. They can learn from others and themselves through the sharing of common experiences (Berg & Reuss 1998; Lietz, 2007). The group format is cost effective, allowing one clinician to treat multiple clients simultaneously. Additionally, the group format fits within the acclimatized practices of an addiction treatment center, increasing the likelihood that these practices will be used (McCollum et al., 2004).

There are specific advantages to SFGT. First, the ability to utilize others' exceptions and solutions creates flexibility, allowing SFBT ideas to easily be applied in a group setting (McCollum et al., 2004). Topics are not constrained to substance-related issues, so group participants can freely share without having to fit the dominant constructs of the group. Topics are organized to address what is most helpful and resourceful for clients. Solution-building becomes powerful, because solutions are not only created by one individual, but by multiple group members (McCollum et al., 2004). Many solutions are formulated in the group, as clients offer solutions that others had not previously considered. Group members view one another's suggestions as different from those offered by treatment professionals, whom they consider to be more like outsiders.

Berg and Reuss (1998) suggest that the solution-building process allows clients to achieve a sense of control within their lives and thus improves their self-esteem. A qualitative analysis found an increased sense of control among group members who attended at least one session of SFGT (Quick & Gizzo, 2007). Instead of being passive recipients of problems, clients in SFBT feel a sense of direction, hope, and agency when relating to their problems. In SFGT, group leaders co-construct dialogue oriented toward change. The group serves as a source of accountability, because clients discuss proposed changes in front of their peers, making them aware of their intentions (McCollum et al., 2004).

Group members who are indecisive or disinterested in change are not confronted in SFGT. They are treated in the same manner as other groups members and are encouraged to participate if they would like to. Respect is given equally to all group members. Neither goal-setting from the therapist nor simple advice from clients is permitted in the group process, as both imply that clients lack the skills necessary for their own well-being. Clients set their own goals and the means for attaining them. Problematic dialogues are discussed, but in the context of change (McCollum et al., 2004).

The SFGT therapist works the same way the SFBT therapist does, by posing solution-focused questions to individual group members and processing responses in the context of the group (Berg & Reuss, 1998). The group begins with an introductory topic oriented in solution-talk. For example, "How many times have you been tempted to use but been able to abstain?" Solution-oriented conversations have ripple effects within the group. Once one participant begins to elicit solutions, other group members tend to

explore their own solutions as well. Utilizing the group as a collaboration towards solutions reorients the group to the process of change (McCollum et al., 2004).

Nevertheless, a limitation of this approach is the fact that clients who are unmotivated or not yet ready to change can undermine other clients' progress (McCollum et al., 2004).

Miracle questions are posed in SFGT to elicit hope for the future. Scaling questions provide the therapist with ideas about how close groups members are toward reaching their goals. Scaling questions are relationally extended by posing questions about ratings other people close in their life would give them. Group facilitators emphasize exceptions in a detailed manner (McCollum et al., 2004). Individual goals and solutions are connected to the larger group to ensure a supportive atmosphere. Group facilitators take a break during each session to formulate compliments for each group member. Additionally, they create an overall group theme that includes the problems and solutions expressed by individual group members. Then, clients create their own goals based on the theme of the session. They write down small steps they are willing to take between group sessions to achieve their goal and read them aloud to the group. The group session concludes, and the next group meeting begins with a follow-up of clients' successes toward their goals throughout the week (McCollum et al., 2004).

Quick and Gizzo (2007) conducted a mixed method analysis of SFGT and found that small goals and behaviors, socialization, communication, hope, and non-problem talk are the elements of change in this approach. Results were positive for clients attending SFGT, but since the clients received multiple services, it was difficult to determine what specific approaches contributed to the changes identified (Quick & Gizzo, 2007). Outcomes about change processes in SFGT share some commonalties with Moo's (2008)

necessary components of substance misuse support groups. Moo (2008) suggests that aspects that promote bonding among group members, like socialization and communication; goal direction, such as using solution-talk instead of problem-talk; and the increasing of self-efficacy serve as the overall foundation of SFGT, because the model is built upon increasing resources and hope (Timko et al., 2012).

Outside of addiction treatment, SFGT has been conducted with couples on the subject of improving parenting skills, demonstrating promising results (Li, Armstrong, Chaim, Kelly, & Shenfeld, 2007; Zimmerman, Jacobsen, MacIntyre, & Watson, 1996; Zimmerman, Prest & Wetzel, 1997). Proudlock and Wellman (2011) reported a significant increase in functioning among adults with severe mental health issues. Another study found increased self-esteem among group members attending SFGT (Springer, Lynch, & Rubin, 2000).

Sabri (2017) conducted a dissertation study that found considerable support for the use of SFGT for treating substance misusers in the context of an inpatient addiction treatment facility. Smock et al. (2008) conducted a study on SFGT for substance misusers that utilized comparison groups. Group members receiving SFGT improved significantly as compared to those in the traditional group treatment. This was the first study to compare SFGT to traditional treatment methods. The researchers recommended SFGT as a useful approach for the treatment of substance misusers (Smock et al. (2008).

Multiple family groups. In Multiple Family Groups (MFG), several families experiencing similar problems are treated in the context of one large group (Gelin, Cook-Darzens, & Hendrick, 2017; Schaefer, 2008). Since research suggests that interactions occurring among multiple families promote change as effectively as interventions

performed by a group facilitator, the fundamental task in MFG is to encourage dialogue among the members of multiple families (Garrido-Fernández et al., 2016; Gelin et al., 2017). Observing dialogue and interactions between and within families helps group facilitators make sense of individual behaviors within the larger social context (Thorngren & Kleist, 2002). The group process is complex, consisting of interactions between therapists and clients within individual families, between multiple families, and within the group process (Cassano, 1989).

Therapists' involvement with the group in MFG shifts as group bonding takes place. During the beginning phases of the group processes, group facilitators build rapport and facilitate interactions within individual families. As group members become more comfortable with each other, facilitators begin encouraging conversations between families. Saayman, Saayman, and Wiens (2006) explain that by the end of the group process, the facilitator's role consists of "merely regulating the social bonds that have developed during the course of the group" (p. 407). Supportive interactions among family members create the context for therapeutic change to occur, as group participants act as co-therapists (Saayman et al., 2006). Essentially, as social bonds increase, families act as the main catalysts of change for each other. Ideas presented by family members who relate closely to other group family members can be highly effective, as their common experiences develop a deeper connection than that of the group facilitator (Thorngren & Kleist, 2002).

Another phenomenon unique to MFG is the *transparental phenomenon*, which takes place when parents involved in dysfunctional transactions with their own children can be competent, understanding, and supportive of other group members' relationships

with their own children (Garrido-Fernández, 2016). The supportive interaction between a parent and another group member's child promotes positive responses from the child, allowing parents to recognize a different way of being in relationship with their own children. The child who is receiving support is also benefited by this interaction. Therefore, changes occur on two levels and impacts both families (Gelin et al., 2017).

Nevertheless, families may not always experience other families in such a positive manner; this can serve to inhibit the change process (Schaefer, 2008). Ideally, the sharing of multiple perspectives about the phenomenon of addiction can broaden families' perceptions and create new possibilities for being in relationship with the substance misuser. However, each family enters the group with its own dominant social constructs about addiction, which could also clash with other families' constructs. One family's anger can provoke negativity in another family and create an unsupportive therapeutic environment. Just as the complexity of the group can facilitate change, complex dynamics can also discourage change. Therefore, Behr (1996) advises that interventions in MFG "must provide powerful counteraction to the negative dynamics which can so easily emerge" (p. 9).

The MFG approach is referred to in the literature using a variety of titles, including *Family Group Therapy*, *Multiple Family Therapy*, *Family Group Counseling*, *Multiple Family Session*, *Family Meetings*, and *Partner Groups* (Schaefer, 2008). A variety of benefits are associated with MFG, including the reduction of stigma regarding the associated problem, better engagement, increased participation, enhanced communication skills, a broadening of perceptions, and the ability to learn from other families (Behr, 1996; Belle, 2015; McFarlane, Link, Dushay, Marchal, & Crilly, 1995;

Schaefer, 2008). In general, MFG combines family and group therapy concepts (Gelin et al., 2017; Thorngren & Kleist, 2002); more specifically, it incorporates psychodynamic, attachment theory, cognitive-behavioral, psychoeducation, and experiential methods (Garrido-Fernández et al., 2016; Saayman et al., 2006; Thorngren, Christensen, & Kleist, 1998).

The MFG approach does not adhere to a singular therapeutic model, which has been cited as a limitation making the approach difficult to study quantitatively.

Comparing MFG with other treatments or generalizing results to larger populations is difficult without knowing the measurable, defining features of this therapeutic modality (Gelin et al., 2017). Nevertheless, MFG has been under investigation in the research for the past 48 years (Schaefer, 2008; Thorngren & Kleist, 2002).

Current research on multiple family groups. Peter Laqueur and his colleagues originally founded MFG as a means of working with schizophrenic clients and their families. He invited family members to take part in groups within their substance misusing family members' residential treatment programs. The initial goal of MFG was to increase communication within and outside families. Eventually, the power of vicarious learning between families became evident (Schaefer, 2008; Thorngren & Kleist, 2002). For example, a mother could learn about motherhood by observing the interactions of other mothers in the group, without having to be told to do anything differently by an outside professional (Behr, 1996).

Studies on MFG were predominantly conducted in the 1970s (Schaefer, 2008); from the 1980s to mid-1990s, the popularity of MFG studies diminished (Garrido-Fernández et al., 2016). Despite the decrease in studies in the literature, addiction

treatment centers began utilizing this type of modality in the 1980s to involve family members in substance misusers' treatment (Stanton & Todd, 1982). Over the last 20 years, research on MFG has renewed, particularly as applied to populations with severe mental health problems (Gelin et al., 2017). Currently, the strongest evidence found for the efficacy of MFG is for individuals with chronic psychosis and their families.

William McFarlane created a psychoeducational MFG model for schizophrenic clients that included education, problem-solving, communication, and social skills (Gelin et al., 2017). McFarlane's psychoeducational MFG has been found to reduce schizophrenic relapses by 50 to 60%, as compared to individual therapy and medicine alone. Outcome studies indicate that MFG is "superior to single family approaches for first episode psychosis patients compared to individual family therapy" (Gelin et al., 2017, p. 7). Additionally, the APA classifies McFarlane's psychoeducational MFG as the most effective treatment for severe mental health problems (Gelin et al., 2017).

The use of MFG for the treatment of mood, eating, and substance misuse disorders is currently being investigated (Heatherington et al., 2015). Thus far, all studies report positive outcomes for the implementation of MFG in residential or outpatient addiction treatment centers (Belle 2015; Boylin et al., 1997; Garrido-Fernández et al., 2016; Henggeler et al., 1991; Schaefer, 2008; Springer & Orsbon, 2002). Conner et al. (1998) found higher rates of treatment completion when MFG was incorporated into substance misusers' treatment process. Belle (2015) found that substance misusers participating in MFG were 80% less likely to start misusing substances again, compared to individuals in treatment without family involvement. Less than 10% of substance misusers whose families were not involved in treatment remained sober. Schaefer (2008)

found positive shifts in family relationships as a result of MFG, including the ability to change problematic family behaviors, enhanced communication skills, and increased feelings of closeness among family members. In spite of these favorable results, Garrido-Fernández et al. (2016) and Gelin et al. (2017) assert there is a need to continue developing this modality and its application with the field of substance misuse, because there is an absence of controlled clinical trials indicating its effectiveness.

The need for established research appears even greater when considering that psychoeducational models of MFG are more popular than other family therapy treatments in the context of addiction treatment (HHS & SAMHSA, 2015). Most addiction treatment facilities utilize MFG as the only way to include families in substance misusers' treatment, since they are often faced with constraints on time and resources (HHS & SAMHSA, 2015). The content and structure of MFG conducted in residential or outpatient rehabs vary considerably. Some MFG groups are held one evening per week for two hours (Boylan et al., 1997); in others, therapists meet with substance misusers and their families three times per week and facilitate three-hour psychoeducation MFG with families while the substance misusers receive individual therapy once a week (Conner et al., 1998).

Four out of seven studies exploring the use of MFG with substance misusers and their families were based on the disease model of addiction, using psychoeducation as the main intervention (Boylan et al., 1997; Conner et al., 1998; Drake, 2017; Schaefer, 2008.) Therapeutic activities in these groups are structured around disease-based concepts. Schaefer (2008), for example, presented an integrative MFG approach that combines CBT, MI, Structural, Feminist, and narrative therapies with psychoeducation oriented

toward the disease model of addiction. Advocating Twelve-Step philosophy while utilizing therapeutic interventions that promote the dominant constructs of society can be problematic. For example, a facilitator working in the narrative therapy tradition who suggests that group members introduce themselves as *addicts* can limit group members to only behave within the constraints of that label. A fundamental goal in narrative therapy is to promote alternative narratives that are less social constraining, while the goal of the Twelve-Step philosophy is to enforce those labels; this creates a conflict for facilitators attempting to combine the two approaches.

It is not problematic to integrate different models of therapy in MFG; however, integrated versions of MFG should be consistent in their theoretical assumptions about the phenomenon of addiction. While any type of family involvement is a step in the right direction for addiction treatment, interventions conducted in MFG continue to be dominantly based on individualistic notions of addiction. According to HHS and SAMHSA (2015), the most popular family intervention in addiction treatment is based on the disease model of addiction; it sees addiction as a family disease requiring family members to be treated separately. Furthermore, HHS & SAMHSA (2015) classify MFG as a treatment approach operating within the disease model of addiction. It seems contradictory to treat families and substance misusers in groups together while classifying these groups under theoretical assumptions that believe in separate treatments for substance misusers and their families.

Drake (2017) developed an MFG model for substance misusers and their families that combines Multisystemic Therapy, systems theory, and person-centered approaches. The author asserts that interventions and activities in her integrative MFG model

specifically reflect the whole being greater than the sum of its part, as posited in systems theory, and that individuals have the internal resources to overcome their difficulties, as suggested in person-centered therapy. In her book about the MFG model she developed, Drake provides a copy of the assessments, worksheets, and Power Points utilized during the duration of the MFG. Topics covered include the following:

Addiction, Mental Health, and Co-occurring Disorder, Impact of Addiction on the Family Member, Stages of Change, Family Problem-Solving, Giving and Receiving Feedback, Assertive Communication, Coping Skills, Codependency, Support Recovery & Not Addiction, Effectively Coping with Loved-Ones' Addictive Behaviors, Getting Help for Your Codependency, Practicing Good Stress Management, Reducing Stress through Relaxation, Productive Ways to Deal with Anger, and Preventing Relapse as a Family. (Drake, 2017, pp. 54-55)

Prior to participating in the groups, families are expected to write a letter about their feelings and behaviors surrounding their substance misusing loved one's addiction and present it to him or her. Drake (2017) provides examples of behaviors to write about in the letter, which is embedded in notions of enabling—for example, “picked up his/her mess . . . was unable to concentrate . . . told lies to cover up problems” (p. 50), and so on. The structure is either carried out in a two-day intensive or 16-week session format. The topics, content, and interventions remain the same regardless of the structure. In the 16-week format, the first six weeks are dedicated to skill-oriented trainings and psychoeducation about the disease of addiction. Therapists teach family members skills utilizing worksheets provided in the book. During the two-day intensive format, the same dynamic occurs. Family members attend groups without the substance misusers for the

first half of the day. In week seven, substance misusers are invited into the MFG and taught communication skills and ways to build and sustain healthy relationships.

Therapists using this approach suggest that family members seek their own treatment for codependency and focus on themselves. Weeks 13 through 16 teach stress management, relaxation, anger management, and relapse prevention.

The theoretical underpinnings of this model of MFG are inconsistent. Upon close examination, this modality is more closely associated with CBT and family disease models than with systems theory, as it is oriented toward teaching skills and is grounded in a belief in separate treatment for codependency issues. A model genuinely embedded in the notions of systems theory would avoid separating families and substance misusers, because behaviors only make sense within larger family systems. Family therapists operating from systems theory would not limit their therapeutic practices by separating family members and only obtaining partial descriptions of the problem. Furthermore, they would not promote ideas about individuals focusing on themselves. Since systems and parts within systems are interconnected, there is essentially no self, only relationships.

Drake (2017)'s MFG model claims to borrow from person-centered theories about families having the resources within them to address problems. However, if this were truly the case, the interventions embedded in this modality would not involve the facilitator acting as the expert, telling families what they need to do to be healthy, deal with anger, and communicate in an effective manner. Instead, the facilitator would elicit family members' own descriptions of healthy behaviors and explore the internal resources that would allow them to begin behaving within their own constructs of health.

Although this modality of MFG claims to have theoretical underpinnings from a systemic, resource-based orientation, it appears to be more similar to what Al-Anon meetings offer in local communities.

Springer and Orsbon (2002) developed a model of MFG for adolescent substance misusers and their families that integrated Structural Family Therapy, Mutual aid/Interactional theories, and SFBT. Their article about the model was only descriptive in nature; they did not conduct a research study. Mutual aid/Interactional theories posit that families act as agents of change for each other; accordingly, group experiences can give families an opportunity to learn about others' perceptions of their problem, practice healthy interactions, and receive suggestions from others with similar life difficulties. Springer and Orsbon's MFG approach also borrowed techniques, rather than theoretical assumptions, from SFBT, including scaling and miracle questions. These techniques serve to assist families in establishing goals. Essentially, theories about family pathology and other interventions were borrowed from Structural Family Therapy, while two non-pathologizing techniques were borrowed from SFBT.

The same limitation, integrating therapeutic models with conflicting philosophies, applies to Springer and Orsbon's (2002) model as to Schafer's (2008) model of MFG. Structural Family Therapy is grounded in notions of pathology, while SFBT avoids such notions. Although this integrative model of MFG is systemically oriented, it also contains clashing theoretical assumptions. Thus far, all studies of MFG for substance misusers in addiction treatment facilities have been oriented in pathology-based notions of addiction. Springer and Orsbon (2002) integrated a small component of solution-focused scaling and miracle questions. However, strength-based concepts were integrated with

pathology-based concepts, which risks negating the benefits. There is only one study in the literature exemplifying an MFG modality with substance misusers and their families oriented in purely postmodern, non-pathology-based notions of addiction.

Anton et al. (1981) conducted a study on an MFG model based on the Structural Family Therapy approach. The study was conducted with opiate misusers who were prescribed Naltrexone, a medication used to prevent relapse. The goal of the MFG model in Anton et al.'s study was to provide psychoeducation, disrupt patterns of enmeshment, establish boundaries between sub-systems, and promote stable family relationships. The researchers found that substance users involved in the MFG program remained in treatment and compliant with Naltrexone longer than those who did not participate.

Garrido-Fernández et al. (2016) conducted an empirical study with opiate misusers receiving methadone. They integrated systemic concepts and used reflecting teams within the MFG model they utilized. A reflecting team is a technique derived from family therapy in which a team of therapists observes the therapeutic session or, in this case, the group process. They then have a discussion in the presence of the clients about their personal observations from the therapeutic session or group process (Garrido-Fernández et al., 2016). Reflecting teams allow for alternative realities to emerge. Clients are presented with an array of alternative viewpoints and can choose the ones that most closely match their own constructs. Reflecting teams offer a process of collaboration between clients and therapists, deemphasizing theory and promoting new realities (Garrido-Fernández et al., 2016).

The outcomes of Garrido-Fernandez et al.'s (2016) study were promising, demonstrating client improvements in the areas of employment, social support, and

mental health symptoms. Additionally, clients' methadone doses decreased. However, the participants involved in MFG and those receiving standard treatment both increased their alcohol intake. Garrido-Fernández et al. (2016) note that this is a common phenomenon in harm reduction methods, as substance misusers often increase one substance while cutting back on another; this requires further investigation. Although this modality of MFG was grounded in postmodernist assumptions, it did not include any elements of SFBT.

Thus far, the literature does not include any information about a purely SFBT-based MFG model grounded in the theoretical assumptions of postmodernism. Furthermore, there is a gap in existing knowledge about how to work interpersonally in an individually-oriented treatment facility, considering most family interventions in rehabs do not reflect those interventions utilized by the general population of marriage and family therapists (HHS & SAMHSA, 2015). This is evidenced by studies of MFG that claim that the model is built upon interpersonal epistemologies, but is actually reflective of individualistic assumptions about addiction.

I conducted this study in an effort to fill the gap in the existing research by conducting a post-hoc analysis of a completed clinical project that involved the implementation of an intensive SFBT-MFG weekend within an individually-focused inpatient addiction treatment center. Using a modified version of traditional action research methodology, I explored the organizational and personal challenges, processes, and effects related to the project. This was the first study in the United States to produce qualitative results about the processes and outcomes of a purely postmodern MFG for adult substance misusers and their families.

CHAPTER III: METHODOLOGY

Research is defined as a process of investigation that increases understandings about problematic phenomena (Stringer, 2014). It is conducted in a variety of ways, including concentrating on a specific problem, formulating theories, or systematically investigating inquires (Stringer, 2014). Action research is a research method designed to systematically investigate problems. Contexts appropriate for action research include education, community, businesses, and medical and mental health settings (Stringer, 2014). This approach is commonly utilized in the context of program development with a concentration on change; it aims to enhance the efficacy and proficiency of service delivery within local communities, while simultaneously promoting the well-being of everyone involved (Stringer, 2014).

This study does not qualify as a standard action research project; however, I did borrow certain elements of the action research approach. I conducted a post-hoc analysis of a clinical project that I completed during my time working as a clinician at an inpatient addiction treatment facility. The project involved my providing therapeutic services to adult substance misusers and their families. I utilized SFBT as my primary clinical approach and MFG in the context of an intensive family weekend, and I administered evaluation surveys throughout the duration of the clinician project. During my involvement in the clinical project, I operated as a clinician. For the purposes of this study, I transitioned into the role of researcher.

My work as a clinician was deeply informed by the procedures and philosophies of action research, so I selected these methods to analyze and evaluate the information I

produced through my clinical project. This information served as archival research data for the post-hoc analysis.

The major focus of this study was the development of an SFBT-MFG approach for adult substance misusers and their families. The clients' and families' feedback was critical in creating and refining my approach. If not for the clients' and families' open, honest opinions about the therapeutic weekends I facilitated, I would have been at a serious disadvantage. In addition to my process of development, the other major focus of this study was the organizational and personal challenges I experienced as a systemic clinician operating in an individually-oriented system.

Throughout the remainder of this chapter, I will further describe the action research approach, as its methods are similar to the processes I utilized to create and implement my clinical approach in the completed clinical project. After describing traditional action research in the upcoming sections, I will outline the specifics of my study and the ways in which the project aligned with and departed from the traditional action research methodology.

Traditional Action Research: Philosophical Rationale

The action research method was created by Kurt Lewin and is grounded in a qualitative framework; its focus is more oriented toward research processes than research outcomes (Chenail, George, Wulff, & Cooper, 2012; Stringer, 1996). For example, quantitative methods produce research reports that allow readers to know if what is being tested is effective or ineffective, while qualitative reports allow readers to know about the processes that make those outcomes effective or ineffective. Action research is derived from three approaches of qualitative inquiry: phenomenological, interpretive, and

hermeneutic research (Stringer, 2014). The notion of honoring research participants' unique realities is borrowed from phenomenology; the utilization of research participants' interpretations to modify cycles in the research process so they reflect interpretive elements and meanings associated with the problem under investigation comes from hermeneutic research (Stringer, 2014).

Action research is a qualitative method grounded in a postmodern paradigm. Consistent with qualitative assumptions, it accounts for multiple realities in research studies and values the worldviews of the research subjects over those of the researcher (Creswell, 2013; Stringer, 2014). Action researchers assume "truths" produced in traditional scientific research result from the worldviews of scientists and/or professionals who dominant larger institutions in society (Stringer, 2014):

Programs and services often fail to provide for the real needs of the people, especially with marginalized or disempowered social groups. In some cases the failure to recognize the deep-seated disconnection of the service from the social reality of the people aggravates the problems the service was meant to remediate. (p. 44)

Action researchers assume that attempts to implement change in a social context will be met with resistance if the needs of the people under study are not considered. The approach advocates the need to change the standard scientific procedures that dominate the social sciences. Consistent with postmodern theories, human reality constructs are seen as likely to fluctuate depending on the research context. Stringer (2014) notes, "Investigation of the social and behavioral worlds cannot be operationalized in scientific terms because the phenomena to be tested lack the stability required by [the] traditional

scientific method” (p. 43). Thus, action research offers contextually appropriate ways of conducting research within the unique contexts in which problems are embedded (Stringer, 2014). Since the approach rejects hierarchical notions that place the researcher in the expert role, action researchers establish collaborative relationships with their subjects.

Position of the Researcher

Action research abandons the term *research subjects* and instead uses the term *participants*, which reflects the shift in power between them and the researcher (Stringer, 2014). The researcher is considered a *consultant* or *co-participant* in relation to the participants in the study (Stringer, 2014).

The first steps of standard scientific research involves the researcher defining a problem and formulating a hypothesis. In action research, the participants define the problem based upon the context of the organization in which the research takes place. Thus, the attainment of knowledge is a collaborative process between the researcher and the participants (Stringer, 2014). In action research, participants can also be identified as *stakeholders* (Stringer, 2014), a term used to refer to anybody in relationship to the problem and, therefore, recruited into the research process (Stringer, 2014). The researcher “acts as a catalyst to assist stakeholders to define their problems clearly and to monitor and support their activity as they work toward effective resolution of the issues that provide the focus of their investigation” (Stringer, 2014, p. 20).

Since action research recruits all people affected by the research problem to be co-researchers, the primary researcher maintains a positive working relationship with each group of stakeholders, to avoid problems that could hinder the research process.

Action researchers present themselves as neutral and “nonthreatening” (Stringer, 2014, p. 81), with the ability to embrace and negotiate the multiple viewpoints shared by various populations of people. When working with diverse groups of people, disputes are inevitable. During these times, the researcher mediates stakeholders’ varying concerns, aiming for a resolution with which all parties are satisfied.

The researcher strives to create personal relationships with all stakeholders involved in the research process. Stringer (2014) suggests that action researchers should facilitate informal meetings at cafes, restaurants, community events, and other public places, as “the more freely researchers are able to participate in the ordinary lives of the people with whom they work, the more likely they are to gain the acceptance crucial to the success of action research” (p. 84). Facilitating an action research project requires the researcher to elicit a sense of empowerment among stakeholders by broadening their own understandings of the research phenomenon while encouraging them to actively implement viable solutions for the problems under investigation (Stringer, 2014).

Description

To facilitate the process of change and solution-building among stakeholders, action researchers explore stakeholders’ concerns and perspectives related to the focus of the research (Stringer, 2014). Furthermore, action researchers incorporate stakeholders in continuous, systematic cycles of investigation about the problem. The basic cycle utilized in action research is the *Look, Think, Act Routine* (Stringer, 2014). Defining the problem and gathering data occurs during the Look cycle. The researcher analyzes and presents the analysis back to stakeholders for feedback during the Think cycle. The last cycle, Act, consists of implementing a solution-oriented plan of action (Stringer, 2014). After the

plan is implemented, another cycle begins, building on the changes made in the previous cycle. Cycling in action research is a disorderly process, because researchers and stakeholders construct, reconstruct, and work through reiterative cycles in a non-chronological order (Stringer, 2014).

Although processes in action research do not solve all the problems within an organization, resolved problems are effective because they are formulated from voices of the people directly experiencing the problem (Stringer, 2014). Action research acknowledges that generalized solutions produced by experts utilizing standard scientific procedures are often unsustainable, because they fail to consider individuals' complexity and uniqueness. Rather than producing a one-size-fits-all resolution, the goal of action research is to elicit explanations of problems under investigation, grounded in stakeholders' conjointly agreed upon solutions. The main task is to ensure that the stakeholders' perceptions are the main focus of the research project, while the objective is to "make a difference, in a specific way, for practitioners or their clients" (Stringer, 2014, p. 10). Making a difference, or effecting change, begins during the first stages of action research (Chenail et al., 2012); this differs from traditional scientific research, in which change is often produced at the end of the study.

Hypotheses and theory are defined differently in action research. For example, the process of testing a hypothesis involves stimulating some kind of change in relation to the identified research problem (Stringer, 2014). Theory, in action research, does not propose explanations for why things occur as they do; rather, it is "a theory of method" (Stringer, 2014, p. 39) that describes how stakeholders can be included in the research process to produce advantageous outcomes. Theories derived by experts conducting orthodox

scientific studies are not discounted in action research; however, they are endorsed only after stakeholders' theories have been considered and examined thoroughly (Stringer, 2014).

Stringer (2014) notes that there is no definitive point marking the end of an action research project, due to the nature of the cycling process. Since new information and suggested changes are constantly emerging from the varied perspectives of stakeholder groups involved in the Look, Think, and Act cycles, it becomes difficult to determine an ending. In spite of this, Stringer (2014) notes that "there is usually a time when it is possible to stand back, metaphorically speaking, and recognize significant accomplishments. The time for celebrating has arrived" (p. 207). The next section provides an overview of the cycling process in action research.

Look (Data Gathering)

The first step in the Look cycle is to develop a plan for the research project. Action researchers achieve this by acquiring contextual information about the setting in which the research project will take place, including past experiences related to the phenomenon under investigation. Stringer (2014) states, "Past events sometimes leave legacies of deep hurts and antagonisms that severely limit prospects for successful projects unless they are handled judiciously" (p. 85). Other important contextual data collected in the research process includes information about relationships among co-workers, clients, bosses, and other stakeholder groups. Additionally, the researcher may be curious about a company's principles and values and, accordingly, conduct a systemic investigation in order to develop a deep understanding of the context in which the research will take place.

The next task in the research process is to decide which stakeholders to include in the study. In traditional research, this is commonly accomplished through random sampling. However, action research utilizes “purposeful sampling, which consciously selects people on the basis of a particular set of attributes” (Stringer, 2014, p. 77). A social analysis, or social map, can be utilized to assist researchers in deciding which groups of people affected by the problem should be included. Though it is unlikely that every single person with a relationship to the problem will participate in the research process, a social map can assist in this decision-making process (Stringer, 2014).

Prior to enrolling participants in the study, action researchers must ensure that their recruitment methods are ethically sound. For example, they must provide stakeholders with an Informed Consent document explaining the purpose and processes of the study in a clear and consistent manner. After taking the appropriate ethical steps to ensure the safety of the participants in the study, the researcher elicits stakeholders’ unique perceptions about the research problem. The researcher’s goal is to help stakeholders “define the problem or issue in terms that ‘make sense’ in their own terms” (Stringer, 2014, p. 101). This task occurs throughout the duration of the research project, as the researcher consistently engages stakeholders in constructing and reconstructing the research problem. This process is similar to the formulation of a hypothesis in traditional scientific research (Stringer, 2014).

As mentioned previously, hypothesis testing is different in action research; it entails stimulating some kind of change in relation to the research project moving forward. Researchers and stakeholders are constantly formulating hypotheses about the essence of the research problem. Rather than determining a single hypothesis, multiple

fluctuating hypotheses are identified throughout all the cycles of investigation. Hypotheses in action research do not provide answers, but rather elicit multiple understandings of the question under study (Stringer, 2014). The testing of these hypotheses occurs during later cycles in the research process, when change starts to emerge.

Defining the problem is an important step in action research and is considered a vital part of the inquiry. Stringer (2014) emphasizes the significance of this part of the research process: “. . . often problems are designated by people in positions of authority and defined in terms that either valorize their own perspective or demonize those central to the problem” (Stringer, 2014, p. 99). The researcher’s role during the initial phases of action research is to maintain a stance of curiosity about the worldviews of the people affected by the issue firsthand, rather than attempt to obtain factual data (Stringer, 2014).

There are several ways researchers can acquire general data about the nature of the problem and, more specifically, stakeholders’ perceptions about it. In action research, sources of data include interviews, tape recordings, focus groups or group interviews, field notes, participant observation, client records, reports, photographs, videos, surveys and information from the research literature (Stringer, 2014). Field notes are written personal observations from the researcher about any experiences, events, or phenomena related to the problem under investigation (Stringer, 2014). Topics included in field notes include researcher observations regarding “places, people, objects, acts, activities, events, purposes, times and emotional orientations” (Stringer, 2014, p. 114). The first cycle of the Look phase focuses solely on the problem under investigation by attempting to understand stakeholders’ multiple realities relevant to the research issues. During the first

cycle, interviews with primary stakeholders are the focal point of the data collection and analysis procedures. It is only after the first cycle is implemented that the researcher can begin to integrate other data sources to broaden stakeholders' viewpoints.

Within the Look cycle, researchers gather data about the functioning of the organization and formulate definitions of the research problem utilizing stakeholders' constructs. This is similar to a traditional scientist's process of formulating a definition of the research problem in the beginning phases of the research project; however, the Look cycle in action research is repeated, even after the problem has already been defined. The Look phase, which involves defining the problem and collecting relevant data, is repeated in action research, because the description of the problem is considered ongoing and indefinite. The abundance of stakeholders involved in defining the problem produces multiple problem descriptions throughout all cycles of the research process. After the initial problem definition is formulated, new problems within the overall problem will soon emerge (Stringer, 2014). It is the nature of the world we live in that we cannot escape problems. Therefore, the primary task in the Look cycle becomes the continual focus on collaboratively formulating and collecting data about the initial problem and identifying new problems as they emerge during each implementation of the Look, Think, and Act cycles (Stringer, 2014). After the researcher acquires a thorough description of the organization's context, recruits and interviews primary stakeholders about the problem definition, and collects and records data, it is time to move on to the next cycle of action research: Think (Stringer, 2014).

Think (Data Analysis)

The first step in the data analysis process, known in action research as the Think phase, is to gather data accumulated in the Look cycle and choose a method to analyze the information. Prior to beginning the data analysis process, action researchers are encouraged to re-read the data, focusing solely on stakeholder meanings and perceptions without being distracted by information from other data sources. To do this, researchers separate data according to stakeholder groups. For example, client data are analyzed separately from employee data. The remainder of the Think cycle consists of integrating secondary data sources into the analysis. Stringer (2014) explains, “In a health program, patient and health professional perspectives might be complemented by evidence-based information from the professional literature” (p. 147).

In action research, there are two ways to analyze data: *categorizing/coding* and *analyzing critical incidents* (Stringer, 2014). The first step in categorizing and coding is known as *unitizing the data* by identifying “the discrete ideas, concepts, events, and experiences incorporated into their description to isolate the elements of which their experience is composed” (Stringer, 2014, p. 141). The next step is separating the data into categories and developing category names in a process known as coding. After grouping categories together, the researcher then develops themes and organizes categories and their themes into a *category system*, which is “some rational form providing a clear picture of the categories and subcategories of information related to the topic of investigation” (Stringer, 2014, p. 143).

The second method of examining data, analyzing critical incidents, directs the analysis toward significant, meaningful occurrences that have made a lasting impression on stakeholder groups:

Such events may appear as moments of crisis, triumph, anger, confrontation, love, warmth, or despair that have a lasting impact on people. They may result in a “lightbulb” or “a-ha” experience that provides people with greater clarity about puzzling events or phenomena or leaves them with deep-seated feelings of alienation, distrust, anger, or hopelessness. Key experiences or epiphany events, however, can be moments of joy and triumph, wonderful experiences that affect people’s lives in positive ways. (Stringer, 2014, p. 144)

To facilitate an analysis of critical incidents, action researchers begin by reviewing the data and identifying events or experiences that appear to have had a compelling effect on participating stakeholders. They then identify the specific elements of data that appear responsible for creating that compelling experience. The next step involves listing this information underneath the name or pseudonym of each participant. In the last step of this process, researchers “compare lists to identify experiences and features of experience common to group of participants” (Stringer, 2014, p. 145).

Unlike other aspects of the action research process, in which researchers and stakeholders work collaboratively, the coding, categorizing, and analyzing of critical incidents is handled exclusively by the researcher (Stringer, 2014). The goal is to interpret the data utilizing exact descriptions of stakeholders’ perceptions while trying to limit acts of interpretation filtered through the researcher’s own worldview. An additional measure is taken to ensure that the stakeholders’ perspectives are adequately represented.

After completing their independent analysis, action researchers then facilitate meetings with representatives of stakeholder groups to share the outcomes of their analysis in the form of a presentation, which is free of difficult scientific concepts that stakeholders might have difficulty understanding. This step in the Think phase is a collective experience in which representatives of stakeholder groups are invited into a meeting to ensure the analysis sufficiently represents their voices. Stringer (2014) notes, “The purpose for this activity is to provide the means for achieving a holistic analysis that incorporates all factors likely to have an impact on achieving an effective solution to the problem investigated” (p. 147). In the next cycle, Act, researchers utilize outcomes from their data analysis to formulate action plans addressing the problems upon which the investigation is built.

Act

There are three stages within the Act cycle: *plan*, *implement*, and *evaluate* (Stringer, 2014). After the outcome meeting with stakeholders, researchers organize additional meetings about actions to be taken to remediate the problems discovered in the data analysis; this is identified as the *planning phase* (Stringer, 2014). During planning meetings, the participants make decisions about resolving the problems that were identified in the analysis. Researchers advise their participants to engage in dialogue about actions they can take to improve their results. Outcomes of the analysis may include one problem or many, but each must be accompanied by a specific proposition for resolution (Stringer, 2014) drafted by the participants. Researchers assign roles and responsibilities to the participants for successful implementation of the action plans they

create. Stringer (2014) outlines a series of steps for participants to take during the planning phase:

1. Identify the major issue(s) on which their investigation focused
2. Review other concerns and issues that emerged from their analysis
3. Organize the issues in order of importance
4. Rate the issues according to degree of difficulty (it is often best to commence with activities that are likely to be successful)
5. Choose the issue(s) they will work on first
6. Rank the rest in order of priority for action. (pp. 168-169)

The next phase, implementing, is the period when participants implement the resolutions derived from the planning stage. The researcher's main goal is to provide the participants with support, facilitate ongoing communication and mediate any conflicts emerging between participants during the implementation of action plans (Stringer, 2014). Lastly, during the evaluation stage, researchers organize another meeting with stakeholders. The evaluation meetings provide the opportunity for stakeholders to discuss concerns, remediate any unsolved conflicts, and identify any unsettled problems. The Act cycle ends once the issues identified during the Look phase are no longer problems (Stringer, 2014).

Rigor

In action research, validity is defined as “the best available approximation of the truth of a given proposition, interference, or conclusion” (Trochim & Donnelly, 2008, p. 14). Action research is not conducted to establish a truth; it follows postmodern assumptions regarding multiple truths. Therefore, traditional ways of establishing validity

cannot be applied in action research. Rather, issues of validity in action research ensure that truths are relevant to the context in which they are studied (Skinner, Edwards, & Corbett, 2015; Stringer & Genat, 2003).

Action researchers check for trustworthiness to demonstrate that their research outcomes are not biased to reflect only their personal belief systems. When they determine the trustworthiness of a study, action researchers are essentially asserting that they “have rigorously established the veracity, truthfulness, or validity of the information and analysis that have emerged from the research process” (Stringer, 2014, p. 92). Trustworthiness is demonstrated through methods of credibility, transferability, dependability, and confirmability (Stringer, 2014).

Credibility is determined by ensuring that the processes and methods utilized during the research study are ethical and trustworthy. Several methods establish credibility, including persistent observation, triangulation, member checking, diverse case analysis, and referential adequacy. Persistent observation is defined by the act of writing observations about “what is actually happening, rather than describing it from memory or from an interpretation of what people ‘think’ happened” (Stringer, 2014, p. 93). Triangulation involves examining multiple sources of data. Meaning is confirmed or challenged by exploring multiple viewpoints on the same topic of investigation (Stringer, 2014).

Member checking is naturally included in the second step of the Think cycle. After analyzing the data, action researchers are expected to facilitate a meeting with stakeholders, to present the analysis and ensure that the outcomes of the analysis reflect their worldviews. This is the essence of member checking: providing participants the

opportunity to critique and validate the analysis. Diverse case analysis relates to issues of inclusion and is conducted to ensure that constructs derived from different stakeholder groups are included in the data analysis (Stringer, 2014). Referential adequacy refers to “concepts and ideas within the study [that] should clearly be drawn from and reflect the experiences and perspectives of participating stakeholders, rather than be interpreted according to [a] schema emerging from a theoretical or professional body of knowledge” (Stringer, 2014, p. 93).

Transferability ensures that the outcomes of the study can be generalized to other populations. Since the results of an action research study can only be considered applicable to the context in which the study was established, transferability implies a different set of assumptions (Stringer, 2014). Transferability in action research does not mean that results cannot apply to other contexts; rather, researchers interested in utilizing the study’s outcomes must make decisions about context, in order to determine whether the results are applicable. These decisions are determined by action researchers’ ability to thoroughly describe “context(s), activities, and events” (Stringer, 2014, p. 94).

Dependability is defined as the “extent to which people can trust that all measures required of a systematic research process have been followed” (Stringer, 2014, p. 94). Furthermore, dependability establishes the likelihood that other professionals will interpret similar outcomes (Skinner et al., 2015). Lastly, confirmability occurs when researchers use an audit trail of the data to verify that the procedures they described conducting genuinely took place (Skinner et al., 2015). Audit trails allow readers to view all the sources of data in a detailed, organized manner to confirm the fidelity of the data analysis outcomes (Stringer, 2014).

Dependability and confirmability can also be established by an external auditor, a professional with experience in analyzing qualitative research who is not associated with the research (Skinner et al., 2015). Essentially, establishing rigor in an action research project allows action researchers to follow a set of processes validating the trustworthiness of the study and to confirm that the results are not superficial. It is particularly important to establish trustworthiness when facilitating an action research study, because action research has been criticized for lacking methodological rigor due to its radical departure from traditional ways of establishing it (Skinner et al., 2015).

So far, I have described qualities of, and procedures and commitments involved in, typical action research projects. The following section describes methodological procedures specific to the study I implemented. It clarifies the ways in which the study both aligned with and diverged from action research methodology.

The Research Study

Philosophical Rationale

In creating and implementing my clinical project, I was guided by the philosophical assumptions of SFBT. There are many intersections between action research and the SFBT philosophy. Action researchers focus on the perceptions of their participants, and they utilize their voices in the research process to build solutions related to the topic of study; solution-focused therapists prioritize their clients' worldview and utilize their voices in the therapeutic process to build solutions for the problems they present in therapy. Like action researchers, solution-focused therapists believe in multiple realities and truths; they recognize language as a form of social construction between humans.

Whereas SFBT focuses on solutions relevant to clients, action research focuses on solutions relevant to a research problem; nevertheless, both approaches place a heavy emphasis on solution-building. This became evident to me when I conducted the post-hoc analysis of the clinical project. Just as I attended to the solutions of my clients, I also focused on the solutions within the archival research data that the research approach highlighted.

Position of the Researcher

As a researcher conducting a post-hoc analysis of a completed clinical project, my position was that of an independent social scientist analyzing archival research data. However, during the clinical project itself, I conducted myself much like an action researcher. I maintained a collaborative, neutral, non-expert position in relation to the clients and families I worked with, allowing me to create a non-judgmental context in which families could feel comfortable sharing their opinions and feedback—both negative and positive—about the weekend programs in which they participated.

Solution-focused therapists assume the same non-hierarchical stance as action researchers. Since I worked with diverse populations of families coming from different cultures and backgrounds, it was necessary to honor and collaborate on multiple perspectives emerging throughout the duration of the clinical project. If not, it would have failed, as I would have found myself in constant conflict with families' worldviews that did not match my own. Had I not maintained a neutral position, I would have been unable to handle the difference in perspectives among these diverse families.

Look Cycle

Developing a Plan for the Research Project

While I did not, as a researcher, develop a plan for the clinical program, since it was already completed, I took many collaborative measures as a clinician to develop a plan for the family weekends before beginning the clinical project. After the first meeting I had with the CEO, in which we confirmed my responsibility to implement a family program, I attended one preexisting family program within the organization. The second meeting I attended included the CEO, my clinical supervisor, and me. The rest of the meetings that took place during the planning stages of this clinical project were focused on preparing for the weekends and reviewing what took place afterward. In these meetings, I met with the CEO, program director, clinical director, and family program coordinator, as well as with my clinical supervisor, to discuss the details of the family weekends before each one took place. I was supposed to attend another family weekend in the organization prior to implementing my first family weekend; however, this never occurred due to issues pertaining to client confidentiality.

During those meetings, I obtained information about past and current attempts at implementing a family program within the organization. I wanted to be sure I had a deep understanding of the organization's treatment philosophy, values, principles, and vision for a family program. Essentially, I systematically investigated contextual factors related to the organization by collaborating with the upper-level management prior to developing this clinical approach.

Sampling

As the clinician implementing my project, I engaged closely with the facility's CEO, the clinical/program director, the family program coordinator, co-workers who were directly and indirectly involved with the project, clients, client families, and my clinical supervisor. As a researcher, I couldn't sample from recently collected data from various stakeholders, as the project was already completed; thus, I sampled archival data and subjected it to a post-hoc analysis.

As a solution-focused brief therapist following the assumptions of second-order cybernetics, I placed myself within the clients' system, actively immersing myself in their worldview while remaining conscious of my position and paying attention to the possible effects my actions could have on the system. Action researchers position themselves in a similar way, as they are also considered primary stakeholders. Herr and Anderson (2014) emphasize this point:

As action researchers, we work under the assumption that we are “in” the research, that we are both researchers and actors. There is no pretense of the neutral or objective observer, but rather, from the beginning, we lay claim to the reality that we are “settling in action” research to address a local context and concern and that we are actively involved in the problem-solving process. (pp. 88)

As a researcher, I was limited in my ability to become involved with other stakeholders, since the clinical project was no longer active when I began conducting the research. Nevertheless, during the implementation and development of the clinical project, I maintained the position of a program developer and clinician implementing the program and, therefore, of a clinical stakeholder. I was consistently involved with other

stakeholders as I defined and redefined elements of the clinical approach during each weekend I implemented.

While acting as a clinician, I enacted processes similar to purposeful sampling in action research. While I did not conduct a social analysis or map to decide who would be involved in the clinical project, I participated in supervision meetings in which I consulted with my supervisor about the selection of employees within the organization to include throughout the duration of this project.

Defining the Problem

As a clinician, I constructed the initial problem through feedback and requests from the CEO and other employees in upper management, who asked me to develop a family program. The CEO desired an effective family program for his facility. He explained that he was familiar with research showing positive outcomes for the inclusion of families in addiction treatment. However, he also told me that he could not find anything in the literature about an evidence-based family program for adults, making sure to mention that past attempts to develop such a program in the facility had been unsuccessful.

During the actual implementation of the clinical project, clients and families participating in the family weekend identified problems. As mentioned earlier, I distributed evaluation surveys upon the completion of each weekend and interpreted any negative feedback I received as a problem that needed to be changed during the next family weekend. Defining the problem through the feedback of the people most affected by it is consistent with an action research approach. Other stakeholders also contributed to the definition of the clinical problem. Throughout the duration of the project, several

colleagues working as marriage and family therapists at other inpatient rehab facilities for adults approached me, asking for guidance in implementing a family program. They informed me that their respective clinical directors had approached them with requests to develop an effective program for adult substance misusers and their families.

The research problem has already been defined; however, the processes contributing to the changes that occurred throughout the duration of the completed clinical project have not. Therefore, the purpose of this study was to explore the organizational and personal processes involved during the development and implementation of the clinical project.

Data Gathering

I identify as a solution-focused brief therapist and, consistent with SFBT, was curious about changes occurring among clients and their families prior to their participation in the therapeutic weekend. I distributed pre-treatment-change questionnaires to clients and families during the first and third sessions of the family program (See Appendices A and B). The families were provided with a brochure that included information about my treatment philosophy and approach, a description of the treatment experience, and a short description of who I am as a therapist (Appendix C). Additionally, they received an invitation to participate in the family weekend, which included the time, place, and location (Appendix D).

Clients and their families were referred by clients' individual therapists to take part in the family program. During all three weekends, I distributed post-treatment evaluation surveys to participating clients and families (Appendix E). My background as a systemic thinker influenced my decision to also distribute evaluation surveys to my co-

workers; the program director, who was also acting as the clinical director during that time; and the CEO of the organization (See Appendix F for the Staff Evaluation Survey). My goal was to achieve an in-depth, systemic understanding of the feedback I received from the family weekends (See Appendix G for the Agenda of Family Weekend 1; Appendix H for the Agenda of Family Weekend 2; Appendix I for the Agenda of Family Weekend 3).

Abiding to the theory that the whole is greater than the sum of its parts, I recognized which perspectives of multiple systems in the organization would be most helpful in forming an adequate picture of what worked and did not work in the family program weekends. I audio recorded and transcribed meetings with my clinical supervisor to achieve an in-depth understanding of the ideas we discussed during the development and implementation of the clinical project. Additionally, I journaled about my relationships with others in the company, as well as my challenges, fears, and disappointments. In this way, I provided my supervisor with an in-depth understanding of my progress in the development and implementation of the family program, so he could better advise me through it.

I journaled about all of my meetings with the CEO, so I could remember important elements to incorporate in the family program. While implementing the project, I wrote about the group activities I facilitated and the clients' and families' emotional reactions. I journaled after each cycle of the program, to ensure I would remember what worked, what did not work, and what activities clients and families reacted to, whether negatively or positively. Journaling provided me with an effective

way to ensure that I was not leaving out any important contextual information relevant to the improvements I made during the clinical project.

Action researchers undergo similar observational processes about the problem under investigation in the form of field notes for their sources of data. As a clinician, I did not write field notes; however, my journal entries elicited information about my observations. Additionally, action research includes surveys and the research literature as data sources. As a clinician, I distributed evaluation surveys and briefly examined the existing literature to see if I could find information relevant to my clinical project. The clinical information that became archival research data for the purposes of conducting this post-hoc analysis included the following:

1. Journal logs of meetings during the development and implementation of this project
2. Transcriptions of audio-recorded supervision meetings with my clinical supervisor
3. Pre-treatment change questionnaires from clients/families
4. Evaluation surveys from clients/families
5. Evaluation surveys from co-workers
6. Journal logs about each weekend and reactions to activities occurring within the weekends
7. PowerPoint presentations utilized during family weekends, specifying group activities facilitated during the first, second, and third cycle of the clinical project
8. Personal journal entries about my reactions to co-workers and clients, as well as my challenges, disappointments, and fears

In action research, data sources derived from interviews with primary stakeholders are analyzed first, followed by other data sources. As a clinician, I did not conduct interviews, but distributed surveys. In making changes to the family weekends, I followed similar chronological steps to review the clinical information I had acquired. I utilized information from my meetings with upper management to inform my development of the program. Then, during the implementation of the weekends, I utilized clients' and families' feedback on the evaluation surveys from each previous weekend to guide the changes I made for the next weekend.

Think Cycle

Methods of Data Analysis

I utilized traditional action research methods to analyze the archival research data in two separate processes, making moderate modifications. First, I utilized categorizing and coding to explore the personal, organizational, and clinical processes by analyzing my personal journal entries and supervision sessions. Next, I applied analysis of critical incidents to clinical stakeholders' pre-treatment change questionnaires and evaluation surveys to examine the viability of an SFBT-MFG approach.

I utilized the outcomes of my data analysis to assist me in writing a category-theme infused narrative that describes my experience of implementing an SFBT-MFG approach in an individualistic system of health care. The narrative, along with the results of my study, will be presented in Chapter IV. In the following paragraphs, I will first describe the steps I took to analyze the data utilizing the traditional action research methods of analysis: categorizing and coding, and analysis of critical incidents. Additionally, I will describe the modifications I made to traditional action research

analysis procedures. Then, I will describe the citation system presented in Chapter IV, which I created to reference the outcomes of my study within the narrative.

Categorizing and coding. The first step in categorizing and coding is to separate the data according to stakeholder group. Within my personal journal entries and supervision sessions, Douglas and I were the two clinical stakeholders. While Douglas was not directly involved in the clinical project, he played a significant indirect role in it. Our supervision sessions highly influenced the decisions I made during the clinical project. As a result, he was considered a clinical stakeholder.

I engaged in standard categorizing and coding procedures, following the first step of separating the data based on stakeholder group. Next, I completed the second step in the categorizing and coding procedures by reviewing my research questions and re-reading all of my personal journal entries and supervision sessions. Then, in keeping with traditional recommendations for categorizing and coding in action research, I reviewed the data for a second time, highlighting information that was relevant to my research question and crossing out any irrelevant information. Finally, I copied the relevant information into a separate Word document, so that all the relevant information was in one place for the unitization process.

To unitize the data, I followed traditional action research procedures of categorizing and coding. I identified “ideas, concepts, events, and experiences” (Stringer, 2014, p. 164) within each unit of information and isolated units of meaning by placing forward slashes between them. After isolating units of meaning, traditional action researchers sort those units into categories. I did not follow this recommendation and chose to modify this step instead. Rather than sorting units of meanings into categories, I

sorted them into four different timeframes: Prior to Weekend One, Weekend One, Weekend Two and Weekend Three. This allowed me to achieve the purpose of my data analysis and identify changes between weekends. I designated a timeframe for the period before the weekends, since I spent more time planning the project than implementing it. I organized the narrative in Chapter IV according to these timeframes.

The next step in the categorizing and coding process of traditional action research involves coding the categories as a way to further organize the information. Since I had not yet created categories at this point in the analysis, I deviated from standard procedures in this step. Instead, I coded units of meaning. Next to each unit of meaning, I assigned a code that captured its content and essence, allowing different units of meaning to have the same code. Then, in keeping with traditional categorizing and coding procedures, I placed similar groups of codes with each other, creating a system of organization.

I developed a system of organization by creating headings and listing the codes pertaining to those headings underneath. To create the headings for the clusters of codes, I identified the commonalities connecting them. For example, codes such as *no sleep* or *discouraged* were placed under the heading *personal reactions*; the *irritated client* and *unenthusiastic participant* codes were placed under the heading *participants' reactions to me*. By the end of this phase, I had four documents including a set of headings with codes listed under each heading. Since there were many codes for each heading, I lumped sets of codes together under their headings and created categories.

Consistent with standard action research protocols for categorizing and coding, I created categories by grouping codes into related groups. For example, I placed the codes

Shifting how I work, *Coming off authentic*, and *Comfortable* under the category *Positive shifts about how I am relating to myself as a therapist*, which was listed under the heading *Personal Reactions* in Weekend Two. In some cases, there were two or three of the same code underneath each category. Since there were 20 or more categories for each weekend, I further condensed the information into a manageable categorical system by creating *Featured Categories*; this step represents a divergence from traditional action research protocols.

I assigned the Featured Category designation to those categories with the most codes associated with them and with particular significance to the clinical project. For example, certain categories had only two codes listed underneath them, but if they signified a turning point in the clinical project, I designated them Featured Categories.

The last step in the categorizing and coding process of standard action research is to identify common themes across stakeholder groups. Although I followed standard action research procedures by creating themes across different sets of data, I also diverted from these methods by identifying themes across weekends rather than across stakeholder groups. Once I completed the analysis, I had a list of categories, featured categories, and themes, which elucidated the changes that occurred throughout the weekends.

Analysis of critical incidents. Following traditional action research protocols, I utilized analysis of critical incidents to explore the viability of an SFBT-MFG by analyzing the pre-treatment change and evaluation surveys. The first step I took to analyze the pre-treatment change questionnaires and evaluation surveys was to review the data as I did in the categorizing and coding process. During my review of the archival research data, I separated pre-treatment change questionnaires and evaluation surveys by

weekend, creating three groups: Weekend One, Weekend Two, and Weekend Three. Then, I labeled each piece of data according to the stakeholder group the information came from: clients, families or staff. Additionally, I assigned numbers to the physical copies of the data. Next, I made a document listing only the questions from the pre-treatment change questionnaires and evaluation surveys and typed the clients' and families' responses underneath each question. At the end of the document, I listed staff's responses, since they completed different evaluation surveys from the client and family members. Once I was done generating the electronic versions of the data, I ended up with three different Word documents listing all of the clinical stakeholders' reactions from weekends one, two and three. I placed the clinical stakeholders' reactions to the weekends in one document so that the different voices of each clinical stakeholder group remained the focus of the analysis, a fundamental aspect of conducting action research.

Next, I went through all of the clinical stakeholders' responses and identified events or experiences that were meaningful or significant. Since one question on the evaluation survey asked clinical stakeholder groups what was most significant or meaningful about the weekends, I was guided by the participants' responses rather than my own ideas about what was most meaningful for them. After highlighting the experiences participants reported as meaningful and significant, I identified the main features and elements making up the experience and typed these in red next to the participants' experiences.

The last step in the analysis of critical incidents involves looking across all of the experiences, features, and elements common to groups of participants and deriving themes. I followed traditional action research analysis procedures and derived themes

common to groups of participants across all three weekends. This resulted in outcomes that highlighted elements of the weekends that participants across all weekends and stakeholder groups found meaningful and significant. In this step of the process, I ultimately discovered the answer to my research question about the survivability of an SFBT-MFG approach in an individualistic paradigm of mental health.

Citation system for categorizing and coding. As mentioned previously, the findings of this study are represented by citations within the narrative presented in Chapter IV. I developed this system of citations to allow the results of the study to be easily identifiable within the narrative. I wrote about a total of 11 supervision meetings and logged 34 personal journals entries throughout the clinical project, which I analyzed using action research's categorizing and coding procedures.

Douglas and I held our first supervision meeting on October 11, 2016, and the last one on February 22, 2018. Our first seven meetings took place in the timeframe designated *Prior to Weekend One*; the eighth took place in timeframe *Weekend One*; the ninth and 10th took place in timeframe *Weekend Two*; and the 11th took place in timeframe *Weekend Three*. Within the narrative presented in Chapter IV, supervision meetings are assigned the citation SVM; the number following those letters represents the particular supervision meeting. For example, SVM3 is the citation for my third supervision meeting.

I completed 55 pages of journal entries during the clinical project; I wrote the first one on August 24, 2016 and the last one on March 1, 2018. I wrote pages one through 19 within the timeframe *Prior to Weekend One*; pages 20 through 33 during timeframe *Weekend One*; pages 34 through 46 in timeframe *Weekend Two*; and pages 47 through 55

in timeframe *Weekend Three*. Within the narrative in Chapter IV, personal journal entries are cited as PJ, with the numeric number following the letters representing the page number on which the information can be found in my personal journal.

Within the system of citations that I created for the outcomes of the categorizing and coding analysis, there were three levels of outcomes: themes (TH), featured categories (FCG), and categories (CG.) After each set of letters, there is also a number that distinguishes the different themes, featured categories, and categories from each other (e.g., TH4, TH10). I presented a set of references for the featured categories, categories, and themes—along with their corresponding numbers—at the beginning of Chapter IV, so that readers can refer back to the beginning of the chapter to access a definition of each finding cited in the narrative. Each citation of a theme, category, or featured category is followed by a list of sources that lets the reader know which data source I utilized to derive the results of the study.

Citation system for analysis of critical incidents. I collected a total of 79 evaluation surveys from clients and their family members throughout all three weekends. This included 19 pre-treatment change questionnaires, which I only distributed in Weekends One and Three. I also distributed and collected six staff evaluation surveys during the clinical project, specifically during Weekends Two and Three. I utilized standard action research procedures for the analysis of critical incidents to analyze the data mentioned above.

After I completed the analysis, there was one level of outcome: themes. Themes are represented by the same letters as the themes from the categorizing and coding analysis: TH. As in the citation system for categorizing and coding procedures, a number

follows the letters to indicate which specific theme it is. The references for themes from analysis of critical incidents is also found at the beginning of Chapter IV, along with the references from the results of the categorizing and coding analysis.

Themes from the categorizing and coding analysis can be distinguished from themes from the analysis of critical incidents by the sources listed thereafter. Though I used the same citation system for both, the sources from which the themes were derived are different.

In the categorizing and coding process, I derived the themes from my supervision meetings and journal entries. Therefore, a citation including a theme that pertains to supervision meetings and personal journal entries indicates that I derived it from the categorizing and coding procedures. In the analysis of critical incidents, I derived the themes from pre-treatment change questionnaires and evaluation surveys. Therefore, a citation referring to a theme that pertains to a weekend and clinical stakeholder group indicates that I derived it from the analysis of critical incidents. For example, one citation I used to represent a theme derived from the analysis of critical incidents is TH5; WK1: CL5, FM3; a citation for a theme I derived from categorizing and coding is TH6; SVM2: p. 11, 16; PJ, p. 5, 7.

I used the citations WK1, WK2, and WK3 to refer to the three weekends. I did not mention individuals by name, but rather referred to them by stakeholder group. Clients are represented by the letters CL, family members by the letters FM, and staff members by the letters ST. The number following the letters identifies which client, family, or staff member provided the response. As mentioned previously, I labeled each piece of data with a number corresponding with a stakeholder group, in order to

distinguish clients', family members', and staff members' evaluation surveys from each other. For example, the citation WK3, FM4 indicates that the information can be found on family member four's evaluation survey in Weekend Three.

Appendices. Due to the nature of action research, the same cycling process never repeats itself in the Look, Think, Act routine. Accordingly, I never implemented the same family weekend twice; nor did I always stick to what I had planned for the weekends. Sometimes I did not have enough time for all the activities, while other times I spontaneously facilitated unplanned group exercises. The outline of the weekends in the appendices shows the activities I previously planned and prepared to implement. The narrative in Chapter IV discusses how the planned activities evolved and changed based on the interactions that took place during the weekends.

Act Cycle

Plan

The first stage in the Act cycle is to create, plan, and organize additional meetings for a collective discussion of the solutions to the problems derived from the Think cycle. Since I did not have access to the stakeholders, I did not facilitate meetings with them. Instead, I independently created the hypothesized resolutions I derived from my post-hoc analysis.

As a clinician, I informally consulted with other clinical stakeholders about resolutions to problems that arose during family weekends, which influenced how I approached their resolution. For example, some of my co-workers engaged in informal conversations with me after the family weekends, to ask me how it went and share their own feedback with me. Within these conversations, we would discuss problems that

arose over the weekend and collaboratively brainstorm different solutions. I always welcomed and considered the opinions of my co-workers throughout this clinical project. Additionally, I also maintained close communication with my clinical supervisor, who also collaborated with me to identify different possibilities for resolving the problems that arose during the clinical project.

Implement

During the implementation of the solutions stage, action researchers' main goal is to support, guide, and mediate conflicts, while holding stakeholders responsible for implementing solutions. My clinical project had some differences and similarities to a traditional action research project during this stage. Since I was the only clinician who facilitated family weekends, I was the only stakeholder involved in implementing solutions and changes. Whereas client and family stakeholders were responsible for defining problems during the clinical project, they were not responsible for implementing solutions to those problems, as they did not have the credentials to facilitate therapeutic groups. Therefore, it would have been unethical to hold them responsible for implementing solutions.

My clinical supervisor fulfilled the role of support and guidance during this stage of action research, helping me mediate any conflicts that arose during the implementation of the family weekends. As a researcher, I had no solutions to implement, since the clinical project had already concluded. Instead, through a post-hoc analysis, I analyzed processes within the solutions I implemented, which led to changes that took place while the clinical project was active.

Evaluate

The evaluation stage involves organizing meetings to process any unresolved concerns from the Act cycle. As a clinician, I was involved in clinical meetings prior to the start of each workday. Traditionally, these meetings would consist of the treatment team establishing which therapeutic groups would occur that day and delegating which clinicians would be responsible for facilitating these groups. Additionally, therapists discussed their caseloads and any concerns they had with their clients.

During the clinical project, Monday morning meetings were reserved for processing what took place in the family program the previous weekend. I did not work on Mondays, so I participated in the meetings by phone. These meetings were similar to evaluation meetings in action research, as they involved discussing my evaluation of the family weekend in the presence of other clinical stakeholders. I facilitated discussions about the family dynamics among clients who attended the weekend and processed conflictual dynamics that emerged over the weekend. I explained how I resolved family problems for each client participating in the family weekend, and I ensured that each individual therapist had the opportunity to share any remaining concerns or suggestions about the family weekend. Once all concerns were addressed, the meeting was adjourned, and the next phase of the clinical project began, as I utilized the evaluation surveys from clients and their families to make changes for the next family weekend.

Establishing Rigor

I established rigor in this study by using the same processes of credibility, transferability, dependability, and confirmability inherent in the tradition of action research. The steps are as follows:

1. I established persistent observation through the archival data sources utilized within this study. Persistent observation ensures that information incorporated in the study is based on actual written observations. My personal journal entries qualified as persistent observation, because I consistently wrote them throughout the duration of the clinical project.
2. I established triangulation in this study by ensuring that the meanings I derived from my data analysis were relevant to the constructs of multiple stakeholders. The evaluation surveys served to reveal the personal constructs of staff, clients, and family members related to the family weekends. Therefore, the evaluation surveys provided me with the means to evaluate meanings in the context of multiple stakeholder groups. Simultaneously, I established referential adequacy by deriving concepts and ideas directly from the stakeholders' worldviews. I accomplished this by using data sources that contain precisely quoted descriptions of stakeholders' perspectives.
3. Transferability was begun in Chapter I of this dissertation, through my thorough description of the treatment context in which the clinical project took place. The planned agendas for the three weekends can be found in the Appendices of this dissertation; any modifications to the original agenda are described in Chapter IV. This way, readers can obtain an accurate description of the group activities, interventions, and modifications I facilitated in each implementation of the family weekend. This information will allow readers to obtain an accurate sense of the treatment context in which the clinical project

took place and make accurate judgments about whether the outcomes of this study can be applied to other contexts.

4. I established dependability and confirmability by keeping a journal of the steps I took to analyze the archival research data and form an audit trail. I submitted the audit trail to my committee Chair, who has expertise in qualitative research and acted as the external auditor of the data analysis audit trail.

Ethical Considerations

Researchers have an ethical responsibility to do no harm to participants in a study; accordingly, they must inform participants of “the purpose, aims, use of results, and likely consequences of the study, a process known as informed consent” (Stringer, 2014, p. 89). As this study consisted of a post-hoc analysis of archival clinical data, there were no participants. Nevertheless, I have ensured the privacy and confidentiality of clients prior to, during, and after the completed clinical project. At the time of the clinical project, I purchased a lockable filing cabinet and stored all clinical information related to the family weekend in my work office, which required a code to unlock and enter. After my time of employment ended, I transferred my filing cabinet to my home office, where all the clinical information remained stored; I ensured that it was always locked. I saved any electronic copies I created of the archival data during the data analysis to a USB drive, which I also stored in the locked filing cabinet. During the study, I de-identified all personal information and conducted the analysis in the security of my home office, which no one entered. Upon completion of this study, I will shred all non-clinical sources of

data. As part of my responsibilities as a licensed clinician operating under the 491 Board in Florida, I will retain my clinical records for seven years, whereupon I will shred them.

In my role as a clinician and program implementer, I ensured that every client and family member signed an Informed Consent document prior to participating in their family weekend activities (See Appendix J). When initially introducing myself to clients and families before the start of group sessions, I verbally reiterated issues pertaining to confidentiality. I explained that while I would protect clients' privacy and confidentiality, other families in the room may not. I emphasized the importance of avoiding sharing any information discussed throughout the weekend with other individuals. I also explained that as a mandatory reporter, I would report any suspected child or elder abuse, or any mentions of harm to self or others. I encouraged clients to avoid walking in and out of groups, to ensure that nobody outside the room could hear information discussed during group activities. I gave the clients permission to walk out of the room if they decided they no longer wanted to participate, or if the group became too overwhelming for them. Another therapist was always in the building to address any client or family member who needed to leave. I gave the group an opportunity to ask me questions about the weekend and provided each client and family member with an agenda specifying information about group activities, breaks, and session timeframes.

I explained to the clients that I would collect evaluation surveys at the end of each day, but they were not required to complete them. I instructed them to avoid putting any identifying information on the surveys, but I informed them that if any identifiable information did appear, I would not share it with anyone else prior to obtaining their written consent. Action research studies entail a level of transparency on the part of the

researcher (Stringer, 2014). As a clinician, I demonstrated the same transparency during the clinical program.

Conclusion

Action research represents a drastic departure from traditional ways of conducting scientific research. It is grounded in a qualitative framework and abides by postmodern assumptions of multiple realities. As a result, scientific terms found in traditional studies have different meanings when applied in action research. Action researchers engage in reiterative cycles of investigation—defined as the Look, Think, Act routine—to define the research problem, gather and analyze data, implement solutions, and evaluate outcomes. However, they do not progress through these cycles independently; stakeholders, those individuals affected by the issue under investigation, are recruited to act as co-researchers throughout the duration of the study.

Action researchers utilize stakeholders' voices to collaboratively define the problem, analyze the data, and implement solutions. They maintain a friendly, neutral stance that allows for effective collaboration with stakeholders throughout the study. Establishing rigor in action research does not consist of proving a particular truth or generalizing the outcomes to the larger population. Rather, repetitive, systematic cycles of investigation are undergone to create context-specific solutions for the problem under investigation. Credibility, transferability, dependability, and confirmability are procedures utilized to ensure that the voices of multiple stakeholder groups are included in the analysis, and that individuals can trust the analysis procedures that occurred during the investigation.

While I did not follow the exact procedures found in a traditional action research project, my post-hoc analysis of the clinical project revealed somewhat analogous elements in the implementation and refinement of what was offered during the three family weekends. For example, I used a cycling process to make improvements to the clinical approach, and I implemented new changes each time I facilitated the program. Nevertheless, because the clinical project is completed, I did not have access to previous stakeholders for member checking the outcomes of my analysis.

When the study began, I transferred the clinical information into archival research data. While I conducted the independent post-hoc analysis, I used the appropriate procedures to ensure that the outcomes of the analysis were focused on the voices of major stakeholder groups, especially the clients and family members who participated in the weekends. I derived analytic themes from the stakeholders' perspectives and took all available measures to ensure that my biases and constructs did not influence the way I conducted the post-hoc analysis. As a clinician, I abided by all ethical guidelines to develop and implement a clinical approach that would cause no harm to the clients and families with whom I worked. As a researcher, I followed the same ethical procedures of confidentiality and privacy to avoid revealing the identities of anyone associated with the project.

In the next chapter, I will present the story of my experience as a marriage and family therapist implementing a family program for adult substance misusers and their families while working in an individualistic paradigm of addiction treatment. This story also contains the findings I derived from the different sources of archival research data

described in this chapter. In Chapter V, I will discuss the implications, limitations, and future directions of the study and its findings.

CHAPTER IV: FINDINGS

Sober Heaven

Sober Heaven was a partial-hospitalization and outpatient treatment program for substance misusers founded on disease-based notions of addiction. It was a private facility with mostly all clients paying for their treatment by self-pay or through their private insurance. Other clients who couldn't afford treatment were granted scholarships from Sober Heaven. No clients were legally mandated to attend Sober Heaven. It was one of three locations offering clinical services based on a similar treatment approach. When I was first introduced to Sober Heaven, the administrators were looking to be cutting edge and promote evidence-based treatment. The treatment experience at Sober Heaven was described to me as follows:

Our addiction treatment center specializes in intervention, outpatient service, life coaching, addiction recovery, alcoholism treatment, behavioral disorders and substance abuse treatment. Our client-centered treatment services are delivered in a state-of-the-art facility with both clinical and residential areas, offering not only the necessary resources, but a beautiful accompanying esthetic. Most of the Sober Heaven staff were in long-term recovery and practiced 12-step facilitation therapy or CBT.

Clients at Sober Heaven were transferred to the clinical building for treatment between 8:30 and 9:30 a.m. and stayed on the property until 4:30 pm. They met with their individual therapists one to two times per week; every other day, they attended their primary group, which was facilitated by their individual therapist and included all clients assigned to that therapist's caseload. Throughout the rest of the day, participants engaged

in group sessions on topics such as art or music therapy. They also attended other group sessions focused on specific recovery-related topics. For example, one day an individual therapist would run a group on relapse prevention and the next day facilitate a group on handling difficult emotions. The clients participated in neurofeedback on a daily basis. They could also elect to participate in trauma groups, which were divided by gender. After completing the clinical day, clients were transported to 12-step meetings and other outings by the center's behavioral technicians, who were staff members in long-term recovery.

My involvement with Sober Heaven began on August 24, 2016 during a phone conversation with Dr. Smith, the CEO of the company. I approached him with the hope of continuing to work with dually-addicted couples, as I did at my previous place of employment. Dr. Smith did not seem too enthusiastic about the inclusion of couples' work within his partial hospitalization programs. I asked if perhaps I could create a couples' program for his outpatient curriculum instead. He told me I had thrown him a "curveball" (PJ, p. 1), but was open to hear my ideas. We agreed to meet one week from the time of our initial conversation, to discuss possibilities for the couples' program I had in mind. I created a PowerPoint and was ready to defend my argument to institute a program for dually-addicted couples at Sober Heaven.

During my next meeting with Dr. Smith, he told me he was no longer open to a couples' program and expressed that he highly valued a family program instead. He was aware of the positive research outcomes advocating for the inclusion of families in substance misusers' treatment and told me he wanted to offer such services to the clients who attended his program. He told me some therapists had previously implemented

family programs at Sober Heaven, but without much success. Those family programs that had been tested were embedded in the perspective that family members are sick or sicker than the substance misusers. Accordingly, they incorporated psychoeducation techniques to teach clients and families about the disease of addiction while also teaching families how to set boundaries with their substance misusing loved ones. I agreed to institute a family program instead of a couples' program, thus initiating the clinical project at the heart of this study.

I could have created a family program embedded in modernist assumptions about families as healthy or dysfunctional, which would have fit nicely within Sober Heaven's disease-based model of addiction. It would have made my job as a family program developer much simpler. However, a modernist orientation did not align with who I was or what I believed to be most effective for families. As I embarked on the journey to develop a family program, I was simultaneously navigating the journey toward my Ph.D. in Marriage and Family Therapy from Nova Southeastern University (NSU). I was learning about many diverse therapeutic modalities and ways of helping individuals, and I was eager to put it all into practice. While my training at NSU prepared me to work with families from either a modern or postmodern perspective, the postmodern modalities I learned formed the best fit with my personal views and, eventually, led me to discover who I was as a therapist. Through my training, I came to identify myself as a postmodern therapist with a particular bent toward the SFBT model. The more I studied, the more I understood, and the more I desired to implement postmodern methods in places where postmodern ideas were scarce.

I entered the field of addiction treatment prior to beginning the clinical project and realized that postmodern practices were nearly non-existent within this field. It was then that I realized I could use my postmodern training to offer a different way of helping substance misusers and their families. I became a clinician on a mission. Believing strongly in the therapeutic practices I was learning, and in families' ability to heal from addiction without believing they are sick or wrong, I decided to take the road less traveled and plunge into one of the biggest challenges of my academic career. My ambition became to find a way of practicing postmodern, systemic addiction treatment in a context marked by modernist assumptions about the phenomenon of addiction. I was also determined to figure out how I could utilize the SFBT model to best serve clients who were accustomed to being treated by professionals who demand that they change.

As a solution-focused therapist, I do not demand anything from my clients, because I believe it only causes them to remain the same. In my view, individuals are more likely to make lasting changes when they decide they want those changes for themselves. Guided by this perspective, I initiated my clinical project knowing there would be discord between the therapeutic modality I practiced and the therapeutic modalities utilized by other staff members. I sought off-site supervision to learn how to navigate these challenges and effectively utilize my background in systemic therapy to make a difference in the lives of the clients and the overall system.

The findings discussed in this analysis not only reflect the experiences of clients and their families in a solution-focused family weekend, but also reveal the many complexities and challenges I faced during my process of integration into the system. Some of this complexity arose from my being a systemic thinker introducing family

therapy principles to an individualistic healthcare setting; a strength-based clinician operating within a pathology-based system of addiction treatment; and a new employee working to gain the respect of colleagues with different ways of thinking about addiction treatment.

To discuss the outcomes of my findings, I followed traditional action research recommendations for presenting written reports. Stringer (2014) notes:

Recent developments suggest new ways of formulating written reports that more effectively represent people's experience and enable audiences to understand more clearly the impact of events on people's lives. Denzin (1997) points to the need to formulate more evocative accounts that provide empathetic understandings of events and experiences, research reports that look and sound more like fictional works—novels or short stories—than the impersonal, objective accounts common in many official reports. (p. 214)

I will explain the outcomes of my data analysis in this chapter by providing a narrative description of how the clinical project unfolded. The narrative will reveal the categories and themes I derived from my analysis. First, I will present various categories and itemized lists appearing in the next few paragraphs. Next to each category and theme, I will include a citation that coincides with the category or theme, so that readers can easily refer back to the outcomes of my analysis while reading the narrative.

As mentioned in Chapter III, I organized the analysis into four different time periods during the clinical project—Prior to Weekend One, Weekend One, Weekend Two, and Weekend Three—to illuminate shifts within my experience and the participants' experiences regarding the SFBT-MFG weekends. I conducted two separate

analyses utilizing traditional action research methods, in order to explore each of my research questions.

For the first analysis, I categorized and coded my personal journal (cited throughout the chapter as *PJ*) and supervision sessions with Dr. Douglas Flemons (cited throughout the chapter as *SVM*) to highlight the problems I and other clinical stakeholders faced applying an SFBT-MFG model in a disease-based setting. In addition to the challenges presented within my process of integration, I also analyzed the methods of integration I learned from Douglas, which allowed me to successfully integrate into the system. I include these effective methods of integration as themes in the analysis. Since my analysis produced an abundance of categories from each time period, I refer to some categories as “featured categories,” in order to capture the essence of my experience in fewer terms. Featured categories are cited as *FCG*, while regular categories are cited as *CG*. The featured categories and general categories for the time period prior to the first weekend are as follows:

joyful (FCG1), comfortable (FCG2), scared (FCG3), questioning my legitimacy (FCG4), instability (FCG5), poor communication (FCG6), not a priority (FCG7), a threat (FCG8), insecure (FCG9), conflicting theories as a problem (FCG10), unestablished relationships (CG1), moderate interest (CG2), limited therapeutic context (CG3), lack of trust (CG4), minimal interest in the weekend (CG5), not seeing SFBT as a fit within the system (CG6), cautious to endorse SFBT (CG7), turmoil (CG8), minimal warmth (CG9), maintaining peace (CG10), be respectful (CG11).

The featured categories and general categories for Weekend One are as follows:

scared (FCG11), angry (FCG12), minimal optimism (FCG13), failing to trust my therapeutic approach (FCG14), outlander (FCG15), hostile clients (FCG16), gaining entry (FCG17), failing to give the problem enough attention (FCG18), loss of therapeutic skills (FCG19), dispirited (CG12), sad (CG13), ineffective exercises (CG14), unmotivated clients (CG15), minimal change (CG16), exercises working (CG17), altering group dynamics (CG18), successful group interaction (CG19).

The featured categories and general categories for Weekend Two are as follows:

playing it safe by conforming to the beliefs of the larger system (FCG20), beginning to get comfortable (FCG21), fears about coming off as incompetent if not promoting the 12-step philosophies (FCG22), staff beginning to trust me (FCG23), beginning to let my guard down (FCG24), successful integration as group facilitator (FCG25), beginning to make a difference (FCG26), creating a context for therapeutic change (FCG27), either SFBT or 12-steps (FCG28), experimenting (FCG29), moderate anxiety (CG20), active therapeutic engagement (CG21), certain staff continue to view me as a threat (CG22), insecurities about modality clashes with co-workers (CG23), unsuccessful integration of SFBT (CG24), high emotional expression (CG25), meaningless (CG26), abiding to 12-step philosophies (CG27), addiction cannot be anything other than a disease (CG28), learning how to use SFBT as a compliment to 12-

steps in certain exercises (CG29), placing a division between treatment inside the weekend vs. out (CG30), trying to fit opposing theoretical concepts into one box (CG31).

The featured categories and general categories for Weekend Three are as follows:

positive shifts about how I am relating to myself as a therapist (FCG30), scared about the instability of the company (FCG31), respected as a competent colleague (FCG32), trusting friendship with co-workers (FCG33), participants requesting private sessions (FCG34), be creative (FCG35), families acting as agents of change for each other (FCG36), shifting family dynamics (FCG37), sticking to who I am as a therapist (FCG38), exercise making a difference for participants (FCG39), still learning how to balance multiple viewpoints in one room (CG32), satisfaction (CG33), co-workers referring clients to me (CG34), internally accepting co-workers' difference within their treatment approach (CG35), maintaining participants interest (CG36), minimal loss of attention from participants (CG37), establishing what works (CG38), transparency phenomenon occurring in the context of the group (CG39), struggles with presentation of neurological effects of addiction (CG40), company is falling apart (CG41), environment filled with fear (CG42).

The themes I derived from my personal process throughout all three weekends are as follows:

emotional complexities (TH1), fear (TH2), feelings related to my sense of competence (TH3), comfortable/uncomfortable (TH4), trust/distrust (TH5), therapeutic growth (TH6).

The themes I derived from my supervision sessions about effective methods of integration are as follows:

be respectful to alternative realities (TH7), never make them feel wrong (TH8), make an empathic statement (TH9), look for elements you can endorse (TH10), broaden context (TH11), support and juxtapose (TH12).

The second analysis I completed was based on the clinical stakeholders' perspectives about the SFBT-MFG weekend. I conducted an analysis of critical incidents to identify meaningful experiences within participants' responses, as indicated in the evaluation surveys and pre-treatment change questionnaires they completed. Then, I looked across meaningful experiences reported in Weekends One, Two, and Three to identify commonalities in participants' experiences. This resulted in the following themes:

relief (TH13), enhanced communication (TH14), opened something up (TH15), honesty (TH16), positively affecting clients' recovery (TH17), understanding (TH18), informative (TH19), a sense of support (TH20), learned (TH21), family sculpting (TH22), hearing other family's perspectives (TH23), interacting within their own families (TH24), interacting with the substance misusers (TH25), poor time management (TH26).

Throughout the remainder of this chapter, I will present the findings of my study, outlined above, in the form of a narrative, to share my experiences of practicing SFBT in the context of a disease-based addiction treatment facility for adult substance misusers.

Prior to Weekend One

At the end of August 2016, I facilitated a meeting with Dr. Smith to discuss the details of the family program. We discussed our philosophical orientations of addiction, and he made it clear he believed addiction was a disease. Internally, I struggled with the theoretical difference: “once I heard that, my gut dropped a little. I think it is going to be a problem. How in the world am I going to fit into that culture?” (PJ, p. 1). It was at this point that my process of integrating into the system began.

While I did not agree with Dr. Smith’s theoretical standpoint, that addiction is a disease, I smiled and agreed with him anyway. I did this because the only way I knew how to integrate myself into a system with different epistemological viewpoints was by failing to have a voice. From the initiation of the project through Weekend Two, I handled most theoretical conflicts with upper management and other staff by staying quiet. Although I was demonstrating two lessons Douglas taught me about integration—be respectful towards alternative realities (TH7; SVM1, pp. 1-2; SVM6, pp. 2, 6; SVM7, p. 29; SVM8, pp. 1, 3; SVM9, p. 6; SVM11, p. 1; PJ, pp. 7-8, 16, 22, 32, 44, 54) and never make them feel wrong (TH8; SVM1, p. 1; SVM4, p. 11; SVM6, pp. 7-8; SVM9, p. 6)—I attempted to practice this by failing to speak up, which was not the most effective way to do it.

Organizational Reluctance

Despite my internal struggle with the differences between my theoretical orientation and Dr. Smith’s views about addiction, I agreed to go to one of Sober Heaven’s three facilities to interview for a full-time therapist position. I had not anticipated that I would be interviewed for a full-time position, so I was unprepared to

meet with the staff members who interviewed me. Nevertheless, I was excited about the opportunity. When I got to the facility, I met the two therapists who interviewed me. Both of them came from a disease-based orientation and believed that the best way to help substance misusers was through confrontation. As a solution-focused therapist, I believe the best way to help substance users is through empathy. During the interview, one of the therapists asked, "If a client acted up in group and got angry with you, how would you handle it?" (PJ, p. 2). My first thought was, "I've rarely dealt with clients disrespecting me, because I don't approach them in a way that makes them feel the need to respond defensively." I knew that saying this out loud would come across as disrespectful or even nonsensical, since the interviewers did not come from a systemic epistemology. Instead, I responded by saying that I would take the client aside after group and have a private conversation with him to address the behavior. Since both therapists held the belief that confronting substance misusers is the only way to rid them of their faulty character traits, my non-confrontational approach did not sit well with them. From their theoretical standpoint, my way of addressing angry clients was too passive in nature and would, therefore, be unhelpful. Throughout the rest of the interview, I continued answering questions about the scenarios they presented in the non-pathologizing way I was trained. The more I answered this way, the more confused looks I received. Before leaving the facility, I already knew I had not gotten the job.

My gut instinct was right. I was not hired for a full-time position, because a "more experienced" (PJ, p. 3) candidate was chosen. Despite having previously worked at rehab facilities, holding a license as a marriage and family therapist, and being an advanced doctoral student who had been studying and conducting therapy for the past six years, I

was deemed inexperienced. This incident reflected the conflict between therapeutic assumptions about what constitutes effective therapy. Theoretical clashes, such as the one I experienced in my interactions with the Sober Heaven team, often came up in my interactions with staff prior to the first weekend of my clinical project. I found myself in many similar scenarios feeling like “I just wasn’t talking in their language” (PJ, p. 2). In fact, at the outset of the clinical project, I often found myself viewing the theoretical conflicts between the staff and me as a major problem (FCG10; SVM1, p. 1; SVM6, p. 1; PJ, pp. 1, 13, 17).

Conceptual Clashes With Traditional Treatment

Dr. Smith was still willing to give me a shot; he offered me a part-time opportunity to create and implement the family weekend. Since he did not specify the therapeutic orientation he wanted me to utilize in the family program, I decided to bring my postmodern orientation into the field of addiction and utilize SFBT as the philosophical orientation for the weekends. I spent the next nine months creating a family program for Sober Heaven. The time it took me to develop the family program reflects the great difficulty I had trying to figure out how to bring SFBT into a pathology-based system. Failing to believe that I needed to confront dysfunctional family dynamics and tell family members they are as sick as their substance misusing loved one added another layer of complexity and prolonged the planning stage. Instead, I believed my goal was to invite the family members into my solution-focused curiosity, so they could act differently towards the substance misuser and be available in a different way than they were prior to the substance user entering treatment. Contrary to the theoretical orientation

of the facility, I did not believe my goal was to solve families' problems by figuring out everything that was wrong with them.

My plan was to shift the families' focus and open up space for some kind of change to occur, no matter how big or small. Due to the differences between my approach and the facility's primary modalities, I experienced many emotional challenges (TH1; SVM1: p. 1, 16; SVM6: pp. 1, 3-4, 7, 9; SVM8: p. 1; SVM9: pp. 1, 5, 10-11; SVM10: p. 2; PJ, pp. 1, 5-7, 8, 10-11, 13, 16, 17-19, 20-21, 28-29, 31, 33-34, 36, 44-46, 48, 50, 52-55). However, my feelings about the family weekends shifted tremendously throughout the course of the clinical project. The confidence I had going into it plummeted by the end of Weekend One. After experiencing some success in Weekend Two, my sense of confidence began to rise again. Then, just when I thought I had secured a successful family program in Weekend Three, fear began to creep up again, which I will describe in further detail later on in this chapter.

In addition to the fear I grappled with, I also faced many theoretical challenges regarding the ideas commonly promoted in Al-Anon. It was highly likely that the families who would participate in the three weekends had also attended Al-Anon meetings at some point and learned about the concepts of codependency, tough love, and enabling. These concepts, seen as the gold standard for interventions with family members of substance misusers, were also highly respected within the system I was working in, so I knew I could not neglect to discuss them.

I wanted to discuss codependency in a way that would generate opportunities for change within the dynamics of the families' relationships. So, one day I walked into supervision with five main definitions of codependency, reworded to avoid pathologizing

the relationships between substance misusers and their families. For example, one definition of codependency is trying to change someone else at the detriment of your own physical, emotional, and spiritual wellbeing. I rewrote this definition as, “trying to help someone else see the damage addiction is creating in their lives” (PJ, p. 11). I planned on presenting these rearranged definitions of codependency at the family weekends, expecting all the clients and families to have great epiphanies about codependency and say, “Thank you for relieving me from the codependent prison I’ve been living in.” In my head, I was facilitating a therapeutic reframe by altering definitions of codependency in ways that sounded less pathological.

Douglas thought I was “absolutely right to do it as an exercise” (SVM4, p. 11); however, the way I was attempting to implement the reframe was not likely to take hold with the clients and their families. Douglas put it this way: “Because, it is just like, ‘Oh, you are just trying to say something nice to me or say something nice about me or take the edges off this.’ So, your effort to change it could react against it, because you are just trying to be nice or, ‘You’re so nice, Sandra’” (SVM4, p. 12). He helped me realize that it would not work to just walk into a room full of strangers who have come to accept codependency the way it has been societally defined since 1975 and tell them to think of it in a non-pathological way.

Another topic of discussion in my supervision sessions during the planning stages was the risk of coming across too hopeful. As a solution-focused therapist, I was interested in having the families answer pre-treatment change questions before attending the first weekend, in order to begin facilitating change before the project started. I initially wanted them to answer the question, “What do you know about your loved one

that keeps you hanging in there after so many disappointments?” on a piece of paper and bring it with them to the first weekend for discussion.

Although Douglas thought it was a wonderful question, he was concerned about the fact that, without an established therapeutic relationship (CG1; SVM6, pp. 7, 9), I would be working from a limited therapeutic context (CG3; PJ, pp.1, 11). He stated:

Asking them to do something, but ahead of time, uhm, when some of them are not going to be in the solution-focused therapy window, some of them are going to be window shopping, so they may not all be invested in doing it. You might do better, your pre-treatment curiosity being kept to a minimum, and then think about the first thing you have to do with them is join with them.

Since I did not know the families and they did not know me, my therapeutic context was limited; that made all the difference in how they would respond to my therapeutic questioning. I remember walking into my fourth supervision session with Douglas holding a 55-page document that offered a full description of the theoretical underpinnings, therapeutic values, and goals and exercises I would utilize during the weekends. I borrowed ideas for multiple family group exercises from various books and put tremendous effort into reimagining the activities in a solution-focused way that I thought would be wonderful. Despite my enthusiasm, Douglas shared many concerns, as none of the exercises took into consideration the context of my relationship with the facility and the participants with whom I would be working. Furthermore, he pointed out that the exercises I created did not pay any special attention to the clashes between my modality and the traditional treatment approach.

Douglas told me to “go and take stuff like that and just think it through. See what you can do, and then come back” (SVM4, p. 19). I thought he was telling me only to rearrange the codependency exercise, but he was talking about “everything” (SVM4, p. 19). I felt a sense of frustration with his suggestion, because I thought I had walked in with a nearly finished product for the family weekends. Instead, I was being told to “forget what you already have done” (SVM4, p. 18). Despite my annoyance, I recognized that if I were to implement the weekends without considering the elements Douglas told me to think further about, I would have been no different than the previous therapists who had unsuccessfully attempted to institute a family weekend.

Anyone can select multiple family group exercises in various books and rearrange some elements of them to fit their therapeutic background, putting it all together for a family weekend program within a short span of time and failing to pay attention to any other relevant variables. However, not many clinicians know how to approach the creation of a family weekend with an extra level of sensitivity to the many extraneous variables that could jeopardize even the most successful multiple family interventions. This was the lesson Douglas was trying to instill in me. Initially, I designed the exercises with a sense of naivete, determining the effectiveness of each activity based upon how solution-focused I could make it. Instead, Douglas helped me realize that it was not about the exercises themselves, but rather about my process of integration and facilitation of the group dynamics, that would determine the success of the exercises in the context of the family weekends.

Another suggestion Douglas gave me during one of our supervision meetings was to think about my way of working and then fit it into Sober Heaven’s way of working. In

another sense, he taught me “how not to bump up against them” (SVM3, p. 1). We agreed that I would collaborate with upper management and figure out their vision for a family program, to ensure that what I was creating would meet their needs as well as mine.

While I attempted to facilitate the kind of collaboration Douglas and I discussed, it was difficult to get responses from upper management; after all, they were responsible for an entire rehab facility. At the time, however, I failed to take this into consideration and reacted to the lack of responses about my program by determining that it was not a priority in the system (FCG7; SVM7, PJ, pp. 16, 18). Douglas had a different take on it. He helped me realize that “what you recognize as flexibility and part of your therapeutic strength they may misinterpret as, uhm, a lack of confidence and not knowing” (SVM3, p. 3). As a result, he suggested that I create a brochure-like document including a description of myself, my treatment philosophy, treatment approach, and treatment experience (See Appendix C).

After I was done rearranging the exercises and incorporating Douglas’s suggestions, I created the brochure and sent it to upper management. In this way, I had a finished product I could speak confidently about while remaining open to any changes they wanted me to make during the next meeting, during which I would discuss implementation. Remaining open to suggestions allowed me to respect their realities, which I mentioned previously as a method of integration utilized during the clinical project.

Preparing to Implement the Family Weekends

On June 22, 2017, I drove to Sober Heaven’s corporate office to discuss the implementation of the family program. I felt joyful (FCG1; SVM1, p. 1, 16; SVM6, p. 4;

PJ, pp. 1, 5, 16, 18) comfortable (FCG2; SVM6, p. 3, PJ, pp. 9, 17, 18) and scared (FCG3; SVM7, p. 4; SVM4, p. 17; PJ, pp. 1, 3, 5, 7, 16-18) at the same time. I was joyful because I finally had a finished product I had spent so long developing; I was excited to offer something other than Al-Anon to substance misusers and their families. I felt comfortable, because during supervision, Douglas had helped me work through many of the conceptual challenges I experienced. But I also felt nervous and fearful about how the staff, clients, and family members would receive me and respond to my strength-based approach.

When I arrived at Sober Heaven, I did not anticipate that anybody other than Dr. Smith would be present during the meeting. However, three other staff members—two members of upper management and one therapist—were there. Although I was unsure why they were there, I remained respectful. Dr. Smith began the meeting by asking me to explain the family program I planned to implement:

I spoke of my desire to create something that was effective and worked. I then went on to explain the actual program, including how the weekend would start and end. The keywords I utilized were *connection*, *strengths*, and *continued support*. (PJ, p. 4)

After I finished explaining the family program, Jessica, the other therapist who was present in the meeting, described the family program she was currently facilitating. At the time, I was unaware that there was another family program already occurring, since the first few times I spoke with Dr. Smith, he explained that he was having trouble with effective family programing. As a result, I felt a sense of confusion. After she was done discussing her family program, the members of upper management explained that

Jessica began implementing a family program in November of 2016, three months after my initial meeting with Dr. Smith. From my perspective, it seemed that Jessica was having success with her weekends, as they had been running continuously for nine months. Initially, there were three other Sober Heaven locations, so Jessica was hired with the intention of having her implement her family weekend at one location while I implemented my family program at another. However, at the time of our meeting, the company was going through structural shifts, and there were no longer multiple locations at which to implement family weekends. As a result, Dr. Smith and the members of upper management suggested that Jessica and I collaborate and combine our ideas. Jessica facilitated family weekends at the end of every month, and the next one was set to take place the following weekend. I was instructed to attend the upcoming family weekend, in order to get a feel for what was already being done and think of ideas about how to move forward in my process of collaborating with Jessica.

On June 26, 2017, I had a phone conversation with Jessica about my attendance at the upcoming weekend. Since she was facilitating an intense psychodrama, she checked in with her clients to see if they would be okay with my being there. She told me the clients were not comfortable, so I never attended the weekend.

On July 11, 2017, I called Jessica to schedule a meeting to discuss our ideas about collaborating on a family program. She called me back, stating that her role in the company had changed, and she would be stepping back into a primary therapist position. She explained that I would report to the clinical director about preparing for my first family weekend. It was at this point that I began to feel insecure about the direction of the clinical project (FCG9; SVM6, pp. 1, 3; PJ, pp. 1, 4-5, 11, 15, 17-18). I perceived

Jessica's decision to no longer facilitate family weekends as a sign that she did not want to work with me. After the initial meeting we attended with Dr. Smith, I worried that she would think I was trying to compete for her job. Nevertheless, I was hopeful that during our process of collaboration, she would realize that my intentions were not to oust her. Upon learning that she was no longer acting as a co-therapist for the weekends, my worries intensified. I began to perceive her communication with me as guarded and believed she viewed me as a threat (FCG8; SVM6, p. 1, 4; PJ, pp. 11, 13-14).

Since Jessica had already been facilitating family weekends for quite some time, another therapist coming in to do the same thing had the potential to jeopardize her standing in the company. I began to wonder how this would affect the way other clients and staff members perceived me. Would they be angry and assume I was the reason Jessica was no longer facilitating family weekends? Would they believe I was taking something important away from the clinical program and become upset because someone they did not know was taking over? I realized that another layer of complexity was being added to my process of integration. During that time, my goal became "to navigate this in the smoothest way possible" (SVM6, p. 8) by maintaining the peace (CG11; SVM6, pp. 8, 3; SVM8, p. 1).

After Jessica explained to me that she would no longer be involved with the family weekends, she sent an email to inform the rest of the company about her role change. She stated that she would help me transition for the first family weekend, which I would facilitate at the end of August, 2017. I was unsure how she would help me transition. First, I thought Jessica would be my co-facilitator throughout the entire project. Then I thought she was completely dropping out, and now it seemed as if she

would be partially involved for the first weekend and perhaps the second one as well. I was confused about her role and started to get concerned:

It is not that I am so worried about the actual weekend, but everything is so new. A new facility, new clients, new co-workers. I don't know the ins and outs of the facility. I am going to have to figure out who can help me set up my computer, who is who, who are the techs who will be there with me on the weekends, how will I obtain breakfast and lunch for the clients, where will the location be? And so, those are the type of things I felt relieved about having Jessica with me, because she knows the company better than I, since I am new. (PJ, p. 7)

Overwhelmed by my feelings about being the new person with a new approach, I wrote Jessica a follow-up email to acknowledge the transition she was going through as well. It said the following:

Good Afternoon,

I just wanted to follow up from the previous email you sent informing us about your role shift within the company. I wanted to thank you for allowing me to come in, as I am sure you have been working hard on the program for some time.

Although I was looking forward to working with you, I understand a full caseload of patients while trying to be involved in a family weekend would not allow you the time needed to engage with family weekend. It has been a pleasure thus far to work with you, and I appreciate the time you are going to take to help me transition in August. I also will be in contact with Mary to schedule a meeting to continue moving forward. Hope you have a nice evening,

Sandra DiMarco. (PJ, p. 8)

Reflected in the email above are two elements of integration, one of which I mentioned previously: “be respectful towards alternative realities” and “make an empathic statement” (TH9; SVM6, pp. 6-9; PJ, p. 44). I began the email by respectfully acknowledging Jessica’s reality regarding her recent role shift, and thanking her for allowing me to be part of the clinical program. Then, I exhibited an aspect of empathy by acknowledging the hard work she put into the family program and facilitation of a family weekend, in addition to her full caseload. She responded by simply saying, “Thank you.” I was discouraged. A two-word response to everything I wrote was not what I anticipated; I perceived it as her being short with me. Nevertheless, I kept those feelings to myself and proceeded with the clinical project by emailing the clinical director to schedule a meeting and discuss the logistics of Family Weekend One.

Meeting the Staff

I met with the clinical director on July 21, 2017, and we established that Family Weekend One would take place on August 27 and 28, 2017. We agreed that I would meet with staff on July 26, 2017 to introduce the program and encourage individual therapists to promote the family weekends with their clients. I also agreed to meet with the outpatient clients on July 31, 2017 and the PHP clients on August 2, 2017 to introduce the family program and encourage participation from them as well. I felt comfortable and supported by the clinical director, which was a relief since my experience with one of the staff members appeared to get off to a bad start.

Prior to meeting with the entire staff to introduce the family program, I was told that Jessica felt a sense of isolation from me. I was asked to utilize the language of “our program” instead of “my program.” I would have utilized this language, but since Jessica

and I were no longer collaborating, I figured it was unnecessary to refer to the program as “ours.” Nevertheless, abiding by lessons from supervision, I remained respectful of what was requested and did not create a conflict about this. I was told there would be a meeting to address the issue with Jessica before my meeting with the staff, at which she would be present, but that meeting never occurred.

On July 26, 2017, I met with the staff to discuss the family weekend, feeling awkward due to the dynamics with Jessica. At the start of the conversation, I asked about the staff members’ thoughts regarding the importance of including families in addiction treatment, in an effort to determine their theoretical orientations. Their theoretical standpoint would dictate the words I would utilize while discussing the family weekend. I wanted to use their language in the same way I use clients’ language in therapy.

The staff members at the meeting responded to my curiosities by asserting that families are just as sick or sicker than the clients, a view that corresponds with the theoretical assumptions of Al-Anon. They described family members as enablers suffering from the disease of codependency. I knew from my supervision sessions that I could not just walk into a room full of colleagues with such beliefs and tell them that families do not pathologically enable, but rather act as resources. However, still believing I had to deal with our theoretical differences by staying quiet, I smiled and nodded my head to each of their responses. Although staff members utilized a great deal of disease-based language, they all agreed about the importance of involving family members in treatment. Therefore, I felt satisfied that, at the very least, the staff held family therapy in high regard, even if it was not the type of therapy they were used to witnessing.

Throughout the meeting, I felt fearful and anxious. I believed I was stepping on Jessica's toes and assumed that everyone else agreed and was judging me negatively for it. Since I do not have access to the internal workings of others' minds, I had no way of knowing how they perceived me; but since Jessica was an established employee and I was a newcomer, I could not help but think they were mistrusting of me (CG4; SVM6, p. 1; PJ, pp. 5, 7, 10, 17). My fear and anxiety in the meeting blocked my ability to clearly focus on my initial goal of paying attention to the way staff members talked about families so that I could talk about families in a way that made sense to them. Instead, I began talking about families as resources, even though everyone in the room had just told me they believed families are as sick as, or sicker than, clients.

Because my views contrasted so sharply with those of my colleagues, I should have reserved my views about families for the very last part of the conversation, rather than sharing them right away. Had I come from a disease-based orientation and viewed families as sick, I could have discussed my views at the start of the conversation, since they aligned with everyone else's therapeutic orientation. However, since my orientation was different from theirs, I needed to navigate the conversation in a way that allowed other staff members to accept the alternative approach I was trying to promote. In other words, I needed to create "a context for them to be looking forward to it not through the same perspective, not through the same eyeglasses that they look at the rest of it" (SVM9, p. 5).

Rather than immediately starting the conversation by stating my views about family members as tremendous resources for substance misusers, I should have looked for elements to endorse in staff members' theoretical orientations (TH10; SVM11, p. 1;

PJ, p. 54). I could have begun the discussion by endorsing the elements I agree with in the disease-based orientation of addiction, for example by pointing out that families' sickness can escalate when they do not know how to address, communicate, or interact with substance misusers. A disease-based therapist focuses on the sickness in families, and a solution-focused therapist focuses on behavioral patterns in families. I would not have devoted an entire discussion to the sickness in substance misusers' family members, because as a solution-focused therapist, I would have been going against who I was. Nevertheless, beginning the conversation by utilizing everyone else's language of "sickness" but then "leaving it behind to a certain degree" (SVM4, p. 11) by describing the behaviors inherent to that sickness would have allowed them to agree with my statements more easily.

Next, I could have broadened the context of the argument (TH11; SVM1, p. 1; SVM6, pp. 7-9; PJ, p. 22), then supported the legitimacy of their statements while also juxtaposing them with my own assertions (TH12; SVM1, p. 2; SVM4, p. 11; SVM6, pp. 7, 9; SVM9, pp. 5-6). For example, I could have broadened the context of the conversation by making some general statements about common problems found within the behavioral interactions of addicted family systems. Then, I could have discussed other ways in which families are affected by addiction. After this, I could have established the legitimacy of Al-Anon and acknowledged the importance of that program's philosophy, which can allow family members to behave differently towards the substance misusers. I could have gone on to acknowledge that there are a variety of approaches to help clients and their families act differently towards each other, each of which emphasizes a different way of intervening. Some models focus on cognitive patterns, others on

emotional expression, some on the past, and others on the future, all describing how each of these areas is valuable when it comes to therapeutically helping another individual.

After processing a variety of ways to help clients and their families, making sure to include the ones staff members believed to be most helpful for clients and families, I could have then juxtaposed them with my own way of helping clients and their families. For example, I could have presented the juxtaposition something like this: “I very much respect all the work done in Al-Anon meetings, and I am very committed to offering something to the families that doesn’t reflect what they already know, because then it may not be worth the commitment and time families will spend making travel arrangements only for the family weekend to be more of the same. The family weekend will be different, and it will be different in a way that is meant to complement the work you each are doing throughout the week with your clients. So, you will notice some similarities in the family weekend in regard to your own therapeutic work, but you will also probably notice some differences. I think it is very important we all have different ways of accomplishing the same goal, which is to further the sobriety of the clients and enhance the wellbeing of all family members.” Again, no one could have disagreed with wanting to help their clients.

Instead, I immediately described the weekend as strength-based, client-centered, and resource oriented, coming on a little strong. A few therapists asked about the logistics of the weekend, such as the time, location, and whether kids would be involved. Some therapists appeared curious, while other therapists did not seem to think that solution-focused therapy was the best fit for family weekends (CG6; SVM6; pp. 2-4, 9; PJ, pp. 1, 4, 7-8, 10, 13-15, 17).

The same therapist who interviewed me for the full-time position I never got was in the meeting; he asked about the interventions I planned to use. I explained that I would facilitate conversations in a strength-based way, while instructing clients and their families to complete various group exercises with each other to promote changes in their behavioral interactions both within and beyond the weekend. I asked him if this answered his question, and he told me it did not. I further explained that the group exercises consisted of resource-oriented questions that would be discussed in the context of the group, and some exercises would require families to break off into their own individual family groups. He did not say anything but made a facial expression that suggested he was not satisfied with my response. In the moment, I assumed his facial expression meant he thought it was unwise to send families off into their individual groups. Interpreting it this way, I proceeded to further explain my involvement with the families once they broke into groups, saying that I would be active and engaged with each family group during the exercises, walking around the room to ensure that the families were staying on track. I explained that I would also observe the content of the families' conversations, as well as family members' body language and tone of voice, in order to ensure that everyone was taking group exercises seriously. He did not say anything else thereafter.

I had another incident with the same staff member, which happened when I was in conversation with another therapist, who had asked me a question about treatment modalities for families. Before I could finish answering the question, he entered the conversation and answered the question for me, explaining it through his own therapeutic perspective. By doing so, he discounted everything I said, because we came from a different orientation. He continued to ask me several questions in front of the other staff

members in a way that suggested he and others were cautious about endorsing the solution-focused approach (CG7; SVM6; p. 5; PJ, p. 6, 11, 13). It was clear they did not see a way for me to fit into their system. By coming into it, I had the potential to undermine the stability of other staff members, especially considering the transformational changes happening in the facility on a weekly basis.

After the meeting was over, I spoke with the clinical director, and we had a supportive conversation, which was what I needed. Internally, I was in turmoil (CG8; SVM6; p. 1, 9; PJ, p. 6-8, 13-14, 18); I felt minimal warmth (CG9; SVM6; p. 3; PJ, pp. 10, 15-16) in my interactions with other staff members. The cautious endorsements from staff members, and other insecurities I had about my relationships with them, led me to believe they had minimal interest in my family weekend (CG5; SVM6; p. 3; PJ, p. 10). At the end of the meeting with the clinical director, we confirmed the dates on which I would meet the PHP and outpatient clients to encourage their participation in the program. Upon leaving, the clinical director introduced me to the outpatient director, who would introduce me to the outpatient clients the following day.

Meeting the Clients

The next day, I met with the clients from the outpatient program. The outpatient director provided a brief introduction about who I was to the clients. While she was introducing me, I noticed that there was some tension between the director and one of the clients, which related to concerns that did not have to do with the family weekend. I felt uneasy, because I did not want to begin explaining the program in a context filled with tension between clients and staff. I assumed the energy would carry into my conversation about the family weekend. Indeed, it did.

At some point in my discussion with the clients, I addressed them as “you guys.” The same client who had tension with the outpatient director thought I was saying, “you addicts,” which led the other group members to tell me it seemed I was placing a division between them and me. This was not my intention. Without establishing relationships with the clients, I would be at risk of their hearing such accusations. After all, how could they know I meant no offense if they did not even know who I was?

The same client continued to cause interruptions during the meeting and, at some point, asked me if I was in recovery. Between the incidents that took place in my meeting with the staff and what was occurring with the clients in the meeting, I started to feel that the whole system was questioning my legitimacy (FCG4; SVM6, p. 8; PJ, p. 16). I always struggled with the question of whether I am in recovery, which I am not. Through my experiences working in the industry, I came to recognize the high value clients place on therapists who are in recovery. In my discussions with other therapists who are also not in recovery, I learned that some handle the question by reflecting it back and asking the client why it is of importance. This is not a bad way to handle the question; however, I personally feel inauthentic when I respond in such a way, as it has the potential to negatively affect my relationships with clients, who may feel I am being dishonest with them. Believing that clients have to trust their therapist for any type of change to occur, I felt there was a better way I could respond to this question. In my next supervision session with Douglas, I addressed the recovery question, and he asked me how I thought I should answer it. Drawing from the conversations I had with other therapists, I responded by saying, “ambiguously” (SVM6, p. 6).

Douglas agreed that I should stick with my desire to avoid coming off inauthentic to clients. However, he thought it was unwise to respond to the question with ambiguity, because it could still come across as inauthentic, leading clients to think I feel ashamed or guilty (SVM6, p. 7). Instead, I could apply the same methods of integration mentioned previously within my response to clients' questions about whether I am in recovery. He suggested that I begin with an empathic statement, establish the legitimacy of the client's question, and then juxtapose it by stating that I am not in recovery (SVM6, p. 6). For example:

You are wondering whether I am in recovery. Is that important to you? Is that question important to you? It is not unusual for that working in, uh, treatment facilities with addictions for people to be curious about that; and often, as you know, many of the people that are working therapeutically with you are in recovery. . . . Many of my therapeutic colleagues, when I worked for other facilities in the past, themselves are in recovery; and it gives them a special entry into really grasping into what it is the person is struggling with and going through. I come at it from a different perspective, so I very much respect how useful it can be, and I am not in recovery and I am still committed to being as respectful and to being as helpful as if I were. And I know that some people who themselves are in recovery would disagree with me. And I respect that as well. My experience has been that a therapist who cares and a therapist who is very, very curious about the experience of the people who they are working with can be as effective as somebody who themselves has gone through the agony that you're going through. So, that is the position that I am coming from. (SVM6, p. 7)

Had I answered the client's question by incorporating the categories of integration, she may have respected the group more and perhaps behaved differently. However, the client continued to act up throughout the rest of the meeting. I handled her acting out by ignoring her, because I knew confrontation would only cause her to escalate and did not feel I could accomplish anything useful by furthering her irritation and placing myself in a position to fight with her. For the most part, I stayed true to my desire to promote a sense of honesty, because honesty was a meaningful experience reported by participants throughout Weekends Two and Three (TH16; WK2: FM3, FM5; WK3: CL3, FM2, FM3, FM5).

At the beginning of the project, I may have come across as inauthentic, but since I did not say much, no one had the chance to know otherwise. During the rest of my meeting with the outpatient clients, a few others challenged me while others remained respectful. Two or three clients brought up Jessica's family program, telling me they attended her weekend previously and found it beneficial. The clients were not trying to rub it in my face; however, due to the insecurities I felt about the family weekends based on my interactions with Jessica and other staff members, I took it this way. At the end of the meeting, some clients clapped and others approached me to sign up for the weekend, so I assumed they were moderately interested in the weekend (CG2; PJ, pp. 16-17).

Two days later, I facilitated the meeting with the PHP clients. When I walked up to the front desk to meet with the clinical director, I was told she had resigned. I was upset to hear this, because she was someone I felt comfortable with during the challenges I had experienced in the beginning. Although I was not completely aware of what was going on in the company, I realized things were in major flux, and the context of the

facility started to feel unstable (FCG5; SVM6, p. 8; SVM7, p. 5, 14; PJ, pp. 6-7, 11, 15-16, 18). I was unsure who I would now report to, but the employee at the front desk made a phone call and figured it out for me. She told me that Sharon, someone from upper management, would temporarily fulfill the clinical director role until they hired someone new.

When I met with the PHP clients, Sharon began the meeting by instructing the clients to set up the chairs in a big circle. Then, she took a seat next to me. Sharon introduced me to the group. I began discussing family involvement in treatment, and Sharon joined the conversation. She asked me questions in front of the group, which could have suggested that I was an intern rather than a licensed therapist. She felt unsure about my therapeutic skills. Since she did not know me or my work, she did not trust me. In an effort to protect the safety of the group, she began to facilitate the meeting. It threw me off, and I stopped talking. Since the outpatient director had allowed me to run the meeting for the outpatient clients, I assumed I would also run the meeting for the PHP clients. After Sharon had been talking for some time, I realized I had to regain my voice. If not, the clients would perceive me as being too passive, which would interfere with their ability to trust me enough to be able to help them. I did my best to transition the dynamics of the conversation and shift into co-therapy-mode. I started bridging my statements with Sharon's, which worked well and allowed me to add my voice to the conversation. Clients remained respectful throughout the discussion and also showed some interest for the family program. The meeting ended well, and some clients approached me at the end with interest in signing up for the family weekend.

After facilitating all meetings with staff and clients to promote the family program, I began working on last minute tasks. I finalized the attendance list, made food orders, and prepared the supplies I needed for the weekend. Communicating with other staff members and families was difficult, because I was unable to access the facility's computer system and email server. As a result, I had no direct way of getting in contact with everyone, which made me feel there was poor communication among us (FCG6; SVM7, pp. 4, 15; PJ, pp. 3, 6, 10, 18).

Due to my inability to communicate with the families, Jessica helped me distribute the pre-treatment change questionnaires via email, which the families were instructed to bring with them to the family weekend. Another short meeting was held with upper management to encourage Jessica's collaboration with me, but she preferred to focus on her new role in the company. Despite all the challenges I faced prior to implementing the weekend, I was eager to begin facilitating the program with the 15 total participants who enrolled.

Weekend One

Achieving Entry into the System

A few days prior to Weekend One, Sharon and Dr. Smith pulled me aside into another room. I assumed they were going to call off the weekend, because I thought other staff members viewed my solution-focused approach as naïve. Furthermore, I felt I was perceived as inexperienced, since this was the reason I was given for not getting the full-time position a year earlier. But I was wrong. Sharon and Dr. Smith had pulled me aside to offer me a full-time position. They seemed excited to bring me on board, and I

accepted the position. This was an essential point in my process of integration. It meant I had gained entry into the system (FCG17; SVM8, p.1-2; PJ, pp. 19, 21-23).

The first two nights prior to implementing the first family weekend, I reread and rehearsed some major topics of discussion from my supervision sessions with Douglas. Although I was excited, what I felt most was fear, because I had no idea how clients and families would receive my approach. Unfortunately, I let my fears consume my thoughts and barely got any sleep the night prior to Weekend One. I wondered what the families would think if they knew this was my first time facilitating multiple family groups and questioned my ability to handle so many families in one room at the same time. The next morning, I woke up and did a lot of self-talk to increase my feelings of confidence, because I knew I could not walk into the first weekend without believing in my abilities.

Day One

I walked into the facility at 7:00 on the morning of August 27, 2017 and began setting up the room to prepare for the day. Jessica was there to help, and Sharon was present as well. After Jessica and I set up for an hour, the time came for families to start arriving. Several people started calling, telling me they were having trouble finding the facility. At that point, I realized I had put the wrong address on the invitation. I was embarrassed and worried that things were not getting off to a great start. Not only was I dealing with my own anxiety about doing something I had never done before, I also had to deal with the families' anxiety about being lost. Jessica, Sharon, and I spent the first hour directing family members to the correct location, and by the time everyone got there it was 10:00 am. I started an hour after initially planned, and only got through five exercises on the first day as a result.

I began Weekend One (see Appendix G) by introducing myself to the group, reciting issues of confidentiality, and presenting the icebreaker exercise. When I asked the families how they could use their commitment to caring to make the world a better place, many of the clients responded with, “I don’t know.” This made me feel that the families were not really with me. Douglas had previously cautioned me in supervision that some participants might say, “I don’t know,” and we discussed some helpful ways to respond. Since my anxiety was heightened from being in a room with so many families, I did not remember Douglas’s helpful suggestion for how to respond. Instead, I accepted the “I don’t know” answers and moved on to respond to those participants who answered the question more directly.

Next, I facilitated a group discussion about participants’ pre-treatment change questions. For me, it felt like a nice conversation rather than a therapeutic discussion, because I did not interact too much with participants’ responses. But the exercise went nowhere. Had I been more interactive during the exercise, I could have utilized my solution-focused thinking to explore resourceful responses in greater depth and construct more therapeutic conversations. For example, across Weekends One and Three—the only time I distributed pre-treatment change questionnaires—participants reported that relief (TH13; WK1: CL1, FM2; WK3: FM4) was a current and anticipated difference resulting from their family member being in treatment. I could have explored what the participants were able to do as a result of that relief in their lives and continued this type of resource-oriented discussion with the rest of the group members.

For the next exercise, I played a You Tube video called *Rat Park* by Johann Hari. I anticipated that participants would enjoy the video and take something away from it, because I received good responses from substance misusers when I showed it in the past. A few participants made positive comments about the video, and the group discussion went okay, aside from one participant suggesting that the information presented was wrong. In the Rat Park video, the speaker makes an analogy about the Vietnam war and drug addiction. A male participant in the group expressed that the information discussed about the Vietnam war was incorrect. Although I was sure the information was correct since I have read about the analogy in multiple books and articles, I never used the video again for the remainder of the family weekends. The last thing I wanted participants to think was that I provided them with wrong information, because it would once again influence whether or not they could trust me. In hindsight, the participants probably did think I provided them with the wrong information, as I did not correct the participant and state the information was indeed correct. As a result, they probably didn't know whose information to trust—mine or the participant's. How could they trust me to help them if they could not trust the information I was providing?

A codependent mess. Up until that point, I felt the weekend was going okay. At the same time, I felt that some of the participants were not as into the exercises as I had envisioned they would be; I perceived their motivation to be low (CG15; PJ, pp. 20, 28, 30, 32). Jessica was present in the groups and made minimal comments during group exercises, while Sharon walked into the room frequently to observe. When I began facilitating the codependency exercise, Sharon coincidentally entered the room. I began by asking the participants to share their thoughts about codependency. After Sharon

heard several participants and me converse about the subject, she began discussing codependency according to her therapeutic model, which is different from the one I was attempting to institute. Jessica, whose therapeutic orientation is similar to Sharon's, joined the group discussion and co-facilitated conversations about codependency with Sharon. I said nothing, because I had nothing to offer to a conversation based on an orientation that does not accord with who I am as a therapist. I began to feel like an outlander (FCG15; SVM8, pp. 1, 3; PJ, pp. 19, 21); "I didn't feel there was a place for my approach. It was like one person wearing two different shoes" (PJ, p. 21).

Sharon and Jessica ran the group for a period of time (FCG14; SVM8, pp. 1-2, 4; PJ, p. 20), which had the unfortunate result of participants beginning to see me as incompetent. It led me to question my abilities as well. The exercise ended with a client and her daughter getting into a verbal screaming match in front of the group. The conversation escalated, and the client walked out of the group, leaving her daughter in tears.

The contrast in Sharon and Jessica's therapeutic orientations and my own was so stark that it shifted the direction of the workshop in a way that I had not intended. For example, each time a participant responded, Sharon or Jessica attached deeper meaning to what they said, even if the participants did not feel that meaning fit with their reality. As a result, some participants became agitated. Others became enlightened, as reflected in their survey responses for Weekend One.

Five family members (WK1, FM8, FM1, FM5, FM3, FM6) mentioned that the codependency exercise met their expectations and was the most meaningful exercise that occurred during the weekend. The nature of the exercise, however,

contrasted with the resource-oriented approach I intended to take. Nevertheless, their approach fit with what families experienced in Al-Anon. As a result, they found it useful, because it met their expectations, mimicking the kind of help they received in other disease-based settings. For example, one family member referred to the presence of “lots of people confronted by complex emotions” (WK1, FM7) as the most significant part of the weekend. This expression—“confronted by complex emotions”—reflects the idea that substance misusers are incapable of comprehending reality so others must confront them to correct their deviant understanding. Reflecting back, I see that it was helpful for participants to have their expectations met, as it meant they were not disappointed. At the same time, however, it meant that the content of the workshops would maintain the pathologizing way of thinking about relationships with their family members, resulting in a double-edged sword.

While a confrontation-oriented approach would suggest that it is helpful for a mother to walk out of group due to feeling overpowered by everyone’s confrontations, when it happened in my group, I saw it as a sign of failure due to my therapeutic orientation. After the mother walked out, the rest of the clients immediately consoled her daughter by sharing what they thought was most helpful for her to hear; all of it was pathological in nature. I decided to call an early break to the group.

When all the participants got up for the break, I remained in my chair without saying a word. While Sharon attended to other participants, Jessica approached me to ask what was wrong. My facial expression must have revealed the

anger I was feeling inside, even though I was trying my best to hold it back (FCG12; PJ, pp. 20-21). I said I did not intend for the exercise to go in the direction it did and stated that I was unsure whether I could continue for the remainder of the afternoon. Jessica was supportive and attempted to calm me down. Reflecting back, I am grateful she approached me, because my anger would have continued to escalate, and I could have become emotionally reactive towards others. If I was left to facilitate the last part of the codependency exercise with such intense feelings and thoughts swirling around inside me, I would not have been an effective facilitator for the participants.

I was slightly calmer after the break, but I remained stuck. Although I knew how to discuss codependency from the orientation Sharon and Jessica did, I did not want to do it, because it did not align with what my beliefs about change. I also could not introduce a resource-oriented discussion about codependency into the conversation, because the participants had just learned about codependency through a pathological lens. By speaking from my own theoretical perspective, I would contradict everything Sharon and Jessica had just told the participants about codependency. Again, my anxiety prevented me from thinking clearly about the clash in theoretical orientations; in fact, it kept me from thinking at all. It was as if I was in a forest being chased by a bear. My fear escalated, and I went into survival mode (FCG11; PJ, pp. 19, 21, 33-34, 48). I grabbed the only resource I thought would save me in the moment and started reading from a sheet of paper that included the notes I had transcribed from my codependency discussions with

Douglas in supervision. In that moment, I completely lost my therapeutic skills (FCG19; SVM9, p. 1; PJ, pp. 20-21, 28, 30).

Not only was I furthering others' perceptions of my incompetence by reading from a piece of paper, I provided nothing therapeutic to the group. I could sense that the participants knew something unusual was happening, because when I was done reading the paper, I saw that they were all looking at me with blank facial expressions. Afterward, when I attempted to facilitate a group discussion about what I just read to them, none of the participants responded to my questions. I thought the families would greatly appreciate learning about codependency in a different light, but after observing the way they responded to the pathology-oriented version, I felt dispirited (CG12; PJ, pp. 19-21, 28, 30, 32, 48). I was discouraged for two reasons. First, in her efforts to be helpful, my colleague had facilitated the exercise from the orientation she believed to be most helpful, which reflected poorly on her ability to trust me to facilitate the codependency exercise. Second, since the exercise had gone in a different direction from what I had planned, the resource-oriented notes I read to the participants created a confusing incoherence. The lack of coherence was a challenge not only for me, but also for the participants. I regretted having ever decided to reframe definitions of codependency and started to get convinced that I was not the best person to facilitate codependency groups.

Solution-focused therapy overload. After the codependency exercise, I only had time to facilitate two more activities. I felt a sense of relief over this, because the next two exercises I had planned for the afternoon were purely solution-focused. Reflecting back, facilitating an exercise by utilizing a therapeutic modality

that contrasted with so much of the therapeutic work led by Sharon and Jessica was a major problem in my process of integration for Weekend One. Since participants were engaged in pathology-oriented exercises for most of the morning, the major contrast in therapeutic modalities would only come across as discordant.

Nevertheless, I began facilitating group therapy in what could be called a *solution-forced* way (Reiter & Chenail, 2016), meaning I only focused on solutions and failed to give problems enough attention (FCG18; SVM8, p. 4; PJ, pp. 29, 30, 32, 44). One participant noticed this and mentioned it in the evaluation survey, stating, “Focus more on energy of the room and address issues rather than putting ‘band-aid’ on wound & moving on. This does not allow for solution. I like Jessica’s method of group” (WK1, FM1). Douglas warned me about this in supervision sessions, explaining, “They have been beat up again and again emotionally, and you do not want your solution-focused approach to be read as naïvely hopeful, because they will write you off” (SVM4, p. 9). They did write me off in Weekend One, as evidenced by the words of another participant, who described the weekend as “dull and boring” (WK1, CL4).

I believe I was attempting to compensate for the codependency exercise by implementing an overly hopeful therapeutic attitude, considering everything I was trying to avoid as a solution-focused therapist had just unfolded in the codependency group. In any event, the survey responses helped me recognize I needed to place a greater emphasis on problem talk for the remainder of the weekends.

During the last two exercises of the first day, I was met with many more responses of “I don’t know,” and “How do I know what is helpful?” I did not feel

that I had the respect of the group and could not wait to get out of there. None of the exercises I facilitated on Day One appeared to have been effective (CG14; PJ, pp. 28-30). I got in my car and immediately started crying as I left the parking lot, reflecting the deep sense of sadness I felt (CG13; SVM8, p. 1; SVM9, p. 10; PJ, pp. 19, 21, 31, 44). Much of my sadness was about having spent so much time preparing and creating a family program, only to feel as if I had bombed it the first time I implemented it. When I got home, I found myself unable to face the reality that I would have to go back there tomorrow.

A successful integration experience. That evening, I spoke to Douglas, and we discussed the best way to approach the situation with Sharon and Jessica. He suggested that I write a respectful, proactive email about my preferences for the second day. The way I responded to the challenges presented during the first day was another vital point in my process of integration. I did not confront Sharon or Jessica and tell them how wrong they were for facilitating the codependency discussion. Nor did I approach them aggressively and create a competition over whose therapeutic approach worked better. Rather, I reassured her that they could trust me by writing the following email:

Good Evening,

In reflecting how the day went, I would like to thank you both in assisting me with the particular complications arising during today's family event. In preparing for tomorrow, I am unsure how much time each of you will have to dedicate to the event due to it being a normal clinical day. It can become quite complex combining two different models of therapy. There is a certain amount

of necessary preparation to occur in order to combine models together in an effective manner. If we all will be collaborating as group facilitators tomorrow as today, I would very much like to be on the same page. I would appreciate meeting a half an hour prior to the program beginning to avoid the model interactive complexity which occurred today. If you will not have the availability to attend the full duration of tomorrow's event, then this meeting is unnecessary. However, if so, please let me know so I can be there earlier to meet with you. Thank you and have a nice evening.

My message to Sharon and Jessica was intended to convey a sense of respect for their time and effort during the weekend, while also broadening the context to address the complexities associated with modality clashes. I concluded by requesting a meeting in order to directly communicate how I would like them to be involved for Day Two.

I never held the meeting with Sharon and Jessica the next morning, because neither of them responded to my email. I assumed that either their availability was limited, or they did not get a chance to read my message. Despite not proceeding with an actual meeting, Sharon and Jessica seemed to respond to the email I sent. Sharon was apologetic for taking over, and I experienced her as being much nicer to me on the second day. She explained that she felt it was necessary to step into the conversation, because when one participant calls out the flaws of another, she sees an opportunity and "has to hop on it" (PJ, p. 21). I made sense of her response by relating it to what would happen if I, as a solution-focused therapist, heard a client

make a statement about some change or difference. It would be hard to hold back and fail to explore the statement further.

Jessica also seemed to indirectly respond to my email. She asked me what I preferred with regard to her presence in the group that day. She reassured me that I could let her know if I did not want her to be there. She later admitted that she thought I was trying to steal her ideas, which would explain her lack of desire to collaborate with me. After watching me facilitate Weekend One, Jessica told me she realized that the family weekend had a strong emphasis on solution-focused therapy, which was not her preferred practice as a modernist family therapist.

Day Two

I began the second day by using the first 15 minutes of group to discuss how the families' evening went; this was not a part of my original plan. I felt like a stranger to all of the participants and wanted to spend time joining with them before jumping into the first exercise of the day. The previous evening, all of the clients had received permission from their primary therapist to go offsite with their families at the end of the treatment day. I felt it was important to discuss their outings, because it was the first time the families had been reunited with their client family members since they had entered treatment. Many of the participants made positive remarks about enjoying the time with their families. It was a nice way to lead into the next exercise. I continued to open up the second day of the weekend by utilizing the first 15 minutes to discuss families' outings during the remainder of the weekends.

In the first exercise of Day Two, I explored the families' ideas about what was keeping them hanging in there. I planned to utilize this exercise the day prior, but ran out of time. Considering the dynamics of the previous day, this could have been another instance in which I was moving too fast into solution talk without addressing the problem. Nevertheless, "the dynamic of the group became lighter, and frowns turned into smiles" (PJ, p. 29). I saw several clients' faces light up when they heard their family members express love for them. The same thing occurred when the family members heard their client loved ones express caring feelings; many of them had not heard such caring words in many months or even years. I defined this activity as "very useful" (PJ, p. 29) and continued to utilize it throughout the remainder of the weekends.

Ripple effect within the system. The next group activity I facilitated was called *Getting from What Doesn't Work to What Does*. My goal was to explore the differences between behavioral interactions during addictive periods and those during non-addictive periods in order to engage participants in a resource-oriented conversation about the changes occurring between the two periods. I instructed participants to break off into their individual family groups and answer questions about their interactions during periods of addictive behavior and non-addictive behavior. Then, I brought the participants back into the group to process their answers.

I began the group discussion by going around the circle and asking each family to process their responses. When I approached one client in particular, she became hostile towards me (FCG16; PJ, pp. 23, 29, 30, 48). Every time I asked her a

question, she sat with her arms cross and aggressively stated, “There is nothing different between periods of addictive behavior and non-addictive behavior. My mother treats me the same regardless” (PJ, p. 29). She had an angry facial expression during the whole weekend. She continuously expressed agitation any time I interacted with her, and the way she spoke to me suggested that she thought I was incompetent. Reflecting back, I recognize that she was Jessica’s client and had previously participated in multiple family sessions with her mother, facilitated by Jessica. Furthermore, Sharon had pulled that client and her family out of the group during the previous exercise in order to facilitate a family session with them.

Looking back, this was a prime illustration of how the clash in modalities affected some of the participants. The type of family therapy that client had received in individual sessions prior to and during the family weekend was completely different from the type of family therapy I was instituting within the weekend. Therefore, she wrote off my therapeutic orientation as inexperienced and saw Jessica and Sharon as the experienced clinicians. Along these lines, a participant who was affected by the modality clashes expressed in the survey, “I feel like the facilitator was not qualified to run this group because she didn’t know us, or our families” (WK1, CL5).

The next exercise I facilitated was family sculpting. One of the clients volunteered to sculpt his family. When I instructed him to include his addiction as a character, he seemed confused at first but seemed to understand better as I explained a bit further. At first, he did not take the exercise too seriously. But as he got more involved in the exercise and other participants began taking on their roles, he

became more serious. This exercise allowed a large group of participants to get involved and interact with each other, which was useful for the group as a whole.

The goal of the next exercise was to explore family recovery. I had the group brainstorm a few desirable aspects of family recovery. Then I instructed the group to break off into individual family groups and answer several questions. The participants did not seem to get into it. I realized my questions may have been too solution-focused, considering the dynamics of the group and the fact that they were not there yet. One client made mention of this, suggesting that I should incorporate “more real topics → ‘heavier’” (WK1, CL6), which was a suggestion I took seriously and changed in Weekend Two.

The last exercise of the day, *Learning From Slips*, went okay. The participants were able to appreciate talking about relapses as slips, and our discussion about the exercise went well. However, when I broke families up into individual groups, clients were confused about the questions I presented. For example, one of the questions asked what other family members could do to help prevent the slip from occurring. Most clients reported that it was their recovery program, so there was nothing their families could do.

Insights about Day Two. Although some of the Day Two exercises were not impactful, others were (CG17; PJ, pp. 28-29, 30). I felt that the second day went better than the first, and the participants seemed to agree. One participant reported, “Day 2 was much better. Much more beneficial. Much more open communication” (WK1, CL6). Despite all my reservations about the weekend, eight of 28 participants reported that the weekend opened their communication. A greater sense

of communication was a response that held constant across all three weekends and was mentioned in the pre-treatment change questionnaires as something participants hoped to be different and desired to work on during the weekend to feel their time was well spent (TH14; WK1: CL1, CL2, CL3, CL6, FM1, FM2, FM4, FM8, FM7; WK2: CL1, CL2, CL3, CL9, FM5, FM7; WK3: CL1, CL4, CL3, CL5, FM1, FM2, FM4).

On Day Two, three group processes unfolded that were not present on Day One. The group members interacted with each other in a meaningful way (CG19; SVM8, p. 1; PJ, pp. 23, 28-30,); some of the exercises appeared to have an impact on participants (CG18; PJ, pp. 29-30); and some change occurred, even on the smallest level (CG16; PJ, p. 28). For example, one participant spoke about the family weekend as having made “some progress” (WK1, CL5). Furthermore, I observed some shifts on Day Two in the way participants oriented to themselves and others. Some participants indicated that the family weekend would make a difference in the future, because they “opened up more than usual” (WK1, FM7); other expressed the belief that “it will continue to bring us closer and fix our communication” (WK1, CL2), and still others indicated the importance of “experiencing how to deal with the addiction and how to deal with the family” (WK1, CL4).

The second day went better for multiple reasons. I did not walk into a room full of complete strangers and made an effort to focus on joining, which led me to feel more comfortable than I had the previous day. The issue with Jessica and Sharon was resolved because I spoke up through e-mail instead of staying quiet.

Lastly, my solution-focused demeanor made an impact on some participants. They confirmed this by stating that their expectations were met, because “it was different. I think it was very positive” (WK1, FM5). Another person said “very much so, very encouraging!” (WK1, CL4). Another family member said the weekend would make a difference, because they hoped “to have a more optimistic approach to recovery” (WK1, FM2). Whether it was family members shifting to respond differently to their loved one’s recovery process or clients “growing a lot in my recovery and understanding” (WK2 CL9), several participants mentioned the positive impact of the program on clients’ recovery process in the surveys I collected within all three weekends (TH17; WK1: FM2; WK2: CL5, CL9; WK3: CL1). Additionally, participants indicated in the pre-treatment change questionnaires that they hoped their or their loved one’s recovery process would be positively affected by the family weekends.

Even though participants’ survey responses were more positive on Day Two, my inability to turn off my curiosity was a problem I encountered while facilitating multiple family groups. After one family spoke, I carried the conversation on for too long, because I was eager to learn more about the dynamics of their system. When working with only one family in the room, this is a useful skill. However, when balancing the dynamics of multiple families in one group, the inability to move on to other families becomes problematic. A family member mentioned this as something I could have done differently on an evaluation survey, stating, “Some clients went off on tangents—wish she could have moved things on in some cases so we could concentrate on others and not just me and 2 clients” (WK1, FM1). The

issue of managing time for each family came up in my supervision session, and Douglas cautioned me, “And they are going to be looking at your confidence to help this person not dominate and doing it respectfully.” (SVM5, p. 11).

After the second day of Weekend One, I met with Sharon and Dr. Smith to discuss the details of my transition into the system as a full-time employee. I walked away from the weekend feeling more optimistic than I had at the end of Day One. However, I recognized that I had a long way to go in gaining confidence about facilitating multiple family groups (FCG13; PJ, pp. 21, 23, 31). I began thinking about the changes I needed to make for Weekend Two and found myself looking forward to developing closer relationships with co-workers and clients as a full-time employee.

Between Weekend One and Weekend Two

A few days after I facilitated Weekend One, I met with Sharon and Dr. Smith to discuss the outcome of the weekend. They provided me with suggestions to be less didactic and include more experiential exercises since the only experiential exercise I facilitated in Weekend One was family sculpting. The rest of the exercises failed to include any experiential elements, only solution-focused questioning I posed to families in the context of their individual family groups or the entire group. I took Sharon and Dr. Smith’s suggestions seriously and used it as helpful feedback about what to change in Weekend Two.

As I was setting up my office, I saw the client who participated in the sculpting exercise. He pulled me aside, thanked me for giving him the opportunity to participate in the activity, and told me he felt better. It was reassuring to receive

the compliment, since it was my first time facilitating a family sculpting exercise and was unsure what to expect. I utilized this client's feedback as an indicator that I had facilitated the exercise in a useful manner and could continue to facilitate the exercise in a similar way for the remainder of the weekends.

I began to settle into the system, feeling a greater sense of comfort (FCG21; SVM9, p. 10; PJ, pp. 34, 36, 38-39, 44), and I slowly started letting my guard down with some of my co-workers (FCG24; SVM9, p. 11; PJ, pp. 31, 33). Every morning, members of the staff met to establish which groups which would be facilitated that day by which therapists, and to discuss problematic clients. Although I was beginning to feel a greater sense of comfort around other staff members, I remained quiet in morning meetings, despite having many thoughts. While I had begun to open up to some staff members outside of the meetings, within them I remained guarded. I had difficulty expressing my opinions about problematic clients, because they contrasted so much with what the other staff members thought was helpful. Most of the staff were in long-term recovery, and those who were not followed disease-based assumptions about treatment. The staff who attended the morning meetings were wonderful and well-meaning clinicians, nurses, and case managers. However, since I already dealt with others perceiving me as inexperienced, I believed that expressing my opinion would only further their view of me as incompetent. As a result, I had two internal feelings going into Weekend Two: I felt that the other staff would never understand what I had to offer therapeutically (CG23; PJ, pp. 31-34), and believed I could not speak to others from an orientation that does not view addiction as a disease (CG28; SVM9, p. 1).

For the most part, the staff members were also warming up to me (FCG23; SVM9, pp. 1, 11; PJ, pp. 31-33), but some remained guarded (CG22; PJ, pp. 31-32, 39); I dealt with those people by avoiding them. Sharon and I were getting along well, and she seemed to appreciate the times I went out of my way to help the company. For example, less than a month after being hired to work there, a hurricane hit. I continued to show up for work with a helpful attitude, which differed from how many other staff members dealt with it. Most clients were from out of town, had never experienced a hurricane, and were fearful, so my approach was appreciated.

Another time I went out of my way to support the system happened when a therapist took off for two weeks and I took over the caseload. I worked hard to show everyone in the system that I was a dedicated worker who truly cared about my clients; I believe this helped with my process of integration. Maintaining a respectful, friendly orientation allowed some of my colleagues to trust me and, therefore, begin establishing a positive working relationship with me.

As I prepared for Weekend Two, I felt moderate anxiety (CG20; SVM8, p. 2; SVM9, p. 1, 5; PJ, pp. 31, 34, 37). It was understood that I was the group facilitator for the family weekends; however, I needed at least one other therapist to be present in the building. Since it would be impossible for me to attend to the group while also addressing individual issues as they arose, I needed another therapist to assist me; however, I was unsure who that therapist would be.

My goal for Weekend Two was to change what had not worked in Weekend One, based on the feedback from the surveys, the staff, and my personal observations. For

Weekend Two, I committed to giving greater attention to problems, as I had discussed in my supervision session with Douglas:

I am a little nervous. Uhm, I feel, (sigh) that I need to involve more problem talk in a sense. . . . I feel like I jumped into, like, solution building too much and, uhm, my whole thing is strength, you know solution; but I can be solution-focused and allow people to still talk about the pain in a sense. (SVM8, p. 2)

Furthermore, I desired to move the exercises along more quickly, in order to give attention to all of the families. I also rearranged those group exercises that had not seemed impactful for the participants.

Prior to Weekend Two, an alumnus of Sober Heaven, who was also an employee at the facility, approached me to volunteer himself as a guest speaker during the weekends, as he had done during the weekends that Jessica facilitated. He was a member of a 12-Step self-help group and was employed by the facility to help clients from his own experiences with addiction. He took clients to meetings and emphasized the value of 12-Step support groups. Additionally, he monitored a Facebook support page for family members who attended previous family weekends. He offered this as a resource to utilize in my family weekends. I thanked him and agreed to allow him to come into the weekends under the condition that the participants provided their consent. I held off on giving him an answer about the Facebook support page, because I wanted to discuss the idea with Douglas first. I knew there were many ethical issues to consider when using social media.

Reflecting back, I should have discussed both ideas— the guest speaker and Facebook support page—with Douglas, because the speaker's philosophy did not

correspond with the philosophies I was promoting during the rest of the weekend.

Douglas brought this to my attention during our conversation:

Douglas: And what about the disjunction between the approach that is going on during the week and what the weekend is going to look like? Is that going to be a problem for them or for you?

Sandra: What? I'm not understanding.

Douglas: Well, during the week they are in a pathology-based system of calling them out, and the weekend is. . .

Sandra: . . . is not

Douglas: . . . quite different than that. So the question is, uhm, well it is not a question. It is an issue for you to address. What is the larger treatment context of you offering these weekends, and how does that contrast, set off, what you are doing? Help it feel so even more refreshing. In other words, what is, or how is, it potentially limited by virtue of what is happening in the treatment overall? So, for you to recognize what is the culture within which you are offering this.

Although we discussed this challenge in multiple supervision meetings, it did not take hold until after Weekend Two, when I read an evaluation survey in which a participant responded, to the question of what I could do differently with, "To help us grow" (WK2, CL3). For this particular client, "growth" meant facing complex emotions, healing from traumas through emotional expression about the past, and confronting others about their negative character defects. Other survey responses from participants revealed that they defined growth in a similar matter. One family member said their expectations were met, because the weekend was ". . .very emotional—very helpful"

(WK2, FM6); another said their expectations were exceeded, because it was “very emotional” (WK2, FM1). One of the participants reported that the family sculpting exercise was the most meaningful aspect of the weekend, because it “. . . gave great exposure to the problems we face in the past” (WK2, CL3). All of the survey responses were embedded in a disease-based orientation about what is most helpful for substance misusers.

I thought I could walk into the weekends, offer participants something different, and be appreciated for the work I was doing. Through this process, I learned that my expectations were inaccurate, and by holding them, I was creating a division between the treatment experience during the weekends and what happened for them during the week (CG30; SVM9, pp. 2-4, 6, 9; PJ, p. 39). It was important for me to consider every decision I made regarding the weekends in the larger context of the treatment facility, keeping in mind how differences in therapeutic orientation could potentially limit my impact, such as what happened when my co-therapists operated from an epistemology that differed from mine. When the staff member approached me about coming into Weekend Two as a guest speaker, I should have considered the orientation he was operating from before making my decision. But although I failed to take this into consideration, I was mindful about potential theoretical clashes when it came to deciding who would help me with the weekends.

For a considerable amount of time prior to Weekend Two, I remained unsure about who was going to help me. Jessica had made it clear that she did not prefer to interfere, since we came from two different theoretical orientations. Reflecting back, I can see that this was for the best. One day, another therapist approached me and

offered to help with Weekend Two. I accepted the offer but still had concerns, because like the other therapists in the facility, she operated from a disease-based view of addiction. To address the discrepancies in our perspectives, I told her I wanted to meet prior to the weekend so that she and I would be on the same page.

A few days later, I held a meeting with the therapist. I was nervous about how it would go, because I did not anticipate that she would be open-minded about a different way of working with substance misusers and their families, especially considering that she was in long-term recovery herself. My assumptions were wrong. I began the conversation thanking her for supporting me with the weekend. I explained my solution-focused orientation and distinguished it from the reality she was coming from—something I failed to do when I initially met with the staff prior to Weekend One. I knew this particular therapist came from a 12-Step orientation but also utilized practices from the Motivational Interviewing (MI) approach. She promoted the 12 Steps to her clients and believed in the program because she had successfully been through it herself, and it had saved her life. However, she did not practice too much confrontation with her clients and approached them from a more empathic stance. Therefore, we shared a therapeutic similarity, both upholding empathy as a cornerstone of our approach.

Despite our similar therapeutic orientations, this therapist and I utilized different therapeutic modalities. Knowing this, I did not begin our conversation saying that I was going to facilitate the weekend from an entirely different modality than hers. Instead, I began talking about SFBT within the context of a modality she trusted. Knowing that MI and SFBT share commonalities, I compared the two

approaches then juxtaposed them, in order to create a context in which she, like the clients, could expect things to be different. As a result, she understood how I wanted the weekend to take shape. She reassured me that she would be there to support me with whatever I needed and attend to any client issues that might arise.

From that moment on, she was the therapist who helped me with the family weekends, and we developed a positive working relationship. Furthermore, we even worked together on client cases outside of the family weekends. Though her orientation was disease-based, and we could have easily clashed in our theoretical beliefs about addiction, we found a way to collaborate successfully. I am sure it helped in my process of integration that she was a naturally supportive person.

Weekend Two

Day One

On October 28, 2017, I facilitated the second family weekend (Appendix H). A total of 19 participants were present during the weekend, a larger group compared to Weekend One. Prior to the weekend beginning, I felt nervous. However, it was the type of nervousness I get when I meet new people. Unlike what I felt going into the first weekend, this nervousness was not debilitating and did not cost me a night's rest. Some of the participants were strangers to me, and some were clients I had worked with in other groups. This made all the difference. I felt confident as a group facilitator, because many of the clients already trusted my therapeutic work, and I did not have to work so hard for them to believe I could be helpful. Nevertheless, I still had to gain the trust of the group, because the family members did not know me or my work.

I decided to start with the same icebreaker I led with in Weekend One. Although I received some “I don’t know” responses in Weekend One, other participants responded in a way that seemed to open up the group. Therefore, I figured I would try the exercise one more time and, if the same thing happened, would decide not to include it in Weekend Three. I got a better response to this exercise in Weekend Two, and every participant answered the question in a sincere way.

For the next exercise, I played a short video again but this time, presented new content in order to avoid the issue of my providing perceived wrong information, which I encountered in Weekend One. The video was extremely useful. During my discussion with the participants after viewing it, family members began speaking from a place of compassion, which was one of the goals I hoped to achieve during the weekends. Participants confirmed this by reporting on the questionnaires that the weekend would make a difference in the future, writing things like, “Yes, tools to be used in the future, compassion, forgiveness and boundaries” (WK2, FM3), “Yes, compassion possibly ☺” (WK2, FM7), “Yes, understanding addiction. How to be supportive. Knowing that compassion & love is what an addict needs most” (WK2, FM3), and, “Yes, I think my family and I will be able to have these different life perspectives and continue to embrace gratitude and compassion towards each other” (WK2, CL2). The exercise also seemed to open up a sense of understanding among the families about the substance misusers’ problems and the way they relate to them. Furthermore, the participants indicated an increased sense

of understanding in all three weekends (TH18; WK1: CL3, CL4; WK2: CL1, CL3, CL9, CL10, FM3; WK3: CL1, CL2, CL3, FM1, FM6).

Marrying solution-focused therapy with the 12 steps. The next exercise I facilitated was about codependency. I chose not to use any of the ideas from my supervision sessions during the group discussion about codependency, because I did not feel there was a place for my resource-oriented perspective. Since I observed some family members appear enlightened by hearing about a pathological view of codependency, I was convinced that a resource-oriented approach would be unhelpful. Additionally, after looking over the survey responses in which many participants referred to Jessica and Sharon's codependency exercise as the most significant event occurring in Weekend One, my optimism for a resource-oriented codependency discussion was at an all-time low. I assumed that participants liked being pathologized. However, reflecting back, I can see that my lack of success in facilitating a resource-oriented codependency discussion had to do with integration issues, not with families preferring pathological discussions about codependency. Not realizing this at the time, I tried thinking about how I could change the activity to make the exercise go more smoothly in Weekend Two. I looked over the evaluation surveys to utilize the feedback about what I could do differently. One of the participants from Weekend One expressed a desire to learn more about codependency. In all three weekends, an increased sense of learning was reported as meeting participants' expectations and making a difference for them in the future (TH21; WK1: CL1, CL4, CL5, CL6, FM4, FM5, FM6; WK2: CL3, CL8, CL9, FM1, FM2, FM4, FM5, FM7; WK3: FM3, FM5, FM6).

According to the participants' survey responses, an increased sense of learning resulted from the group topics, learning from other participants, or learning about themselves. For example, one participant reported, "Yes I always wanted to be able to discuss our trials. I learned from the perspective of the clients which I was hoping for" (WK3, FM5), while another stated, "Yes, taking what I learned into practice" (WK1, CL6). Two other participants reported, "Yes, we learned new things and are closer because of this experience" (WK2, FM4), and "Yes, so far I have learned so much that I never knew before" (WK2, FM1). Additionally, one client stated that they "learned how to talk to our loved ones" (WK2, CL8) and another reported, "Yes I learned a new explanation of a slip" (WK3, FM3).

Although I did not have the feedback from weekends two or three when facilitating the second weekend, participants had mentioned learning as valuable in the evaluation surveys I had collected up to that point. As a result, I wanted to facilitate a sense of learning among the members of the group. My way of meeting participants' desire to learn was by providing direct, rather than experiential learning; I turned the codependency exercise into a psychoeducational exercise.

I found a PowerPoint presentation that I had previously utilized in the codependency groups I used to facilitate at my previous job and used it to conduct a psychoeducational group on codependency in Weekend Two. I felt confident about the information in the PowerPoint, because I had been utilizing it for two years prior to getting hired at Sober Heaven. I knew I would not become stuck like I did in Weekend One, because I had presented the same material countless times before. But though I felt confident about the content of the PowerPoint, I did not feel

confident about pathologizing families. As a result, a few problematic issues arose during my process of integration in Weekend Two. I played it safe by conforming to the beliefs of the larger treatment system (FCG20; SVM9, p. 10; PJ, pp. 34-36, 40, 42, 44), and I tried to fit two opposing theoretical concepts into one box (CG31; SVM9, pp. 5-6), which resulted in an unsuccessful integration of SFBT for some of the exercises in Weekend Two (CG24; SVM9, p. 3; PJ, pp. 37, 39).

I talked about codependency in a way that went against my therapeutic beliefs while at the same time remaining consistent with those beliefs. For example, I did not confront or call anyone out on their enabling behavior. If a family member had concerns about codependent behavior, I normalized the behavior in the context of that particular family. I discussed codependency as a relational phenomenon, emphasizing the *co* part, since many participants framed codependency as being the problem of only one individual. Yet, I also defined terms related to codependency, such as enabling, and spoke about boundaries using traditional codependency-related language. At the same time, I made it clear that there was no scientific basis for this term. On one hand, I was promoting concepts of codependency; on the other, I was denying codependency as a respected term. This created a lack of theoretical coherence in the way I discussed the topic.

In the supervision session that followed Weekend Two, my continued struggles with integrating a resource-oriented codependency conversation came up as a problem in my conversation with Douglas:

Sandra: . . . and trying to find it to fit, you know, without getting frustrated, trying to maintain my motivation, can be difficult. I am trying to figure it out, I

mean, I am constantly trying to figure out how can I combine this all? How can I marry this and respect everything I am working with? (SVM9, p. 5)

Douglas helped me recognize that I did not need to “marry” or “fit” systemic and disease-based thinking into one box. He explained, “If you are trying to fit it in, it can be exhausting and probably feel pretty hopeless, because there is such a different set of assumptions” (SVM9, p. 5). The hopelessness Douglas talked about is reflected in my personal journal entries, where I referred to the codependency exercise as “meaningless” (PJ, p. 42); I felt the same sense of self-doubt about some of the other exercises I facilitated in Weekend Two (CG26; PJ, pp. 35, 42-43). But Douglas suggested that I could offer “a way it doesn’t have to mesh in order for it be helpful. You just have to think like a therapist not only with your clients but all of your colleagues and boss” (SVM9, p. 6). As a result of that suggestion, and from that point on, I let go of the idea that I had to combine two different realities into one.

After providing education about codependency in Weekend Two, I provided a handout that coincided with a codependency concept regarding the effort to control others. I created the handout based on an article I read in *Tiny Buddha*, a website that sends weekly emails about Buddhist ideas pertaining to mental health issues, such as depression and anxiety. I felt that the article explained ideas about controlling behavior in a way that made great sense to me. However, reflecting back, I am unsure how it came across to others. Since I had talked about letting go in a Buddhist context with previous clients and noticed them gain an appreciation

for the way the term was discussed, I figured I would try it out within the context of the multiple family groups.

I gave each participant the handout about the Buddhist concept of letting go and invited them to read it by going around the circle and giving each person a turn to read. Afterward, I facilitated a group discussion about participants' reactions to the reading. The participants did not seem too dissatisfied, but they also did not respond as enthusiastically as I thought they would. Furthermore, including an additional codependency activity prolonged the exercise, leaving me with only enough time to facilitate one other exercise that day. Reflecting back, I feel as though I digressed in my therapeutic skills by using a sheet of paper as a therapeutic exercise.

Since I believe time is better spent facilitating experiential activities rather than instructing participants through educational learning, I believe the psychoeducational codependency exercise went poorly. However, some of the participants reported that their expectations were met due to the informative nature of the second weekend. For example, one family member expressed, "The session was very informative exceeding my expectations" (WK2, FM4). Another family member reported that I could not have done anything differently, stating, "No, she did an amazing job!! Very informative" (WK2, FM3). Furthermore, participants across all three weekends reported that the weekend was significant because the information they got was informative and in line with their hopes and expectations (TH19; WK1: CL1, CL4, CL5; WK2: FM3, FM4, FM8, SM2, WK3: FM3, FM4, FM5, FM6, SM2, SM3).

For the last exercise of the day in Weekend Two, I facilitated the same exercise I incorporated in Weekend One, which I thought was impactful; I explored the families' ideas about what they knew about each other that kept them hanging in there. Again, the exercise turned out to be pretty meaningful, leading to positive shifts in group dynamics.

Reflections about Day One. At the end of Day One on Weekend Two, I felt much better about how things went compared to how I felt on Day One in Weekend One. As a result, I experienced two shifts in the way I related to myself as a group facilitator. I was more engaged and active within the group discussions (CJ21 PJ, p. 39, 42), and I was beginning to learn how to manage multiple families in the context of a group (FCG25; SVM9, p. 1; SVM10, p. 2; PJ, pp. 34, 37, 39, 41-43). The families seemed to feel this, too, as reflected in their survey responses at the end of Day One: “she worked it very well” (WK2, FM1); “she did an exceptional job at facilitating the session” (WK2, FM4); “she was great, dialogue was open & truthful” (WK2, FM5); “Yes, Sandra is great at explaining & letting others talk & express their thoughts and feelings (WK2, FM3). Clients’ survey responses consisted of similar feedback; “I thought it was perfect” (WK2, CL4); “She did very well, she helped mediate when needed and kept everyone on” (WK2, CL8); “Group ran smoothly, time ran fast. Thank you” (WK2, CL9); and lastly, “I think Sandra did wonderful, wouldn’t change a thing” (WK2, CL7).

Despite receiving positive feedback from multiple participants, I remained dissatisfied. I felt confident as a group facilitator for multiple families, but not as a *solution-focused* group facilitator for multiple families. I did not believe I had

successfully integrated SFBT into the weekend, especially considering that the codependency exercise was built upon a disease-based discussion. Furthermore, the morning activity I facilitated prior to conducting the codependency exercise reflected assumptions from a solution-focused perspective of addiction, presenting a challenging theoretical contrast. Instead of being “too solution-focused” in Weekend Two, I was bouncing back and forth between a solution-focused and disease-based orientation (FCG28; SVM9, p. 1, 5, 10; SVM10, p. 2; PJ, pp. 35, 43-44).

Day Two

I began the second day of Weekend Two similarly to the second day of Weekend One, inviting participants to discuss their outings with their families the previous night. Each family reported positive experiences, which led into the next exercise about strengths within families. Participants responded positively to the exercise, and it opened up an emotional, yet strength-based conversation. Reflecting back, I was able to think more clearly about strength-based exercises that would be impactful for participants in Weekends One and Two. Of course, every strength-based exercise had the potential to make an impact, if only I had played closer attention to group dynamics and my process of integration. For example, when I was planning the weekend and selecting which exercises to facilitate, Douglas provided me with a piece of advice about incorporating strength-based activities:

. . . if you have this mindset: “When I asked them to do something, what can I establish ahead of time as parameters and establish safety, so that when they go off to do it they won’t play it safe by simply talking about the stuff they know, that they will actually go with me and do something and take a

step in doing something different. Uhm, and that they won't discover what they already know and they would be willing to take a risk of trying something different." So then we got, trust me enough, trust themselves enough, trust each other enough to be vulnerable. Nobody loses face, nobody is wrong and that possibilities for discovering and recognizing that some people will be cynical, some people will be hopeful and not setting yourself up to be criticized by someone who is cynical. (SVM4, p. 14)

I continued to wonder about how some strength-based exercises appeared to work, even when I did not have the full trust of the group in Weekend One. I came to an epiphany when I analyzed the data and concluded that participants valued the expression of emotion, whether positive or negative.

Survey responses indicated that the participants' expectations were met, and they had a significant experience characterized by positive emotion. For example, one family member reported, "Yes, definitely, it was great. People were filled with emotion, strength and hope. . ." (WK2, FM5), while another family member indicated that the most meaningful part of the weekend was "hearing your loved one admit what is important to him! But most important the love of his family" (WK2, FM8). Another client reported that their expectations were met, because they could see the "glow" in their family member's eyes (WK2, CL7). One client reported significance within the weekend, relating it to "letting our family know we love them" (WK2, CL6). Others shared, "that I was reminded how much I mean to my mother . . ." (WK2, CL7); "My father expressing emotions and saying positive affirmations" (WK2, CL4); and "Communication used with love" (WK2, CL1). One

participant indicated that what was most significant was “that all the families came so far and stopped everything to be here for their loved one” (WK2, CL8), which corresponds with a solution-focused concept I often emphasized throughout the weekends.

Prior to breaking off for lunch, the staff member who asked to be a guest speaker joined the group and spoke with the participants, facilitating a hopeful discussion about recovery. He was already highly respected by many of the clients, so he had no problem gaining the trust of the group. Although the conversation went positively and he highlighted the importance of family work, he also emphasized 12-Step and Al-Anon meetings as a necessary component of family recovery, asserting that without those support groups, successful recovery would be unlikely. This contrasted significantly with what I was promoting throughout the weekend, making Douglas’s concerns about incorporating a 12-Step guest speaker much more understandable.

Being innovative. The remainder of the day was intense but creative, since I came up with an experiential exercise in the moment. In Weekend Two, my anxiety was not so high as to prohibit me from experimenting (FCG29; SVM9, p. 11; PJ, pp. 35, 44). I felt a sense of accomplishment, because I was embracing the lessons I learned from Douglas in supervision about being open to experimentation.

After lunch, I facilitated two experiential exercises. The first was family sculpting, which I had planned to facilitate before lunch, but ran out of time. The second was an unplanned creative experiment. In the family sculpting exercise, a participant who described a past marked by multiple traumas and unstable

relationships volunteered to share her experience in the exercise. The group was interactive, and everyone was involved with each other in some way or another, whether by playing one of the characters or contributing to the group discussion thereafter.

I kept noticing the reactions of that particular client, especially during the family sculpting exercise. I knew the client valued 12-Step treatment, because his primary therapist had been in recovery for over 20 years, and they shared a great therapeutic relationship. In other groups outside of the weekends, I had observed this client promoting concepts such as tough love and confrontation. Therefore, I was drawn to his reactions, paying close attention to the differences in how he responded to the strength-based exercises versus exercises more emotional in nature. I knew my process of integration would be more challenging with a client whose ideas about how I could be helpful differed from my own.

I noticed that the client showed greater interest in the experiential exercises, which involved more emotional expression. During other strength-based exercises that involved less emotional expression, he made it obvious through his facial expressions and body language that his enthusiasm was low. He would regularly cross his arms, roll his eyes, and respond poorly to any material he did not prefer. I was bothered by this, because it reconfirmed my ideas about feeling unsuccessful as a solution-focused multiple family group facilitator. I realized I still had work to do in order to effectively integrate the solution-focused model into the weekends. I presented my observations to Douglas in our next supervision session, and he brought up a good point:

Douglas: The work that you're doing is in keeping with what their philosophy is?

Sandra: In my individual sessions?

Douglas: Yeah, whatever you are doing during the week. Whatever your responsibilities are during the week, they would look at you and say, "Sandra is, uhm, doing good rehab work as part of our approach."

Sandra: I would say so.

Douglas: So, then you're contrasting your during-the-week job, which is to provide services in the model that they prefer, and the weekend. There is a contrast.

Sandra: Yeah, but even in my own individual sessions, I don't place a heavy emphasis on just processing emotion.

Douglas: Okay.

Sandra: I am still kind of doing my own thing in a sense, so it is not too much of a . . . you know what I mean, because . . .

Douglas: It is not too much for those of them who have you as their primary therapist.

Sandra: Exactly, yeah.

Douglas: But for the other ones, it might be. (SVM9, p. 2)

The client who only reacted positively to the experimental exercises serves as a good example of the lesson Douglas was trying to instill; the theoretical contrast was too much for him. Furthermore, this lesson was reflected in my relationship with the staff as well. When asked what could be improved about the weekend, one

staff member responded, “More experiential interaction, role playing etc.” (WK2, ST2). To respond to this challenge, Douglas suggested that I create a context for difference—in other words, a context for the “expectation that they are going to get something out of it, and it will perhaps defy their expectations of about what they think is necessary for them to learn how to be sober” (SVM9, p. 4).

The next unplanned experiential exercise had elements of what participants thought was necessary for their growth, as well as elements of SFBT. I created this exercise based on what I learned in Weekend One, which was to honor participants’ problems before I began collaborating with them on solutions. I named the activity the Empty Chair/Reenactment Exercise, which I also used during the subsequent weekend. The first client to volunteer for the exercise presented with a history of neglect in the relationship with his mother. He told the group he had not spoken to his mother in years after he was left unsupervised multiple times at a bar as young child. Another member of the group volunteered to play the role of his mother. I instructed the client and stand-in mother to sit across from each other in the middle of the group circle so that other group members could witness what was transpiring between them.

The client at the center of the exercise rocked back and forth and repeatedly asked, “Why?” as he sobbed uncontrollably. It was as if his own mother was right in front of him, yet it was also different at the same time. The stand-in mother was everything his mother had not been; she expressed empathy to comfort his tremendous emotional pain and attempted to give him the apology he never received. The more she apologized, the more he refused to accept it. He continued to

act out in anger toward her attempts to apologize, but eventually calmed down. It was almost as if an award-winning movie were playing in the middle of the group. The observing participants stared intently at the client as his pain unfolded right in front of them. I utilized empathy to explore the problem and ended by experientially exploring what needed to happen for the client to take the smallest step forward in shifting the pain regarding his mother.

Some group facilitators may have deemed this exercise unsuccessful, because the client never accepted his stand-in mother's apology. However, I recognized that it was not safe for him to accept an apology, as this would be too big a step. I did not force the apology and instead continued leading the conversation from the place he was at, respecting his emotions and using empathic statements while taking care not to move the conversation toward solutions before he was ready. I allowed his pain to be what it was and, once I noticed a shift in his emotionality, followed his lead and directed the conversation into a discussion about what the stand-in mother could do to help transform his pain.

Although the exercise was highly emotional like the previous exercise (CG25; SVM9, p. 1; PJ, pp. 36, 38-39), I did not lose my solution-focused identity while facilitating it. I worked with him in very small steps abiding the SFBT idea that small shifts can lead to bigger changes. I placed the client at the center of his experience and worked within the emotional reality he was living. I also did not tell him he needed to accept the apology or do anything in particular within his interactions with the stand-in mother. Instead, I allowed him to become the expert in

the relationship; if that meant him choosing not to accept an apology, then that was okay because it meant an apology wasn't the solution that would work for him.

I followed the theoretical assumption grounded in Douglas's ideas about separation and connection, rather than in notions about the repression of emotions. My therapeutic goal in the highly emotionally charged exercise was to connect him with the pain causing him to separate from himself by drinking to the point of blackout for the majority of his life, riding home in ambulances without knowing how he got there, and going through countless other scary experiences as a result of being disconnected from himself. Flemons (1991) states:

A distinction does create a boundary which divides, but that self-same boundary simultaneously and irrevocably *connects* that which it separates. Blindness to this simple realization characterizes not only our tragic relationship to each other and our world, but also our relationship to ourselves. (p. 29)

Theoretically, I was staying true to my therapeutic identity, because the high emotional expression in the exercise was derived from ideas about separation/connection. I was also providing treatment to clients in the ways they believed to be most helpful. Because there was a strong emotional undertone to this exercise, it fit for them and I found a way for it to fit for me too. The exercise did not constitute more of the same, because I ended it by exploring what needed to be different in order for the client to take the smallest steps out of the pain and into a more hopeful future. I slowly transitioned the enactment into a solution-oriented enactment. Although he could not look the stand-in mother in the eye, accept her

apology, or give her a hug, he did shake her hand. In my view, this was a metaphorical shaking hands with the pain he so desperately tried to disconnect from, which contributed to the tragic relationship he had with himself.

Although the client did not walk away from the exercise stating, “I’m all healed and am going to call my mother tomorrow!” he did walk away from the exercise feeling a little less angry than before. A few days later, he knocked on my office door to thank me, sharing that he felt a sense of relief, as if a heavy weight had been lifted off his shoulders. I may not have fixed the relationship with his mother, but I did help facilitate some shift in the way he was relating to the pain, so that the relationship no longer imposed the same heaviness on him that it had previously. I created a context for therapeutic change to occur (FCG27; SVM9, pp. 1-2, 5; PJ, pp. 33-34, 38-39, 41-43, 47).

At this point, I experienced a shift in who I was as a therapist. Prior to this experience, I believed I was not practicing good SFBT if I placed a high emphasis on clients’ emotions, since the model emphasizes behavior over emotion. However, Kiser, Piercy, & Lipchik (1993) wrote about emotion and its place in SFBT. During the clinical project, I was influenced by traditional approaches to SFBT and didn’t take Kiser et al.’s work into account. In the beginning of the clinical project, I found myself working harder than I should to keep emotional elements out of the weekend because I felt if I emphasized emotion over behavior, I wasn’t practicing good SFBT. I always understood the therapeutic common factors and “that all successful models of therapy involve intervening in the areas of feeling, thinking and doing” (Rambo, West, Schooley, & Boyd, 2013, p. 60). However, I understood the SFBT

modality to emphasize the *doing* and *thinking* aspects of therapy over the *feeling* aspect. In retrospect, if I had had access to Kiser et al.'s work during the clinical project, I would have felt more resourceful in incorporating emotional aspects of SFBT during the weekends. Nevertheless, I came to my own epiphany during the clinical project and stopped interpreting high emotional intensity as an indicator that I was not practicing effective SFBT. I realized I could do both. In fact, it was necessary to do both, because many of the clients I worked with had a great deal of emotional pain. For me to ignore that part of their story would only reinforce the disconnected way they were relating to themselves. At the same time, I stopped basing the success of therapy on how successful clients were at expressing emotions. If emotions arose within the conversation, I worked to gain a better understanding of how I could incorporate them in a strength-based way. Although I still had a long way to go in successfully integrating SFBT into standard addiction treatment, I felt I was finally on the road to figuring it out (CG29; PJ, pp. 38, 43).

During my discussion with the group after the Empty Chair/Reenactment Exercise, I realized that it had been just as impactful for the observing group members as it had been for the client going through it. Clients and family members saw something in his story that related to their own. Whether it was a father who felt guilty for not spending enough time with his son or a client who reflected about the relationship she had with her own child, the group members were all able to relate in powerful ways.

I realized that the experience of different families coming together from various backgrounds and connecting on the basis of a common problem is

tremendously powerful and more impactful than a single group facilitator can be. I was not the only one who recognized the positive impact that the families had upon each other. Clients' survey responses indicated that their expectations were met, and they described their reasoning in a variety of ways. One participant said, “. . . I was happy to see that families have room to grow and heal” (WK2, CL7) while another wrote about the power of “families growing and healing” (WK2, CL9). One client indicated that “seeing people heal” (WK2, CL6) was the most meaningful thing to happen during the weekend. A staff member reported that the most significant thing about the weekend was that “it helped improve relationships and also gave people a chance to discuss issues . . .” (WK2, SM3) Based on this feedback, I felt I was on the way to knowing how to make a difference within the context of a multiple family group using SFBT (FCG26; PJ, pp. 34, 37-38, 41-43).

As the group members and I were processing the Empty Chair/Reenactment Exercise, Sharon stepped in and asked me, in front of the participants, if she was allowed to make comments. I gave her permission and noted that her way of relating to me was different than it had been prior to that weekend and in Weekend One. She contributed her thoughts to the discussion, which gave me some time to collect myself after the emotionally intense exercise.

The next exercise I incorporated was based upon clients' ideas about the times when they want their families' help. Although this activity did not appear to be as impactful as the other strength-based exercises, the participants did engage in it without any major issues.

The last exercise, which was about relapse, was a second attempt at an exercise I incorporated in Weekend One. This time, I reorganized the questions and asked, “What does your family need to notice when things are starting to become more challenging for you?” I framed the question this way in order for the clients and families to grasp its meaning more easily; as a result, none of the participants were confused about the wording of the question, as they had been in Weekend One.

Unfortunately, the discussion about relapse led to two clients confronting another client, who had mentioned that she wanted to smoke marijuana after treatment. The other clients claimed that her desire to smoke marijuana revealed a lack of seriousness about her recovery process. It all escalated quickly, and the next thing I knew, the confronted client had run out of the room sobbing. Although she had a pattern of leaving groups whenever she was dissatisfied with the conversation, prior to this incident, she had acted respectfully and engaged in group activities in a meaningful way with the rest of the participants.

After she left the group, clients began lecturing her mother about her “enabling” tendencies, causing her to become overwhelmed. I should have done something different in response to the confrontation, but I felt that if I did, the family members in long-term recovery would view me as ineffective. Furthermore, the client’s primary therapist was the one who had previously questioned my suitability for the company, and I assumed that if he found out I stopped participants from labeling the mother as an enabler, which according to him was necessary to break dysfunctional family patterns, he would lose even more respect for the way I worked therapeutically.

Reflecting back, I can see that although I successfully utilized SFBT in the context of some of the group exercises, the weekend also had a significant 12-Step orientation (CG27; PJ, pp. 36, 40, 47). Not only did the guest speaker promote 12-Step concepts, another father who had been in recovery for over 20 years continuously promoted 12-Step terminology throughout the weekend. He had a dominant presence, and I struggled to redirect the conversation whenever he spoke. Despite the minor successes that took place throughout Weekend Two, I still held on to fears about coming across as incompetent if I attempted to shift any conversation that advocated the 12 Steps as the gold standard for addiction treatment (FCG22; PJ, pp. 36, 40).

It was not entirely clear to me what contributed to the confrontation that took place within the group. Perhaps it was the heavy emphasis on the 12 Steps from the guest speaker and other participants, or the fact that there were problems between those particular clients prior to the weekend; or maybe it was a combination of both of those variables. Regardless of what caused the confrontation, it only added to my continued struggle with insecurities about the way my approach clashed with the views of my co-workers and clients. Feeling caught up in this insecurity, I allowed the group members to continue doing what they thought was necessary to help the confronted client and her mother. Instead of thinking about the client being targeted by the confrontation, I let my insecurities about being written off as unqualified clinician handicap me and render me silent.

The other therapist who helped me with Weekend Two was present in the room when the confrontation took place. She attended to the client who ran out the

door while I deescalated the group conflict and ended the weekend on a better note. After concluding the weekend and dismissing the group, I took the confronted client and her mother to my office to speak with them privately, because I did not feel right leaving things the way they ended. I calmed the client down further and, in response to her statements about wanting to abandon treatment and go home with her mother, convinced her that she did not have to leave. Convincing clients to stay in treatment is not part of the SFBT philosophy. However, I also had to adhere to the rules of the system I was working within. Part of my job as a clinician working for Sober Heaven was to talk clients out of leaving when they wanted to end their treatment before the date determined by their individual therapist. Since the other clients were in a van waiting for her to board so they could go back to the residential units, a tech kept coming into my office and interrupting the conversation, stating that the client needed to leave. After the client left with the tech, I sat in the office with her mother for another half hour. I helped the mother process her anxiety about the harsh feedback she had received from the two group members who confronted her daughter and her at the same time. I felt terrible for allowing the group members to come down on them the way they did. Although I was on the way to facilitating the weekends in the resource-oriented way I desired, there were still elements of Weekend Two that I was dissatisfied with and eager to change in Weekend Three.

Between Weekend Two and Weekend Three

As I prepared for Weekend Three, I continued to develop relationships with my co-workers, just as I had done prior to Weekend Two. I also began to develop a sense of trust in my co-workers (FCG33; SVM9: p. 10; SVM11: p. 1; PJ, p. 54).

Although they had no idea about my internal struggles with our philosophical clashes, it was not until Weekend Three that I began to develop a sense of appreciation for what they could offer therapeutically (CG35; SVM11: p. 1; PJ, p. 54). Prior to Weekend Three, I had a *me versus them* orientation. In other words, what mattered most to me was which therapeutic modality worked better. By Weekend Three, I genuinely began to recognize that each therapeutic modality had something to offer in its own way.

As a systemic thinker, I was taught and trained for many years to appreciate all aspects of a system. But despite being aware that I was supposed to think this way, I struggled to embrace the system of standard addiction care. Although I still view the addiction treatment system as flawed to this day, by the end of Weekend Three, I saw what other co-workers could offer to their clients. In Weekend Three, I utilized the differences in the therapeutic approaches between my co-workers and me as an opportunity to enhance my craft as a systemic thinker instead of letting myself be intimidated by those differences, as I had done prior to Weekend Three.

In Weekend Three, I also began to feel accepted into the system. I established a stable work routine and saw clients in individual therapy while planning family weekends for the end of each month. I met with Sharon on November 25, 2017, to set a date for Weekend Three. Deciding that it would be best to schedule it between Thanksgiving and Christmas, we set the dates for December 9 and 10, 2017.

I started to make changes and refinements in preparation for Weekend Three. Five families committed to attending the family weekend, but as the holidays got

closer, three of them canceled due to holiday travel plans. The other two families were eager to attend, but the administrative staff advised me to cancel the weekend and invite the families to the next one. On December 8, 2017, I contacted the families and let them know I had to cancel due to the holidays. They were understanding, and I assured them that I would reach out again in January.

Systemic Transformations

On December 29, 2017, I received distressing news. I was called into a meeting by Sharon, who informed me that due to financial struggles within the company, new investors would be taking over effective January 31, 2018. The new owners entered the system with a different clinical vision, which caused concern among all of the therapists and employees; some staff members began losing their jobs. I was one of the staff members who lost a full-time position in the company. However, I did not lose my job completely; instead, I was transitioned back to part-time in order to keep facilitating the family weekends. After the investors took over, the work environment was marked by a sense of uneasiness (CG42; SVM11: p. 1; PJ, pp. 46, 54). Despite staff members' anxiety about the survival of the system (FCG31; SVM10, p. 1; PJ, pp. 45, 46), everyone came together to support each other.

One day prior to Weekend Three, a co-worker who heavily emphasized disease-based assumptions asked if I would facilitate a family session with one of his clients and the client's brother. I felt honored that he trusted me enough to work with his client and happily agreed to facilitate the session. Weekend Two had caused two important shifts in my relationships with staff members; my co-workers began

to send me referrals (CG34; PJ, p. 46, 53), and I began to feel that they respected me as a competent colleague (FCG32; SVM11: p. 1; PJ, pp. 45, 46, 54-55).

As Weekend Three approached, Sharon, whose attitude toward me had shifted the most dramatically, was let go. Once again, I felt like I was walking on eggshells and became fearful about being forced to let go of the family weekends. Fear was a constant emotion for me throughout the entire clinical project (TH2; SVM4: p. 17; SVM6: p. 8; SVM7: pp. 1, 4-5, 14; SVM8: p. 2; SVM10: p. 1; SVM11: p. 1; PJ, pp. 1, 3, 5, 7, 11, 16, 17-19, 21, 29, 30-34, 36-37, 40, 45-46, 48). In the first weekend, the fear was debilitating, and I was only able to think about how I would survive within the system. By Weekend Two, the fear started to diminish, and I began to get more comfortable. Nevertheless, I remained fearful about the way other clients and co-workers received my approach, which kept me from asserting my power within the group when the confrontation occurred. By Weekend Three, the fear escalated as I worried about losing the family weekends due to the instability within the company (CG41; PJ, pp. 45, 46).

My sense of comfort (TH4; SVM6, pp. 1-3; SVM8, p. 3; SVM9, p. 11; SVM10, p. 3; SVM11, p. 1; PJ, pp. 1, 4, 6-9, 10-11, 13-16, 19, 21, 30-31, 33-34, 36, 44, 48, 55) and trust (TH5; SVM6: pp. 1, 4-5; SVM8: pp. 1-2; SVM9: pp. 1, 11; SVM11: p. 1; PJ, pp. 5, 10-11, 14, 17, 20-23, 29-32, 34, 39, 45-46, 48, 51, 53-55) were also a consistent experience throughout the weekends. During Weekend One, I related to the system with discomfort and a lack of trust but began to feel more comfortable and trusting in the system during Weekend Two. But due to new ownership, my sense of comfort and trust once again began to diminish in the

approach to Weekend Three. In spite of my feelings toward the system, however, I was committed to facilitating Weekend Three and making improvements based on the feedback from Weekend Two.

Weekend Three

Day One

Neurological dilemmas. On January 27 and 28, 2018, I facilitated Weekend Three (See Appendix I.) There were fewer participants in the third weekend than there had been in the previous two. Thirteen participants attended on Saturday, and only eight attended on Sunday, due to scheduling conflicts.

I opened Weekend Three with the icebreaker exercise I had facilitated in the previous weekends, and it went well. For Weekend Three, any exercises which worked previously, I facilitated again. For those exercises that hadn't worked, I either dropped them or changed one or more elements to make them more useful for the participants. For the second exercise, I planned to discuss pre-treatment change questions. However, I played the same video I played in Weekend Two, since a powerful group discussion had taken place afterward. For the second time, this video was a hit, and the families seemed to embrace their substance misusing loved ones with a greater sense of compassion.

In the next exercise, which was psychoeducational in nature, I created a context for behaviors associated with active addiction by discussing the neurological effects of addiction on the brain. Throughout the clinical project, I struggled with the decision to incorporate neurological information. In my experience with family weekends at my previous place of employment, clients and family members

reported that discussions about neurological processes were very impactful. I was often told that such discussions helped family members make sense of behaviors they could not make sense of while their loved one was actively addicted. Through those discussions, families could learn about the brain areas responsible for certain human behaviors, such as logical reasoning and abstract thinking. This allowed them to take into consideration the way substances impact the brain, which could help explain some of their substance misusing family members' irrational behaviors.

I presented the information systemically by making it clear that neurological effects are just one of many variables involved in the formation of an addiction, emphasizing the concept of equifinality. Previously, clients told me it made a positive difference for them and their families to know that they did not act in hurtful ways because they were terrible people, but rather because their brains were affected by substances; therefore, I became convinced that I needed to discuss the neurological effects of addiction within the family weekends.

What I did not consider when hearing the feedback from clients at my previous job about the value of psychoeducational groups on neurological processes, was that the group facilitator at that facility was a well-respected medical doctor in both the 12-Step community and the treatment community in general. He was also in recovery himself. As a result, contextual factors contributed to the success of his groups. He did not have to gain the respect of the group members, because he was already highly regarded with a good reputation both within and outside of the community. His expertise was in neurological processes, and he was able to draw from his own experience in recovery. Unlike this doctor, I am not a neurologist and

did not have an established reputation within the Sober Heaven community; my expertise is in the area of relationships, not the brain.

However, since I had recently learned about addiction as a learning disorder, which I viewed as a more hopeful way of considering the way substances impact the brain, I wanted to experiment with the ideas and see if they would have an impact on the participants. Since participants responded compassionately to the video I played during the weekends, I wondered if explaining the neurological effects of addiction would positively contribute to their sense of compassion. My reasoning was that without recognizing the neurological processes that impact substance misusers' behavior when they are under the influence, it is easier to believe that they are terrible people who act in deliberately hurtful ways. I was passionate about helping families see something different. How could I help them reconnect with their substance misusing loved ones if they believed them to be intentionally out to hurt them? One of the ways I believed I could assist family members in shifting those destructive beliefs was to provide a scientific explanation of addiction that is commonly endorsed in disease-based theories of addiction.

I created a PowerPoint presentation for the exercise, and titled it Scientifically-Based Hope (SVM9, p. 11), based on a conversation with Douglas during one of my supervision sessions. One mother had difficulty understanding the neurological processes of the brain, as they are quite complex. Other participants appeared to appreciate and trust the knowledge I presented them, since five of them shared positive feedback about the information presented on Day One. The most significant event reported by a family member on Day One was my "explaining the

pathways” (WK3, FM4). Another family member indicated that their expectations were met by stating, “Yes! You did a good job of explaining addiction. . .” (WK3, FM4). Two other participants reported, “I felt the facilitator had great information and allowed enough time for discussion” (WK3, FM5), and “I believe it was an informative and engaging day filled with knowledge and take away thoughts very much needed” (WK3, FM6).

Although participants responded positively to the neurological exercise, a discussion arose in which a father disagreed with the scientific basis of addiction; this became a problem in Weekend Three. He believed that his son chose to have an addiction and, therefore, could choose not to have an addiction. Based on this view, he believed that his son’s hurtful behaviors in addiction were intentional. He and his son had an extremely conflictual and distant relationship. Believing in tough love, he kicked his son out of the house, rendering him homeless until he entered treatment. Despite many efforts to stop, the client continued to use drugs; his home became the streets, and his family no longer accepted him.

In a non-confrontational way, other family members attempted to help the father understand how difficult it is to stop using drugs once a severe addiction develops. I allowed the group members to intervene with the father, because I thought it would be easier for him to accept their opinions about addiction rather than the opinions of an outsider therapist he barely knew. Since no one in the group shared his view, I can imagine he felt isolated, even though none of them were abrasive toward him. My attempt at letting the group members influence the father did not work out well. His son only became increasingly upset the more he refused

to see addiction as anything other than the conscious choice he believed it to be. While I did not intend to isolate any of the group members, I also did not want the father to walk away with the same destructive beliefs he came in with, which I witnessed destroy many family relationships. I never got the chance to explore the father's beliefs further or learn about the context of his relationship with his son; he left after lunch and did not return for the rest of the weekend. In retrospect, a question such as, "How helpful has it been for you and your son to have that viewpoint?" could have started an alternative conversation and prevented me from losing a participant in Weekend Three, which had not occurred in the previous weekends.

If even a few more family members held similar beliefs as that father, the Scientifically-Based Hope activity could have ended even worse, because I would have ended up pitting family members against each other, rather than fulfilling my goal of uniting them. I learned that just because I have 12 of the original 13 participants with me, I still need to maintain the interest of the one person who is not with me. Realizing this, I gave some thought to whether I would utilize that exercise in the future (CG40; PJ, pp. 49, 51). Although, I felt a sense of growth as a therapist, which increased throughout the weekends (TH6; SVM1, p. 1; SVM6, p. 1, 3, 8, 9; SVM7, p. 29; SVM8, p. 1; SVM9, pp. 1-2, 5; SVM10, p. 3; SVM11, pp. 1, 2; PJ, pp. 13, 16-17, 21-23, 28-29, 30, 32-34, 38-39, 41-43, 46-55) and corresponded with positive shifts in how I was relating to myself (FCG30; SVM10, p. 3, PJ, pp. 48, 52, 55), I still had a lot of learning to do (CG32; PJ, p. 49).

The next activity in Weekend Three was the codependency exercise I struggled with since the start of the weekends. Up until Weekend Three, I felt dissatisfied with how the exercise had gone. During Weekend One, I completely failed to generate a resource-oriented codependency discussion. In Weekend Two, I presented information that made sense to clients, but it contained a mismatched smattering of theoretical concepts that led me to experience the group discussion as incoherent. In Weekend Three, I confidentiality discussed codependency in the way Douglas and I had spoken about it during my supervision sessions. My sense of competence regarding the codependency exercise, and regarding my place in the overall system, shifted tremendously (TH3; SVM1: p. 1; SVM6: pp. 1, 3, 9; SVM9: p. 1, 10; SVM11: p. 1; PJ, pp. 5, 13, 15-17, 19, 20-21, 28-29, 30-32, 34-37, 39-44, 47-49, 51-53, 55).

When I was planning the codependency exercise for Weekend Three, I originally planned to utilize the same PowerPoint presentation from Weekend Two, even though I, as a clinical stakeholder, defined it as a problem. Other clinical stakeholders, the clients and families who participated in Weekend Two, didn't define it as a problem. I spoke about co-dependency reflecting society's dominant discourse on this topic in Weekend Two, so it was familiar and comfortable for the participants. As a result, no major issues arose during this exercise in Weekend Two. Additionally, I felt stuck in my ability to carry out a resource-oriented conversation about co-dependency. In Weekend One, I read from a piece of paper. In Weekend Two, I promoted co-dependency concepts while at the same time making sure the participants knew there was no scientific basis to the term. So, in Weekend Three, I planned to talk about co-dependency in a traditional way without any of the contradictions. At this point in the clinical project, I wasn't confident in

carrying out a resource-oriented conversation about co-dependency due to the previous unsuccessful attempts, and I had written off resource-oriented co-dependency as impossible within this context. While discussing co-dependency in traditional terms would have satisfied the participants, it would have continued to dissatisfy me because I would offer them nothing different than what they were used to receiving in Al-anon groups. Furthermore, I should have brought up my struggles about resource-oriented co-dependency in supervision. However, as mentioned above, at this point I concluded it was impossible to talk about co-dependency without pathologizing the families because the dominant discourse on this topic within this context was so strong and had such an influence on clients and their families. I didn't think I could do anything to change client and families' conversations surrounding co-dependency. I concluded the contrast between resource-oriented co-dependency and traditional co-dependency was too much for the participants.

During Weekend Three, I began utilizing the Power Point to facilitate the co-dependency exercise. One of the first concepts on the Power Point was *enabling*. Suddenly, my supervision conversations came back into my mind, and I began discussing enabling in a resource-oriented way. I noticed participants listening intently as I spoke, which gave me the confidence to continue discussing other co-dependency concepts from a resource orientation. I began discussing concepts such as tough love without participants knowing that I was not departing from traditional conceptions of codependency. . I stopped utilizing the Power Point after the first slide and turned the exercise into an interactive group discussion. Finally, I was able to achieve my goal in discussing co-dependency in a recourse-oriented way in Weekend Three. On the

evaluation surveys, one participant asked, “Why can’t people in Al-Anon talk about tough love like this?” (PJ, p. 47), so I believe that something I said must have resonated within her. Furthermore, two other participants (WK3, FM3 & FM6) shared their belief that the codependency exercise would make a difference for them in the future, and another reported that the exercise was the most significant part of Day One (WK3, FM1). Several significant processes took place in Weekend Three. I stuck to who I was as a therapist (FCG38; PJ, p. 47, 49) while maintaining the group’s interest (CG36; PJ, pp. 48-49, 51-52) and not losing group members’ attention (CG37; PJ, p. 52). Most importantly, I established what worked when integrating SFBT in a multiple family group setting (CG38; PJ, p. 52).

I concluded Day One of Weekend Three with a solution-focused exercise that I also utilized in the other two weekends, exploring the families’ ideas about what kept them hanging in there. I had success with this exercise in all three weekends, and it served to conclude the first day with a nice strength-based conversation. I noticed that the exercise promoted an increased sense of support among the group members, which was reflected in participants’ survey responses (TH20; WK1: FM6; WK2: CL3, FM3, FM8; WK3: CL1). I believed it also set the tone for the remainder of the evening, which clients and their families would share with each other off-site. By the end of Day One, Weekend Three, I had an epiphany about how I was relating to the group. There were two family members in long-term recovery present in Weekend Three: a mother and father. I noticed that I did not feel intimidated by them, as I had felt by family members in long-term recovery in Weekends One and Two.

I perceived Weekend Three as the most successful weekend, with respect to my ability to integrate SFBT into the system. Nobody wrote off the solution-focused exercises or judged them critically, as they had done when I attempted to implement them in previous weekends. Participants did not feel the need to confront each other, and they did not perceive me as inadequate because I chose not to utilize confrontational techniques. In fact, a staff member indicated that an item of significance during the weekend was “the empathy they felt from the group facilitator” (WK3, SM2). Participants responded to my different therapeutic approach not as an indicator that I was incompetent, but rather that I was competent. Participants affirmed this by reporting that the weekend would make a difference because “my family was exposed to new, varying points of view” (WK3, CL1), and “It was nice to hear an open perspective that was introduced instead of a singular focused opinion” (WK3, FM1). As a result, I went from being undervalued and perceived as “putting on a band-aid” to being valued and “impressing” participants “with the topics that were part of session today” (WK3, FM6).

Day Two

Trans-parental phenomenon. I began Day Two of the third weekend by discussing the families’ outings the previous night. Then I facilitated an exercise that had not gone as well as anticipated in previous weekends: exploring family recovery. I was curious whether this group would respond to the exercise differently, since the dynamics were different. At this point in my weekend, my relationship with the group was established, and I knew I had captured their interest. For this reason, I decided to try the activity one more time.

The families got into the exercise. One mother described her family's difficulty with negotiating the elements of family recovery that could be most useful for them. She explained that she was surprised by the hard time her family was having with this. I explored the mother's experience in-depth and explored group members' interactional patterns and responses to the questions throughout the exercise.

I tried another solution-focused exercise that had gone relatively well in Weekend Two: incorporating clients' ideas about when they went their families' help. No majorly meaningful incidents occurred, but overall, I noticed that the exercise opened up communication within the families. This was supported by participants' survey responses indicating that an opening of some kind took place during the weekends (TH15; WK1: FM1, FM6, FM7; W2: CL1, CL3, CL7, FM3, FM5; WK3: FM1, FM5, SM2, SM3). Participants wrote about the weekends opening up "clarity" about their "problems" (WK2, CL3), "opening up more than usual" (WK1, FM7), realizing their loved one was more "open to change" (WK1, FM6), opening up to "being open and honest" (WK3, SM2), or helping to "open the entire group and letting us all see both sides of things" (WK2, CL7).

One way I helped participants see both sides of things in Weekend Three was by sporadically facilitating a mini therapy session in the context of the group. As a result, two interesting shifts took place in Weekend Three: my anxiety was nearly non-existent (FCG35; SVM10, p. 3; SVM11, p. 1), and for the first time, I witnessed a trans-parental phenomenon take place between two group members (CG39; PJ, p. 50). The mini therapy session involved a mother and daughter. There was a great deal of palpable tension between the mother and daughter throughout the weekend, and it was obvious that the

daughter had a closer relationship with her father, who was also present during the weekend. The mother expected her daughter to be more outspoken, offering herself as the first volunteer for any group exercise; she was greatly bothered by her daughter's lack of verbal participation. If the daughter did not communicate the way the mother wanted her to, the mother interpreted it to mean that she did not care and did not take her sobriety seriously. Having worked with the daughter outside of the family weekends, I knew she was quite serious about her recovery and had been making tremendous efforts to move forward in her life.

I placed the mother and daughter in the middle of the group and facilitated a session with them. I explored the meaning of the daughter's preferred method of expression from both her and her mother's perspective, and aimed to help them develop a shared understanding of it so that it would not get construed in their relationship as a lack of caring. The other participants acted as observers of what was occurring within the middle of the group.

What happened next took me by surprise. Another mother raised her hand and asked if she could contribute to what I was saying. Recognizing the power of one family helping another, I immediately took advantage of the other mother's offer to help. I asked the mother I was working with if it would be okay for me to allow another group member to provide feedback. The mother agreed, and a beautiful conversation unfolded between the two struggling mothers. The mother who volunteered to give feedback spoke about her experience with the same problem in the relationship with her son and described shifts she proactively made in her way of communicating with her son. After the

conversation ended, I added to what that mother had shared and concluded the discussion.

It was evident that the voice of another mother added greater significance to the conversation, because the mini session ended with the first mother talking about what she could do differently within the relationship with her daughter. She told us she could recognize the value of giving her daughter a voice and could see how it would help them avoid mistaken impressions about the relationship and about one another. She no longer placed the blame for the problem on her daughter, because she realized that she was also contributing to it by misinterpreting her daughter's behavior. It was another mother from the group who assisted me in transforming the problem into something other than a fault on the daughter's part.

If there is one conclusion I could take away from the entire clinical project, it is that the power of one family helping another cannot be underestimated. Participants mentioned that the most significant aspects of the weekends that made a difference or met their expectations were hearing other families' perspectives (TH23), interacting with substance misusers (TH25), and interacting within their own families of origin (TH24) (WK1: FM1, FM2, FM3, FM4, FM6, FM7, FM8, FM9, CL1, CL2, CL3, CL5, CL6; WK2: FM3, FM4, FM6, FM7, FM8, CL1, CL2, CL4, CL6, CL9, CL10, SM3; WK3: FM2, FM3, FM4, FM5, FM6, CL2, CL3, CL4, SM1, SM3). For example, one client reported that "just hearing my parents interact with me and others" was the most meaningful part of the weekend (WK1, CL6). Another family member commented, "It was so meaningful to see that we were not alone in this struggle. Our experiences seem to be very similar to everyone else's" (WK1, FM4). Two participants specifically cited a sense

of “connection” (WK3, CL3; WK2, FM4) that they felt with the other families, which was something I hoped would happen, as indicated by my decision to title the weekend *Regaining Connections*. Furthermore, a staff member reported that she observed the family weekends to be significant, claiming, “I observed the bonding that occurred with the families. . .” (WK2, SM3). Other participants shared, “Yes I think the different experiences shared were very helpful” (WK1, FM4), and “I saw what impact addiction has on good people and their families” (WK1, CL5). Still others indicated that “working through problems” (WK3, CL4) with other families and hearing how other families “pulled through it” (WK2, FM7) were the most meaningful aspects of the weekends for them.

The conversation that took place between the two struggling mothers was one of many examples of how families with similar problems can act as agents of change for each other (FCG36; SVM11, p. 1; PJ, pp. 47, 49, 51-52, 55) and create a shift in family dynamics (FCG37; PJ, pp. 47, 49, 50, 52, 55). One of the clients mentioned this difference in family dynamics in his evaluation survey, stating, “my mother and I are closer than we have ever been” (WK3, CL1).

Participants also noticed shifts within their communication. Three family members indicated that the weekend would make a difference in the future, because it provided “effective ways of communication” (WK3, FM4). Another said that as a result of the weekend, “we are all on the same page” (WK3, FM1). One family member said that as the result of the weekend, “I plan to allow him to evolve in his own process” (WK3, FM3). Two family members found that “committing to communicate more” (WK3, FM1) and “letting my sober person know how her lack of communication hurts

her relationship” (WK3, FM4) were the most significant aspects of the weekend. Another client reported that the weekend I facilitated would make a difference in the future, because “she understands addiction and that it has many variables and how to avoid enabling my addiction and instead support my recovery” (WK3, CL1). Lastly, a staff member reported that the most significant occurrence in the weekend was the “. . . opportunity to talk with loved ones in a caring and open way” (WK3, SM3).

The next exercise I facilitated in Weekend Three was family sculpting. A father in the group stepped in to play the role of another client’s father, who had neglected him his whole life. Initially, the client focused the sculpting on the relationship with his brother, because their once close relationship became distant through his addiction, and he yearned for the closeness they once had. Although I knew there was work to do within the client’s relationship with his father, I allowed him to be the expert and choose to sculpt the relationship of his choice. As we got further into the sculpting, he began to focus more on the relationship with his father, without me telling him to do so. We worked through different sculpting positions to demonstrate his family members’ responses to his struggles with addiction and then explored what he wanted to change as a result. His mother watched from the outside with tears in her eyes. We processed the sculpting exercise afterward, which led to an impactful group discussion.

Participants indicated that the family sculpting was an impactful part of Weekend Three, as the participants in Weekend Two had done. In fact, of all of the exercises I facilitated in Weekends Two and Three, the family sculpting was the most frequently indicated in the surveys as being meaningful and making a difference for participants in the future (TH22; WK2: CL3, CL7, CL10, FM6, SM1; WK3: CL1, FM2, FM3, SM1).

Considering the small group size, almost every participant had the opportunity to engage in some way or another with the sculpting exercise.

The last exercise of Weekend Three was an exercise about relapse. In previous weekends, I began the group discussion about relapse by utilizing the metaphor of skating on ice as a way to reframe relapses as “slips.” After the group discussion, I broke participants up into their respective family units to discuss ways in which families can act as resources when the substance misusers are on the verge of slipping or already experiencing a slip.

When I initially created the family weekends, I planned to facilitate two exercises about relapse. However, due to time restrictions, I never had the opportunity to test out the second one. For the second relapse activity, I planned to include the same group discussion I began with in the first relapse exercise, but instead of instructing participants to break off into their own family units to have a resourceful conversation with each other, I would facilitate a guided imagery exercise instead. Since I never experimented with the second relapse exercise I had planned for the weekends, I decided to do so in Weekend Three.

I began the exercise in the same way I had in previous weekends, with a metaphorical discussion about slips. Then I facilitated a guided imagery discussion. My goal was to utilize the guided imagery as a way to help family members feel more comfortable with the idea that a relapse could occur. Furthermore, I wanted them to know that if a relapse were to happen, they are resourceful enough to respond to it in a helpful way, rather than with a profound sense of disappointment that could lead to anger, hate, and other destructive emotions. After taking participants through the guided imagery, I

briefly dedicated some time to processing participants' reactions. However, I did not have a lot of time to dedicate to the group discussion, because the end of the day was approaching.

Two fathers admitted that they began to drift off as soon as they closed their eyes, because they were worn out from the weekend. Other participants shared that they envisioned happiness and good feelings with their loved ones. When I introduced an imagined relapse within the guided imagery exercise, one mother reported that it was too hard for her to imagine it, so she stopped engaging with the exercise at that point. I asked if this happened to anyone else, and another mother responded by sharing a similar experience. I was curious about the similarities in responses between both mothers, but I had to conclude the day. I did not want to keep participants longer than they committed to being there, because it had already been a long day, and I could tell they were getting restless.

When the day was over, the mother whose son had volunteered for the sculpting exercise took me aside. She looked me in the eyes, thanked me, and stated, "This is the first time I can leave my son and not worry about him the whole time" (PJ, p. 50), which I felt was a compelling response to Weekend Three and something I'll never forget.

After Weekend Three

After the weekend was over, I concluded that the exercises had made a difference for participants (FCG39; SVM10, p. 3; SVM11, p. 1, PJ, pp. 48, 50, 51, 52, 53), which resulted in personal feelings of satisfaction (CG33; PJ, pp. 45, 46, 53-54). Additionally, I received another referral from a therapist whose client participated in the weekend (FCG34; SVM11, p. 2, PJ. p. 53). He explained that his client and the client's girlfriend

were impressed by the codependency discussion and wanted to meet with me in the context of a private session. Prior to scheduling the session, the therapist who made the referral reached out to me. He told me that he had decided a couples' therapy session would not benefit the client, since the client's girlfriend was very sick with the disease of codependency. He came to this conclusion, because when he spoke with the girlfriend over the phone prior to the weekend, she told him she did not want to go out to dinner with the client out of fear that he would ask for sex. After the family weekend was over, the couple went to dinner and had sex. As a result, the therapist concluded that the client's girlfriend had no boundaries and could not say no, a defining characteristic of codependency.

A couples' session made sense to the clients and made sense to me, but it did not make sense to the other therapist; this conflict is representative of the larger complexities of the clinical project. The therapist was working within a philosophical orientation grounded in a belief that clients need to avoid relationships until they obtain several years of sobriety. I had to address discrepancies between what I believed to be therapeutically useful, what other staff members believed was effective, and what clients and families believed could help them. This was challenging, because it meant I had to work within a system whose philosophy differed from mine. As with all challenges in life, it was tough but rewarding; in fact, it was among the most rewarding therapeutic experiences of my career. I met all of the challenges within the Sober Heaven system with an eagerness to learn and utilized the difficult experiences to help me hone my skills as a therapist.

Less than a week after I facilitated the third family weekend, I received a message from one of my co-workers informing me that the investors had shut the entire company down. It was a bittersweet ending to the clinical project.

Outcomes Across all Three Weekends

In my data analysis, I found that across all three weekends, 95% of participants agreed that the weekend would make a difference for them in the future. Eighty-five % of participants reported that the weekend met their expectations, and seven % reported that it exceeded their expectations. Only one participant across all three weekends, who took part in Weekend One, stated that the weekend did not meet their expectations. Lastly, six out of 79 evaluation surveys filled out across all three weekends indicated that I could have done something differently to improve the weekends. Most of the suggestions for improvement were related to time management (TH26; WK1: CL5, FM1, FM6; WK2: CL2, CL3; WK3: FM4), such as dedicating more times to exercises (WK3, FM4), moving exercises along at a quicker pace (WK1, CL5), and handling the “individual matters” (WK2, CL2) or “client tangents” (WK1, FM1) to avoid “prolonging” (WK2, CL2) group exercises.

Epilogue

The irony of this story is that as soon as I began feeling like I had a handle on SFBT-MFG, starting to institute change from within and feel accepted and comfortable within the system, the whole system fell apart. Jessica went from thinking I was there to steal her ideas to, by the end of the clinical project, developing a friendship with me. Some days, I stayed after work while we sat in each other's offices and bounced ideas

about therapeutic interventions off each other. Our relationship underwent a positive transformation over time.

The therapist who did not initially hire me for a full-time position told me on my last day as a full-time employee at Sober Heaven that if I ever needed anything in the future, I could reach out to him. The reason I didn't lose the program when the new investors took over was that Sharon fought to keep me. During our meeting, when she informed me about new owners taking over, she also told me the investors selected the family weekends as the first program to cut from the clinical curriculum, which speaks to the way family therapy is underestimated within the addiction treatment industry at large. She explained that she fought for me because she felt I was an asset to the clinical team. Had she not done so, Weekend Three would have never happened.

The staff member who helped me in Weekends Two and Three was the other therapist who initially interviewed me for the full-time position and chose not to hire me; she two had perceived me as unqualified for the job. A month after the facility shut down, she called me to say that she had found a new job and was being asked to implement a family program. She wanted my advice and suggestions.

CHAPTER V: FUTURE DIRECTIONS AND IMPLICATIONS

Although the clinical project came to an end at Sober Heaven, my work did not stop there; I have enough information from my analysis of the data from the project to go back into the field and implement a fourth weekend, based on the feedback I received in Weekend Three. Since my study was not a standard action research project, Weekend Four will be the closest approximation to a standard action-research step, as I will be using my analysis from the earlier weekends to inform what I do next. My analysis has helped me develop specific ideas to implement the next time I conduct a family weekend. Though it will be the first weekend I facilitate in whatever new system I will be working within, I can utilize my findings from the previous weekends to continue adapting and refining the SFBT-MFG modality with adult substance misusers and their families.

I will present a description of my plan for the fourth weekend at the end of this chapter; but first, I will share some reflections about the clinical project in its entirety. Then, I will discuss the implications of my study for other marriage and family therapists and action researchers. Additionally, I will discuss the implications of applying the SFBT model in the practice of addiction treatment and address the implications of this particular study for rehab facilities wishing to incorporate family therapy practices into their clinical curricula. Finally, I will discuss the limitations of the study and conclude the chapter by describing the different directions my research could take in the future.

I began the clinical project with a sense of heightened optimism that I would be able to implement an alternative model of therapy within a disease-based setting without any limitations. I recall Douglas suggesting that I think about the limitations of implementing an SFBT-MFG modality within a disease-based setting. At the time, I did

not understand exactly what he meant, since I did not encounter many issues when I instituted a couples' program at my previous place of employment. When I worked at that previous rehab facility, I maintained my solution-focused orientation without considering the larger context of the treatment facility. While I did struggle a few times with clients who placed a high value on the 12 Steps and, therefore, had specific expectations when it came to treatment, I did not struggle with my co-workers there as much as I did with the staff members at Sober Heaven. For these reasons, I thought I would have no issue walking into Sober Heaven and implementing my different way of working with substance misusers. I was wrong for several reasons. First, the context of the previous rehab I worked for was different; it was a bigger facility with many more therapists who came from a wider variety of therapeutic orientations. By contrast, everyone at Sober Heaven operated from the same disease-based therapeutic orientation. Additionally, I had established relationships with my co-workers at the previous facility prior to implementing my couples' therapy program. The clients knew me and my work, and the staff knew me even better. On the whole, the different contextual dynamics at the two facilities led me to have two very different experiences implementing a family therapy model.

From the first moment of the staff meeting I attended at Sober Heaven prior to Weekend One, I knew that instituting an SFBT family program surrounded by people I had no relationship with and who were all passionate about 12-Step principles would be much harder than I expected. By the end of Weekend One, I had lost hope for the survival of the SFBT modality within a disease-based system. However, after experiencing some successes with the SFBT-MFG modality in Weekend Two, a slight

sense of optimism began to return to me. Still, I felt greatly challenged in my ability to navigate the modality clashes I was experiencing.

I believe the most important lesson Douglas taught me was that I needed to undergo a process of integration. As I previously mentioned, I approached the clinical project with a sense of naivete, thinking I could walk into a disease-based rehab facility and institute SFBT-MFG without encountering any problems. Douglas did an excellent job of alerting me to the many reasons why it would be unwise to approach the weekends in such a naïve way. His guidance not only helped me come to valuable realizations throughout the three weekends, it also shaped my entire career as a family therapist in the field of addiction treatment.

If not for this clinical project, I never would have recognized the additional efforts a systemic therapist who is new to a treatment facility must make in order to gain acceptance. Prior to the clinical project, I dealt with integration issues by directly explaining to clients or co-workers that I approach addiction differently, then proceeding to bombard them with my postmodern theoretical beliefs. Douglas helped me to understand that approaching my theoretical differences this way was unhelpful to my process of integration. During the clinical project, I began paying closer attention to my process of integrating into the system and, as a result, was able to practice SFBT without feeling so handicapped.

When I initially developed the family weekends, I made a list of goals I hoped to achieve. I feel a great sense of achievement in acknowledging that I achieved most of those goals, which included increasing family social support; broadening fixed meanings of addiction and addictive behaviors; decreasing families' feelings of isolation and

stigmatization surrounding addiction; instilling a greater sense of clarity in the families about what they can do for themselves and the substance misusers; instilling a sense of a hope within family members and clients; increasing families' confidence and competence to meet new problems effectively; and creating a context filled with optimism, hope, and possibilities. Interestingly, the participants referred to most of the goals I set out for the weekends on the evaluation surveys. For example, I identified that an increased sense of support was a theme throughout all the weekends, as indicated by participants' responses on the surveys. Other participants provided feedback on the surveys about the hope, optimism, and compassion they gained through the weekends, further affirming that my goals were met.

In addition to the goals I wanted to achieve, I also made a list of the things I wanted to avoid, such as conformity, emotional intensity, sick-role identities, and life-long conditions. While I did not promote a sense of conformity among the participants during the weekends, in my personal process, I conformed to the beliefs of the Sober Heaven system. Emotional intensity did occur throughout the weekends; however, I discovered in Weekend Two that I could utilize that intensity in a resource-oriented way. I recognize that I could not have avoided emotional intensity while facilitating these weekends, because disease-based assumptions about addiction define successful therapy as clients' abilities to express their emotions. Avoiding emotional intensity within my therapeutic work would have presented too dramatic a contrast in what the participants were used to experiencing in treatment. An example of this occurred in Weekend One, when I went into solution-focused overdrive and began discussing behaviors exclusively, ignoring emotions altogether. As mentioned in Chapter IV, this led one participant to

believe that I was putting a band-aid on their problems. This showed me that even participants who know nothing about therapeutic modalities can sense when there are sharp theoretical contrasts within a treatment context.

Since Jessica and Sharon, who were both guided by disease-based assumptions about addictions, facilitated the morning groups in Weekend One, the families were exposed to concepts of sick-role identities and life-long conditions. In Weekend Two, a father in the group, as well as the guest speaker—both of them in long-term recovery—promoted these concepts as well. Despite my efforts to avoid using disease-based terms in Weekends One and Two, I often had to reference them, as participants would speak in the language characteristic of the 12-Step philosophy. It was not until Weekend Three that I was fully able to avoid promoting life-long conditions and sick-role identities, since by then I had absorbed many of Douglas's lessons about the process of integration. Additionally, I experienced many failures in my effort to integrate, which caused me to take a closer look at how I could integrate more effectively without having to promote the beliefs of the larger system within the context of my weekends. Once I learned how to create a group dynamic using my therapeutic orientation while still respecting the beliefs of the larger system—which finally happened in Weekend Three—these concepts did not seem to creep into the conversations as much as they once had.

The smaller group dynamic in Weekend Three worked better than the larger group dynamic, because it allowed for a more intimate experience among the family members. There are many intricacies involved in working with one family in the room, let alone multiple families. Reflecting back, it would have been more efficient for me to facilitate the family weekends twice a month with smaller groups. Since the power of

MFG lies in family members' ability to act as agents of change for each other, establishing a close and safe group dynamic is a priority when facilitating MFG, no matter the facilitator's therapeutic modality. When group members do not feel comfortable with one another, their opportunities for change decrease. In Weekend Two, I began to realize how significantly group dynamics influence the success of the weekends. Therefore, in Weekend Three, I placed a greater emphasis on the relationships between different families, putting great effort into promoting a strong sense of group cohesion. As a result, participants ended up becoming so close that they exchanged phone numbers with each other at the end of the day to continue supporting each other after the weekend was over.

Continued support among participants was something I hoped to promote since the planning stages of the clinical project but failed to accomplish. Families left the intensive weekends feeling a sense of heightened support, only to go back home without anywhere to access support other than in Al-Anon meetings. Since many of the families did not live close to Sober Heaven, continued support would have had to be achieved through some form of technology they could access remotely. Due to the clinical project getting cut short and the complexities with technology and HIPPA laws, I did not have the necessary time to thoroughly investigate the ethical issues that come with incorporating technology and therapy. Nevertheless, other marriage and family therapists wanting to implement a family program in the context of an addiction treatment facility could consider adding an element of continued support into their curriculum.

Implications for Marriage and Family Therapists

For marriage and family therapists (MFTs) working in the field of addiction treatment or any field dominated by individualistic notions of treatment, the outcomes in this study offer the skills to successfully integrate into the system. My deepest desire is that this dissertation will serve as a resource and guide for MFTs, inspiring them to work in the field of addiction treatment with a sense of encouragement instead of discouragement and view their greatest therapeutic strengths as assets instead of weaknesses.

The field of addiction treatment is in need of MFTs; rarely do clinicians have expertise in both marriage and family therapy and addiction (HHS & SAMHSA, 2015). I hope MFTs who identify with the struggles I faced during this clinical project will come away inspired and contribute to the addiction treatment field their skills of compassion, empathy, and contextual sensitivity, all which often come along with the practice of systemic therapy.

It was easy for me to feel isolated working within individualistic systems of healthcare. I hope the findings of this study will invite MFTs to acknowledge the contrasts and limitations between the two fields and utilize the categories of integration to confidently practice their craft within a context that often feels like “two fields [which] have developed their own vocabularies” (HHS & SAMHSA, 2015, p. 30). The difficulties I encountered working in this industry, which I have shared in this dissertation, are not meant to discourage other MFTs from entering the field of addiction treatment. Rather, my intention is to paint a realistic picture of the potential challenges they may face and help them feel more equipped to meet those challenges with a sense of

professionalism, respect, and hope. My hope is that after reading this dissertation they will be more prepared to effectively integrate into a system that abides by different epistemological beliefs. In the next section, I will discuss the categories of integration I arrived at from my analysis, which assisted me in gaining acceptance from the system.

Being Systemic in a Non-Systemic Environment

Be respectful of alternative realities. As a postmodern family therapist who views clients as the experts in their own lives, the notion of therapists determining what is most helpful for their clients does not sit well with me. However, when I first entered the addiction treatment system, I did not undermine the beliefs that other staff members assumed to be the most beneficial for their clients. I also did not explain the theoretical underpinnings of family therapy, defend my views about what best suits clients, and expect them to listen or understand.

At no point during my time at Sober Heaven did I walk into the CEO's office and complain about the way others were receiving my approach. Rather, I responded to the situation in a non-confrontational way that respected the other staff members' realities. This included indirectly reassuring Jessica and Sharon that they could trust me, so that they did not feel the need to come into Weekend Two and facilitate the entire codependent exercise. I respected their reality in the same way that I respect my clients' realities in therapy. I was not there to convert anybody; I was there for them to appreciate what I was doing so they would refer their clients to participate in my family program. I accomplished this objective by making a conscious effort to understand and respect the reality they were working from before juxtaposing it with mine. The findings of this study reflect all of the efforts I made to successfully integrate into the system; they offer a

guide for how MFTs can position themselves within a system when operating from a different set of theoretical assumptions.

Practice empathy and juxtaposition. Support within the process of integration is not demonstrated by conforming to the realities of the larger system and supporting an alternative reality that does not fit for you. Rather, it means considering the reasons why others believe in the alternative realities they do. For example, when Douglas and I first discussed my hypothetical response to clients posing the “Are you in recovery?” question, I committed to not conforming to clients’ ideas about needing to be in recovery in order for me to be therapeutically helpful. Instead, I would utilize empathy to understand and validate their position, then juxtapose it with my statement.

Furthermore, I utilized this category to help me within my process of integration with the Sober Heaven staff. Prior to knowing which therapist would help me during the weekends, I faced a hypothetical dilemma in supervision. Douglas and I discussed the potential assignment of a therapist for the weekends who strongly believed that the solution-focused approach was not an appropriate fit for the context of the weekends, since the theoretical contrasts between the staff and me could negatively impact the participants. Since some therapists were more flexible than others, I wanted a co-therapist who was open to understanding my theoretical foundation.

Douglas and I discussed different ideas in supervision about how I could approach Dr. Smith to discuss my preferences for a co-therapist without offending anyone. I did not want to assert that I would only work with certain staff members, because I would only come across as having a sense of entitlement or pitting staff members against each other; none of this would have been helpful to my process of integration. Furthermore, if

any staff members were to overhear me discussing my therapeutic preferences with Dr. Smith, they would think I was talking badly about them and not accepted me into the system.

Douglas suggested that I talk to Dr. Smith in a way that legitimized the staff's lack of trust for my approach. I would acknowledge that since I was new to the company, it was natural for staff members to be unfamiliar with me and my therapeutic model and have concerns. Then, I would juxtapose that with a statement about what I would prefer for the weekend in terms of staff support. Although I never had this conversation with Dr. Smith, since one of the other therapists offered to help, my plan for approaching Dr. Smith can serve as a guide for MFTs who need to speak with upper management when discrepancies with other staff members arise.

Endorsing elements and broadening the context. One of the main categories that helped me in my process of integration with the staff was always looking for elements I could endorse while broadening the context in my conversations. I provided an example in Chapter IV of how I utilized elements of MI to endorse SFBT, since MI was my colleague's chosen model. Both SFBT and MI are client centered, encouraging therapists to meet clients where they are at through a process of collaboration in the therapeutic discussion. Both models believe that clients should not be forced into change, recognizing that change works best as a result of the person feeling an intrinsic need to change, rather than having it demanded or imposed by others. Discussing the commonalities of the two approaches allowed me to broaden the context of the conversation with my colleague and discuss elements of MI that I could endorse. Since my colleague was familiar with MI, she had an easier time understanding and accepting

SFBT by virtue of its similarities with her approach. Reflecting back, it was no different than the way I planned to integrate the families, by connecting them through their commonalities. My process of integration with the system was also no different.

During the entire clinical project, I stayed in conversation with Jessica by frequently discussing our similarities rather than our differences; this was mainly how I approached all of the staff. There was a great deal Jessica and I could have discussed about our therapeutic differences, but it would not have benefited my process of integration, because it would have been difficult to find elements of the conversation I could endorse. Instead, I tried to focus my conversations with her on what connected us, rather than what separated us. There were certain aspects of her work that did not fit for me, as I am sure there were aspects of my work that did not fit for her. However, I did not bring up those differences before establishing a relationship with her. Our therapeutic differences would come up in our conversations at times, but in the context of my respectful acknowledging that she operated from a more modernist orientation, while I practiced from a postmodern orientation. I validated this difference, explaining that regardless of our differing theoretical orientations, we both had the same passion for helping others. When our differences did seep into our conversation, I never made her feel wrong about the way she approached the therapeutic process. I believe this had an influence on her, because she also never made me feel wrong for practicing SFBT.

Never make people feel wrong. During my first meeting with the staff members, when I introduced the program, the theoretical clashes between us were evident. Nevertheless, I did not walk into that room full of people with opposing beliefs and tell them they were wrong. I did not start a competition or talk back to the staff members in a

condescending way, even when I felt frustrated. Instead, I maintained my sense of respect and professionalism, regardless of how challenging the situation was.

For MFTs working in an environment that operates in a completely different way than they are trained, it is unwise to make other therapists feel wrong about the way they choose to conduct therapy. Doing so will only pit the entire system against the MFT. Though MFTs' alternative theoretical and therapeutic approach may lead certain systems to perceive them as inexperienced, it is important to not make anyone feel wrong for believing what they do about MFTs or their way of doing therapy. Rather, MFTs should make it their job to prove that the system can trust them—not by fighting against it, but by joining with the system, acquiring an in-depth understanding of the reality it operates from, and indirectly demonstrating acts of trust. For example, in Weekend One, my respectful yet proactive email to Jessica and Sharon helped them recognize that I was not going to ignore what happened during the weekend or hold resentment toward them. Rather, I showed them that I cared enough about our relationship, and the family weekends, to debrief with them and ensure that we were all on the same page. I did not directly pull them aside and demand their respect by saying, “Why don’t you trust me facilitating the codependent exercise? I am a licensed therapist and advanced doctoral student. You need to trust me.” I never carried myself with a sense of entitlement or believed that I was better than anybody; my approach was always humble. It is easy to be so desperate to fight for what you believe is most helpful for clients that you adopt a position of defensiveness, but it certainly does not benefit your process of integrating into a system that may be hesitant to trust your approach.

Conforming to the system's beliefs is the easiest way to avoid making anyone feel wrong; however, it fails to be effective, because it corners therapists and keeps them from being able to do anything different. While this may work for the system, it will not work for the therapists, who will lose their voice and sense of self. This is what happened to me prior to Weekend One and until Weekend Two of the clinical project. The challenge is always to figure out how to work with alternative beliefs without upsetting the system, all while staying true to who you are as a therapist. According to a report from HHS and SAMHSA (2015), "Including family therapy issues in substance abuse treatment settings at any level of intensity requires systematic and continuous effort" (p. 149). While it is a challenge, one that is even recognized by the larger system of addiction treatment, it can be met by inviting clinicians to utilize the categories of integration derived from the findings of my study. The categories of integration I identified in this study are not meant to be utilized in a linear way or in any specific order. There is no specific formula. Rather, they are intended to offer MFTs various ideas about and suggestions for having conversations with others to avoid creating adversaries within the systems they are attempting to enter.

Implications for Solution-Focused Brief Therapy in the Practice of Addiction Treatment

The findings of this study suggest that a SFBT-MFG modality can be utilized as a viable approach to addiction treatment within treatment contexts similar to the one described in this study. Had I implemented this project in an exclusively SFBT addiction treatment facility, where everyone endorsed the therapeutic model I utilized and I had established staff and client relationships, the system would have responded with much more acceptance. Nevertheless, the heart of this study was the way I promoted the

viability of SFBT within a system that diverged considerably from the traditional practices of solution-focused therapists.

While the research fully supports family therapy as a best practice for the treatment of addiction, with SFBT in particular showing positive outcomes, there is a big gap between what the addiction research reports as effective and what is actually practiced in rehab facilities. My findings encourage solution-focused brief therapists to sensitively approach the differences between the way they work therapeutically and the way other disease-based clinicians work. For example, when I initially interviewed for a job at Sober Heaven, I assumed I would impress the interviewers when I told them I would not react in a confrontational way to a client who disrespected me in front of other group members. Instead, the opposite occurred. My non-confrontational way of approaching a hypothetical situation with a client cost me a job at Sober Heaven, because it was assumed that I did not have enough experience in the field.

A similar scenario occurred in Weekend One, when I assumed that transitioning the group from problem talk to solution talk after the group had been pathologized would make a positive impression on the group. Instead, I was viewed as being an unqualified group facilitator. Reflecting back, I learned that discussing problems in a curious, empathic way is different from discussing problems in a pathologizing way. This was what I most wanted to avoid during the weekends, because I did not want to go against the principles of SFBT. Douglas suggested that I handle this challenge by utilizing empathic curiosity, to ensure that I was giving voice to the problematic aspects of the participants' relationships, as well as the strengths. I demonstrated empathic curiosity by becoming curious about the pain, trauma, neglect, and other challenges within the

families' relationships. After acknowledging the problem with curiosity and empathy, I was able to transition the discussion into a strength-based conversation. If I moved too quickly with a heightened sense of optimism about solutions to their problems, they would write me off as inexperienced and ill equipped. Therapists practicing SFBT would benefit from the findings of my study by approaching MFG in the context of a disease-based rehab facility with a sense of appreciation for how empathic curiosity about problems can only contribute to solution-oriented conversations. Additionally, they would benefit from remaining mindful of the balance between problem talk and solution talk when working with substance misusers and their families.

In Chapter IV, I discussed my epiphany about the use of positive emotions as a resource-oriented way to address the emotional elements of therapy that substance misusers in addiction treatment facility are used to receiving. Incorporating strength-based conversations with a sense of positive emotion revealed itself to be helpful for the participants, and my findings can encourage other solution-focused brief working with MFG in addiction treatment facilities to use strength-based conversations as a way of eliciting positive emotional responses. Certain questions and invitations—such as “What keeps you hanging in there?” and “Name one of your family members’ strengths that you’ve never acknowledged”— can inspire a conversation oriented toward positive emotion. However, my findings also suggest that solution-focused therapists should be extra cautious when using such interventions. If the family or client is in a heightened state of desperation, therapists should acknowledge the desperation first before shifting into strength-based talk.

While working in the early stages of a new group—without knowing the families, the types of relationships they have with each other, or their sense of hope or hopelessness—group facilitators must be careful about asking certain questions, as some have the potential to backfire. For example, a family member may assert that he or she has been hanging on by a thread. At that point, the solution-focused group facilitator must meet that client where he or she is, by first acknowledging the client's desperation and weariness, then taking small steps toward solution-oriented conversations. Through my experiences, I discovered that overcoming an addiction is not a phenomenon that inspires optimism for families. They have seen their loved ones change into people they never thought they would become, and watched them try to stop using substances countless times, only to feel frustrated when those attempts are unsuccessful. Some families have watched their loved ones overdose and need to be revived right before their eyes, while others have witnessed them deteriorate with each passing day. As someone once said to me, "Sometimes a parent grieves for the loss of a child that is still alive." My findings inspire solution-focused therapists to respect the depth of loss some families may feel, while also emphasizing the possibility of hope to assist in the balance between problem talk and solution talk. Solution-focused therapists working in the context of an addiction treatment facility can deliver SFBT in a way that addresses problem talk within the context of strength-based conversations, while slowly building toward solutions.

Implications for the Rehab Industry

Rehab facilities that want to incorporate family programs into their clinical curricula may benefit from the findings of this study in several ways. Research indicates that incorporating families into the treatment process can serve as a huge motivator for

substance misusers. As one participant wrote in the evaluation survey, “Having my family here was a huge motivation” (WK2, CL5). Involving families in the treatment process can help heal relational elements of clients’ lives in ways that individual therapy may not. At the same time, incorporating a different modality of therapy into the standard addiction treatment system is a challenge. As HHS and SAMHSA (2015) assert, “Though the incorporation of family therapy into substance abuse treatment presents an opportunity to improve the status quo, it also challenges these two divergent modalities to recognize, delineate and possibly reconcile their differing outlooks” (p. 148).

Furthermore, HHS and SAMHSA (2015) suggest that “it is useful . . . for clinicians in each field to understand the treatment that the other field provides and draw on that knowledge to improve prospects for professional collaboration” (p. 30). While my findings did not include integration processes—for example, where I directly sat down with other staff members to gain an understanding of their type of treatment while they gained an understanding of mine—elements of my integration process included understanding the treatment characteristic of the addiction field so that I could endorse elements within it. While it was not the responsibility of other staff members to understand my treatment modality during the clinical project, it would have only benefited the entire system if they had made similar efforts as mine to understand the differences in our theoretical orientations. When I first met the staff members, some of them felt threatened by my potential to jeopardize their positions within the system by bringing in something new. I also felt threatened, because I did not believe my approach

was well-received by other staff members. Therefore, the lack of understanding between the fields caused tension in the system, which is not beneficial for the overall work environment.

As a family therapist working in the rehab industry, I found that the tension in my relationships with other staff members eventually dissolved. Thankfully, I was in supervision, which gave me the opportunity to learn many lessons about how to integrate and gain greater acceptance in the system. It is unlikely that other family therapists will enter the rehab industry knowledgeable about the skills required to effectively integrate into a system. Thus, the challenges outlined in my findings may inspire rehab owners to attend to theoretical clashes between staff members and put methods in place to help staff members understand each other's fields and avoid unnecessary conflicts resulting from a lack of understanding. As HHS and SAMHSA (2015) emphasize, "the program administrator might wish to give advanced thought to how to address issues that could arise over conflicting views" (p. 150).

According to HHS and SAMHSA (2015), one way to achieve communion between family therapy and standard addiction treatment is to articulate "... the underlying values of each and then determining [which] alternatives would work better" (p. 148). The findings of my study suggest something slightly different. As mentioned in Chapter II, researchers have already determined that family therapy produces better long-term treatment outcomes than individualistic therapies. Instead of determining whether an alternative modality works, since it has already been established that it does, energy can be better spent integrating professionals from different fields, so they can work harmoniously with each other's modalities rather than against them. This kind of

collaboration among practitioners could have a larger impact on the clients than any single therapeutic modality could have.

Incorporating a family program into a rehab facility also has implications for the facility's financial resources. First, facilities would need to hire family therapists if they are not already part of the clinical team. If not, clinicians would need to be trained in family therapy. Depending on the program, if clients live at the rehab facility, bringing in families while clinical activities are occurring has implications for confidentiality. As a result, an outside location would need to be secured for the family weekends, which also adds additional costs. Furthermore, if food is provided to the participants during the weekends, which I recommend, catering expenses would need to be taken into account.

According to HHS and SAMHSA (2015), “. . . the American health care insurance system focuses the care on the individual. Little, if any, reimbursement is available for the treatment of family members” (p. 149). This highlights implications about issues of reimbursement for the services provided in the family program. With most rehab facilities in a state of instability with limited resources, financial strains may prevent them from fully taking advantage of the many benefits family programs can provide the industry.

The Method: Implications for Research and Action Researchers

Action researchers may find the outcomes of my study useful in several ways. Typically, they enter a system with the intention of effecting change in some way, no matter how big or small, and they expect to implement a new program or shift the structure of an existing program. Therefore, my findings have implications for action researchers seeking to incorporate new programs in established treatment regimens. The

outcomes of the study could help other action researchers gain entry in an organization and find a way of being seen as credible.

The study's findings also have implications for the setting in which action researchers choose to implement their projects. Close involvement with staff members, who are otherwise selected as major stakeholders, is a key aspect of action research. As Stringer (2014) notes, stakeholders “. . . are likely to invest considerable time and energy in research activities” (p. 168). Inpatient or partial hospitalization systems are typically in a state of high emotional intensity, with client crises occurring daily. Clients are detoxing from substances and can exhibit highly reactive emotional states. Staff also often need to attend to clients experiencing side effects and withdrawal symptoms from medications, some so severe that they can begin hallucinating or become psychotic. As a result, using clients as stakeholders within these kinds of settings can be challenging. Furthermore, clinicians in these settings experience a higher rate of burnout. Most of the time, they are utilizing their time to attend to clients and, as a result, do not have the extra energy to devote to an outside action research project.

It was difficult to involve upper management and other staff members in my clinical project the way I initially envisioned, because they were often busy attending to the larger issues of the system. Furthermore, it would have been a greater challenge to involve family members as stakeholders in the way traditional action research methods suggest, considering most families traveled from out of town for the weekend. Therefore, my findings encourage action researchers who conduct studies in inpatient or partial hospitalization programs to carefully consider the amount of time stakeholders have to dedicate to the research project, in order to make realistic decisions about their level of

commitment. Furthermore, it is helpful to obtain an understanding of the context of the system and the ways it could potentially limit the research project.

With these cautions considered, I found the analysis methods utilized in action research to be a practical method for exploring my research curiosities. Categorizing and coding allowed me to recognize how certain discoveries in my personal journal entries and supervision sessions led to changes throughout the clinical project, as they helped me gain deeper understandings about the personal, organizational, and clinical processes occurring taking place. As Stringer (2014) notes, “Research of this order can produce meaningful descriptions and interpretations of social process. It can offer explanations of how certain conditions came into existence and persist” (p. 136). The categorizing and coding process allowed me to categorize elements of my experience and record the categorizations in separate weekends to analyze shifts and changes across all three weekends.

Analyzing critical incidents allowed me to extricate clients’ and families’ meanings from the evaluation surveys about experiences and events they found significant. By analyzing participants’ meanings through an exploration of their perceptions and feelings, I discovered what is helpful and not so helpful when facilitating an SFBT-MFG in the context of an adult addiction treatment center. As Stringer (2014) explains, the interpretative nature of analysis procedures is useful to explore the “. . . different definitions of the situation, the assumptions held by interested parties and appropriate points of intervention” (p. 136).

The methods I used to analyze critical incidents also helped me illuminate themes participants held in common and deemed most helpful across the three weekends. For

example, I discovered that participations found the family sculpting exercise, among other aspects of the weekend, to be very helpful.

Action researchers can use one or both methods of analysis when analyzing data (Stringer, 2014). Considering my study was two-fold and explored two different research questions, I found the action research methods of data analysis to be fitting, since they allowed me to utilize two different approaches to address each one of my research curiosities.

Limitations of the Study

A limitation worth noting is that my findings are limited in their applicability to other settings. But as Stringer (2014) explains, “That does not mean . . . that nothing in the study is applicable to others. It indicates, however, the need for procedures that carefully explore the possibility that the outcomes of an action research study may be relevant elsewhere” (p. 116). In terms of external validity, this study exemplified rigor through transferability.

I confirmed the transferability of the study by including a detailed description of the context, activities, and events occurring during the clinical project throughout previous chapters. Other researchers interested in implementing an SFBT-MFG in a rehab setting must determine whether the findings from this study are pertinent for the context in which they will conduct and apply their research. Furthermore, other researchers who wish to apply the findings of this study in another rehab setting must consider the uniqueness of their facility’s financial and legal context. All clients who participated in the family weekend were in treatment as a result of their own motivation to be there or one of their family member or friends who influenced them to be there. For

the most part, clients exhibited moderate to high motivation for change and weren't forced into treatment by the legal system. For other rehab programs whose referral process is strongly influenced by the court system, the findings of this study may have limited utility, as clients' levels of motivation make a difference in how receptive they are to treatment and especially their receptiveness regarding the involvement of their families in their treatment process.

Additionally, I, myself, was a limitation in this study. Another clinician who was more confident in the SFBT modality may have more easily implemented a SFBT-MFG within this context. Someone who was more seasoned with the SFBT approach may not have initially forced solutions in Weekend One and may have given greater attention to the problem from the start of the weekends.

Lastly, my study was classified as a modified action research project, as I did not follow standard action research procedures. Certain limitations always come with making such modifications to a method of inquiry. Since I made modifications in each phase of the Look, Think, Act cycle, I will discuss each part of the cycle as it relates to the limitations of my study.

Look

The main goal for this stage is to gather data about the description of the problem by exploring the worldviews of those affected by it (Stringer, 2014). During the clinical project, the nature of the problem was oriented toward the question of whether an SFBT-MFG could survive in the context of a traditional addiction treatment facility. I investigated the problem by exploring the perceptions of the participants who engaged in the SFBT-MFG. I captured their perceptions through evaluation surveys asking various

questions about their perceptions about the weekend, which participants completed at the end of their weekend experience. For example, I asked if the weekends met their expectations and what I could have done differently. I left the questions open-ended so that participants could respond from their own unique perspective. This allowed the participants to define any problems that arose for them while participating in an SFBT-MFG.

There are certain limitations to utilizing surveys. I had to work within a limited set of data, because I was not conducting research during the clinical project. Essentially, all I could analyze were the surveys, my own personal journal entries, and transcripts from my supervision sessions, since I could not contact the participants after the clinical project was over. Stringer (2014) notes that interviews act as the primary source of data in action research, because they “enable the interviewee to explore his or her experience in detail and to reveal the many features of that experience that have an effect on the issue investigated” (p. 105).

Stringer (2014) explains that surveys can be disadvantageous, because they provide limited information and can reflect the worldview of the researcher. While I constructed the survey questions in an open-ended manner, to limit the likelihood of the questions reflecting my agenda as a clinician, some participants provided minimal information. Survey responses ranged from one-word answers to written paragraphs. In some cases, it was hard to make out participants’ responses, because I could not understand the handwriting. Lastly, some survey responses piqued my curiosity, and I wanted further information about them. Since the clinical project was over by the time I began analyzing the data, I was unable to gather more information.

After collecting the data, Stringer (2014) suggests that “researchers should prepare summary statements of information they have acquired and check them for accuracy with relevant stakeholders” (p. 116). Since I did not have access to the clinical stakeholders during the research part of this project, the inability to provide summary statements to the participants about the data I collected reflects another limitation in the Look cycle of my study.

Researchers who are interested in studying a family program utilizing standard action research procedures could utilize interviews and focus groups in addition to evaluation surveys, in order to expand the process of data gathering. If future researchers plan to incorporate surveys into their project, they should employ surveys in a way that allows them to follow up with participants and clarify meanings to obtain more information.

Think

The Think cycle in action research is considered the data analysis stage. Stringer (2014) describes this part of the cycle as “a social process in which people extend and reconstruct information emerging from their inquiry (data and analysis) through continuing cycles of exchange, negotiation, realignment, and repair” (p. 75). During the first part of the analysis, the researcher works independently to analyze the data. Next, the researcher constructs a report containing the results of the analysis and ensures that “the end result integrates . . . [the stakeholders’]. . . perspectives and priorities” (p. 180). The researcher takes this additional step during the analysis in order to ensure that the results reflect the worldview of those involved in the project. Because I could not confirm the results of my analysis with the clinical stakeholders who completed the evaluation

surveys, this constitutes a limitation in the Think cycle of my study. To address this limitation and ensure that I did not analyze the data through my own interpretive lens, I quoted participants' exact words when identifying elements of meaning in their key experiences.

Act

There are three stages involved in the Act stage: *plan*, *implement*, and *evaluate*. The goal of this cycle is to organize meetings with stakeholders to discuss solutions to problems discovered in the data analysis stage. Stakeholders in action research are responsible for implementing solutions to the problems, and additional meetings are held during the evaluation stage to discuss any unresolved problems. As I mentioned in my description of the limitations for the Think cycle, I did not have access to the clinical stakeholders to collaborate with them in designing solutions to the problems they identified during the weekends, nor was I able to meet with them again after I implemented those solutions. Accordingly, I completely modified the second stage of this cycle, which serves as a limitation.

An example of this limitation appeared when one participant reported difficulty understanding questions on the evaluation surveys, due to the wording of the questions. Had I been conducting a standard action research project, I would have facilitated a meeting with the participants so that we could work conjointly and determine a clearer wording of the confusing questions. During the clinical project, I did rearrange the questions based on suggestions; however, I kept them worded in a way that made sense to me but may have been unclear to the participants. If I could have collaborated with the participants, we could have formulated solutions more consistent with their worldview.

Researchers interested in implementing an SFBT-MFG in the context of a rehab facility could conduct a standard action research project, which would allow them to involve the voices of the stakeholders in greater depth through each cycle of the project, allowing for richer information.

Future Directions

Now that I have a family weekend program I can utilize in a meaningful way, I look forward to further refining the program in a fourth weekend, as mentioned at the beginning of this chapter. I plan to continue the cycles of refinement and implementation to gather and analyze feedback from participants and other stakeholders involved in future family weekends. My goal, even as a clinician, is to analyze the weekends more closely, as I have learned to do in this project, so I can identify important feedback that could help make the weekends even more helpful for the participants. The program I will bring to another organization will reflect the changes I will make following the analysis undertaken in this dissertation. The following section outlines my plan.

Weekend Four

In the weeks leading up to Weekends Two and Three, respectively, I conducted a group therapy session with the clients in the rehab facility. Many clients desired to know more information about the weekends, to ease some of their anxieties. In the context of a group discussion, I answered their questions to help them feel more comfortable. As mentioned previously, Douglas suggested that I incorporate a context for difference within these group discussions and repeat it with families while introducing myself during the weekends. That way, participants would not anticipate the same interventions they had received in other settings. As I previously mentioned, one of the participants in

Weekend Two shared that he did not feel he could grow in the weekend, as he did not feel there was a high sense of emotionality within the group activities and discussions. In other words, he found them to be too intellectual, without enough emotion. Another client in Weekend One wanted “heavier” or “more real” topics. To address any clashes in theory or modality with participants in Weekend Four, I will establish a context for difference, as discussed in Chapter IV, prior to starting the weekend. This will help the clients view the weekend through a different lens, rather than expecting it to be the same as other aspects of treatment they were used to receiving.

In Weekend Four, I will start the first two exercises with the same icebreaker and YouTube video I presented in Weekends Two and Three. For the third exercise, I will make better use of the pre-treatment change questions. Some clients and families took their time to thoroughly answer questions on the pre-treatment change questionnaires, which provided valuable information I could have utilized in a group discussion about the shifts occurring within their family systems now that their loved ones were in treatment. I won’t assign a homework assignment prior to meeting the participants, because as Douglas said several times, my first task is to join with them. Instead, I will let them know ahead of time to give some thought to any pre-treatment changes that may have happened, so they feel prepared when they arrive the first morning. I will allot some time during the group to letting them jot down their thoughts about the questions if they have not done so already. This way, nobody will feel wrong if they haven’t given much thought to what I prepared them to think about. Lastly, I will dedicate time for a group discussion in a solution-orientated manner about any problems participants encountered while answering the questions. As I discussed previously, I will keep a heightened focus

on the balance between problem and solution talk, to ensure that I am not moving too quickly in the direction of something different from what the participants are used to in other family-based addiction treatment settings.

For the fourth exercise, I will try once again to conduct the psychoeducational group about the impact of pharmaceutical drugs on the brain. I want to experiment with this exercise again, because I did receive a few responses indicating that it was the most significant in Weekend Three. When I implemented it, the group discussion turned into a conversation about what addiction is or is not, with one father vehemently arguing that addiction is a choice with no biological basis. I will make extra precautions to ensure that the group discussion does not take a negative turn. Prior to introducing the exercise, I will make its purpose clear, explaining that there are multiple ways to view addiction, and a neurological explanation is one of them.

I will explain that the intention is not to argue what addiction is or is not, but rather to enhance understanding about addiction through a biological lens. If any participants respond negatively, I will try my best to respectfully redirect the discussion before participants too passionate about asserting their views. If this exercise did not seem impactful in weekend four, I would cease to utilize it in future weekends.

I would facilitate the codependency exercise the same way I did in weekend three, because it was the first time I confidently discussed codependency from a resource-oriented orientation. I am curious about whether the conversation would have the same impact with a different set of group participants. The codependency exercise would be the last exercise of the day, since I included an average of five exercises on the first day of each weekend. Of course, I would keep a set of additional exercises on hand, so I

could add an exercise if time allowed or change one of them if I did not find it appropriate for the dynamics of the group. As Douglas explained to me during supervision, “[the exercises depend] so much on you getting a feel for how people are and how trusting they are, how afraid they are, how shut down they are, how angry they are, how hopeful they are” (SVM5, p. 14). This was a lesson that I did not absorb during the clinical project. Nevertheless, after completing three weekends and conducting an analysis, I realize how important this lesson is and how much of a difference it can make for the outcomes of the weekends.

The only issue with switching group exercises based on the dynamics of the groups is that I presented a previously prepared PowerPoint presentation in each of the weekends. If I were to rearrange the exercises, I will be unable to rearrange the slides in a way that corresponds with the pre-planned group activities. Before breaking participants up into their respective family units, I presented them with a series of questions I wanted them to work on as a family. I found it useful to present the questions on a projector screen that all participants could see. To resolve this issue, I could type and print the questions, providing each family with a copy. Another way to address the dilemma of utilizing a previously prepared PowerPoint presentation while selecting group exercises in the moment, is to create separate sets of slides that correspond with each group exercise.

The second day of Weekend Four will begin with a group discussion about the families’ outings, if the particular facility structures family weekends the same way. In my experience, participants typically responded positively to being able to spend time with their families. I will utilize their experiences to lead into the next exercise in

Weekend Four, which involves exploring participants' ideas about what they know about each that has allowed them to keep hanging in there. Since participants valued the time they spent with their families on their outings, perhaps they saw something in their family members during their time together that they could utilize in this group discussion. If the experiences during the outing raised some sort of conflict and the families were not in a position to complete the exercise without appearing too hopeful, I will choose a different exercise to facilitate. For example, I could always sporadically facilitate a mini therapy session if I notice tensions among the families after spending time with each other the previous night. The therapy session I demonstrated in Weekend Three was impactful, because it allowed group members to witness a problem similar to theirs and see how it could come to some resolution. If I recognize a high degree of conflict at any point in Weekend Four, I will utilize it as an opportunity to practice solution-focused conflict resolution in the context of a therapy session.

As discussed, family sculpting was a theme in the participants' feedback about what was most significant for them across all three weekends. I plan to continue using this exercise in Weekend Four and into the future. However, I would make changes so that the exercise was more in keeping with what Reiter (2016) called *solution-focused sculpting*. During the second part of the sculpting, I would instruct the volunteer to change the positions of their stand-in family members to reflect what they want in their relationships, as I initially did. Additionally, I would add an element and explore exceptions. Next, I would instruct the volunteer to sculpt a time when they were able to resist the temptation of their addiction. Then, the volunteer would change the positioning of their stand-in family members to reflect their relationships when the exception

occurred. Thereafter, I would take a picture of this exception sculpting. After the exercise was over, I would process the exception sculpting in the context of the larger group. Lastly, I would give the volunteer the photograph to take with them as a resource to carry with them into the future.

If time allows, the next exercise will be the Empty Chair/Reenactment activity. This was another exercise that participants regularly reported causing a shift in how they related to their problem; for some, it produced a sense of relief, and for others it resulted in a feeling that an emotional burden had been lifted. Therefore, I will put in my best efforts to reserve enough time for this exercise. However, I will want to end the weekend with an exercise about relapse; so, if time is limited, I will get into the relapse exercise after the family sculpting.

Since relapse is perceived as a major threat to the recovery process, and relapse rates are high in standard addiction treatment centers—as noted in Chapter II—it was, and will continue to be, important for me to address it in the context of a group exercise during the weekends. If not, I will deprive the participants of opportunities to gather important resources they will need when they or their loved one slips. What better opportunity to address issues related to relapse than with some of the clients' closest supports present?

For Weekend Four, I will choose to facilitate the relapse activity that involves guided imagery. When Douglas and I discussed this exercise in one of our supervision sessions, we agreed that I should keep the process discussion following the guided imagery to a minimum (SVM7, p. 26). However, a participant in Weekend Three indicated on the survey that they wished more time had been dedicated to the guided

imagery exercise. In response to this feedback, I will experiment with this exercise in Weekend Four to determine what will be the best approach for the discussion that follows.

I will conclude Weekend Four by distributing the evaluation surveys. I would also like to incorporate a focus group, to follow up with the participants. This way, I can discuss any questions that came up while I was reading the surveys, obtaining richer information about their perceptions regarding how the weekend went. However, if I carried this on as a researcher, or even just a clinician, I will have concerns about participant bias. The advantage of distributing surveys is the anonymity they offer. Participants did not have to hold back from expressing their true feelings. My fear about being the group facilitator as well as the person talking with participants about their evaluations—of me, ultimately—may keep the participant providing genuine feedback, out of fear of hurting my feelings. To address this limitation, I could invite a co-researcher or co-therapist to facilitate the focus groups.

After conducting a fourth weekend, there will still be work to do. I previously mentioned aspects of certain activities that I would like to experiment with in Weekend Four. A potential future direction for this study is to continue refining the family program by utilizing the method described in Chapter III. In a few years, I could produce a more elaborate manuscript of the family program that could be made available to other clinicians.

Organizational Consulting

Another way the study's results could be utilized in the future is by applying them at an organizational level. As HHS and SAMHSA (2015) regularly assert, rehab facilities

need to take additional measures when incorporating family therapy into their system.

For example, they note:

Agency administrators prioritize the integration of families into substance abuse treatment and identify model(s) and therapeutic interventions best address the community needs. Throughout the agency, the staff has a thorough understanding of how family will be engaged in the substance abuse treatment and family - therapy processes, and implementation of treatment is well-coordinated. (HHS & SAMHSA, 2015, p. 158)

Another point HHS and SAMHSA (2015) make in their *Treatment Improvement Protocol* for family therapy in addiction treatment is the need to “prioritize the integration of families” (p. 158) in rehab facilities. My study exemplifies various ways that family therapists can integrate into these organizations, without the organizations accommodating their process of integration. However, my study does not explain the integration process from an organizational standpoint; it does not describe the measures these systems would need to take to integrate family therapy. Nevertheless, organizations wishing to incorporate family therapy can utilize the findings of this study to assist them with the process of integrating family therapists within their system.

HHS and SAMHSA (2015) report, “Generally speaking, there is a shortage of (1) well trained substance abuse treatment professionals, (2) well trained substance abuse treatment professionals knowledgeable about family issues, and (3) well-trained family therapists who are proficient in traditional substance abuse treatment techniques” (p. 156). As a family therapist with a background in substance abuse, I could position myself as an organizational consultant to assist rehab facilities with their process of integrating

family therapy into their programs. There are many layers to address when it comes to the incorporation of family therapy, due to the lack of familiarity about family therapy within standard addiction care. Furthermore, Lowman (2002) warns about the “complexity and the difficulty” (p. 55) that come with the restructuring of an organization. My findings could apply to entire organizations, helping administrators and staff become knowledgeable about the complexities that come with integration, and teaching them to navigate these challenges as a team.

As an organizational consultant for the integration of family therapy in addiction treatment, I could assist everyone in the system to effectively collaborate with each other, utilizing the clinicians’ unique strengths and helping them work with other staff members who may not come from the same therapeutic orientation or belief system. Solutions for the integration of family therapy into rehab centers would become sustainable because methods would be put into place that ensure it will go smoothly. Staff members would gain the skills to collaborate with each other about various treatment approaches in the best interest of the organization. However, all staff members may not be invested in welcoming the integration of family therapy into their clinical curriculum. Large scale changes in an organization can be uncomfortable, and some staff may express this discomfort by resisting ideas I bring into the system. Therefore, I would have to figure out the best way to gain entry as an organizational consultant.

I could utilize SFBT principles about client-therapist relationships and first gain entry with those employees who are customers for change in the organization. First, I could approach those staff members who may be experiencing burn-out or frustration within their approaches and therefore exhibit high motivation for change within the

facility. The customers for change would be more accepting to an outsider bringing something different into the organization because those are the ones who feel what they are doing is not working and are looking for different methods that do work. The staff members who act more as visitors and complainants would not be as accepting to an outsider since they don't have any problems with the way they are working and wouldn't be invested in doing anything differently. Once the staff members who are customers welcomed me into their system, inevitably the visitor and complainant staff members would eventually welcome me as well. However, my point of entry would be with those staff members who are customers looking for difference within the organization.

I would work no differently with the clients who are part of the system. Clients who are most helped by disease-based assumptions about addiction would be involved in a visitor and complainant type of relationship with me. Since what they are doing in therapy is already working for them, they wouldn't be as invested in receiving different types of therapy compared to those clients who are considered customers. Those clients who have been in and out of rehabs and unable to benefit from disease-based notions of addiction would be most invested in what I had to offer. They would be customers.

Therefore, on an organizational level, the integration of family therapy would require larger scale integration processes and restructuring of the entire system. Lowman (2002) reports that this kind of restructuring requires "extensive learning by the organization and its members" (p. 56), which is where the findings of this study would be pertinent.

A Family Therapy Addiction Treatment Facility

My longer longer-term goal is to use the results of this study to inform the development of an entire addiction-treatment institution organized around family therapy principles. After working in the field for a few more years, I plan on opening up my own rehab facility, which I expect will be buffeted by some of the same challenges faced by the addiction industry in general. Nevertheless, the skills I have gained by conducting this study will better prepare me to deal with the great challenge of putting a treatment method in place that does not necessarily conform with the beliefs underlying the addiction treatment industry as a whole.

Theoretical underpinnings. The first theoretical assumption guiding my organization will be that clients are the experts in their own lives, and change does not occur as a result of others on the outside forcing it. As a result, I will wish for most of the clinical team to consist of family therapists. Therapists from other fields will be welcome to work in the facility, with the expectation that they will respect the treatment philosophies inherent to the organization. Any staff members who do not approach their clients with the utmost respect for the life difficulties they have endured will not have a place in the organization. Clinicians who force clients to stay in treatment will also not fit into the culture of this rehab facility. All staff members will be required to have the necessary credentials and qualifications to work with substance misusers.

Culture of treatment. Essentially, the facility I will create will not consist of different levels of care, such as inpatient, partial hospitalization, and outpatient. Rather, it will be one treatment community with an outside detox program available for those at medical risk. Clients who do not have a place to live will have the option to reside in an

apartment so their basic needs will be met. They can focus all their efforts on improving their lives, rather than worrying about their survival. Clients with a place to live will not be forced to stay within the community.

The focus of treatment will be based upon clients' unique needs. For example, clients with severe, chronic pain issues will have access to holistic methods of treatment, such as acupuncture or chiropractic care in addition to individual and group therapy. Furthermore, I will welcome a wide variety of professionals into the organization, allowing clients to choose the treatment options that fit work best for them. From yoga and meditation to nutrition coaching and personal training, services will be available for clients to select in terms of what will best meet their mental, physical, and spiritual needs.

The treatment facility I envision will offer individual, couple, family, and group therapy to everyone; however, the orientation of therapy will be purely relational and systemic. Therapists will encourage clients' family members and spouses to participate in treatment, but it will not be mandatory. Family weekends will be offered twice a month, in the modality I utilized for this study: SFBT-MFG. Groups will be tailored to the needs of the clients, who will choose which groups to attend. Clients will choose their whole treatment agenda based on the range of services offered in the treatment community. Not all groups will be therapeutic; others will be oriented toward skill building and helping clients reintegrate into society as functioning human beings. Since the population of substance misusers varies in terms severity, not everyone needs help reintegrating, because they are already high-functioning in society. Other groups will be provided to those clients, to meet their particular needs. Overall, the treatment culture will reflect a

sense of respect for everyone's differences, with a common goal of enhancing mental and physical functioning, whatever that looks like for each client.

Challenges of a family therapy addiction treatment facility. While my ideas for a systemic rehab facility sound great to me and maybe others who share my therapeutic values, I can imagine that opening up such a treatment center—which operates according to a vastly different set of assumptions than most rehab facilities—will be more challenging than the integration process I described within this study. Integrating an entire rehab facility based on systemic therapy principles will place the process of integration on a much larger scale level. Ironically, I believe that the biggest barrier to creating such a facility—aside from the resistance of larger systems that heavily influence the addiction world, such as pharmaceutical companies—will be the substance misusers' families. These families could be hesitant to send their loved ones into a treatment program that connects them with the individual's addiction problem. Some families may identify the problem only within the individual, as I witnessed on occasion during the clinical project.

Despite many complexities and challenges associated with opening a systemic treatment facility, it could generate possibilities for treatment that our society has never witnessed before. Since the field of family therapy is built upon principles of diversity and cultural inclusion, a larger percentage of the population could be helped by treatment providers who consider the cultural implications of substance misuse (HHS & SAMHSA, 2015). Furthermore, relapse rates in rehab facilities are considerably high, as mentioned in Chapter II. Accordingly, there is an overall feeling of hopelessness about substance misusers getting better. Family members act as firsthand witnesses to their loved ones'

relapses, feeling a profound sense of failure over and over again as they watch them go in and out of rehab programs. Families become hopeful that each time is the last time they will see their loved ones in treatment, only to feel a sense of devastation when relapses occur and their loved ones stay in the same vicious cycle. Opening up a completely different avenue of treatment could offer those who have been through the same type of treatment multiple times another place to receive help—and, for their families, another reason to regain a sense of hope.

Concluding Thoughts

My curiosity about the phenomenon I explored in this study began long before I facilitated the family weekends at Sober Heaven; it started the moment I entered the field of addiction. I will never forget my first few months working in a rehab facility as a registered Marriage and Family Therapy intern, wondering why I could not utilize the useful tools I learned during my systemic training. I realize now that the issue was not that I could not utilize these tools. In fact, it was absolutely necessary that I utilize the tools to survive in a context that deviated considerably from the one I knew how to work in as a therapist.

Upon starting the clinical project, I made it my goal to figure out what is most helpful for substance misusers and their families in the context of intensive multiple family group weekends. My second goal was to shed some light on the experience of surviving in a system that does not see a therapeutic fit for what you have to offer. I decided to go down both of these roads. Not only could I come to better understand how

to fit into the field of addiction treatment, learning about what is most helpful for families within the context of a family program, but other marriage and family therapists could, too.

I previously discussed my experiences of implementing a couples' program at another facility. Although I was already integrated into the system when I implemented that program, I still faced some challenges. I recall the sarcastic responses I received from my co-workers whenever I discussed the couples' program. Despite being well-respected in the organization, I found that my colleagues doubted my ability to work with couples. This experience is no different from what I experienced at Sober Heaven after Weekend Three, when I had gained the respect of the system but was still not given permission by one of my coworkers to conduct a couples' therapy session with one of his clients. Other staff members assumed that no matter what I did, I would only perpetuate clients' toxicity and dysfunction in couple's therapy and sometimes even family therapy, as well.

When I received the wonderful opportunity to create a family program, I assumed it would be less challenging than my previous experience, because I did not think families were as stigmatized by the addiction treatment industry as couples are. My assumptions were wrong. Although staff members recognized the need to include family therapy in addiction treatment, they stigmatized clients' relationships with their family members just as much as their romantic relationships. From their perspective, just as couples are toxic and sick, so are families. Due to their beliefs about the toxicity inherent within the families of substance users, some therapists did not allow clients' families to participate in the treatment process, even if the clients desired to include them. I recall some therapists at Sober Heaven reporting that some of the clients' families "weren't ready"

for the weekends. These kinds of responses always baffled me, because I believed the exact opposite. My assumption is that families need treatment so they can be ready for each other. How does a therapist determine who is ready and who is not? Furthermore, if there is a great deal of dysfunction in clients' family relationships, and other families can influence change in each other more than a single therapist can, family weekends seem to be an ideal opportunity to create change. I never debated my ideas with other staff members at either of my places of employment, because I was unsure how to challenge their ideas without coming across as disrespectful. Instead, I respected the decisions other therapists made for their clients.

Marriage and family therapists will always have to work within restraints when they practice within an individualistic paradigm of mental health. However, as the findings of this study clearly demonstrate, the limitations do not have to define them or take anything away from how they practice therapy. There is a way of working within these treatment contexts that allows MFTs to stay true to who they are while respecting the beliefs of the system at the same time.

As with all action research projects, the conclusion is the time for us, researchers, to discover "the resolution of the problems with which we started" (Stringer, 2014, p. 184). Although the clinical project at Sober Heaven has ended, and my research on the clinical project is complete, I still have a long journey ahead of me. With all endings come new beginnings; for me, this is only the start of what is yet to come.

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Appendices

Appendix A

Clients' Pretreatment Change Questions

- 1) If I were to ask you to put a number on a 1-to-10 scale that characterizes how your family life as a whole has been the last few months, what number would you choose?

- 2) Whose idea was it for you to get help?

- 3) Sometimes when people make a momentous decision, such as to begin the process of recovery, that choice is preceded or accompanied by other changes. What differences have you noticed recently in what you and/or your family members have been doing or thinking or feeling?

- 4) What do we need to work on together during family weekend so that when you leave, you can look back and say, "This was worth our time and involvement?"

- 5) What do you anticipate being different in your family's life two or three months after you complete treatment? What will each of you be doing differently?

Appendix B

Families' Pretreatment Change Questions

- 1) If I were to ask you to put a number on a 1-to-10 scale that characterizes how your family life as a whole has been the last few months, what number would you choose?
- 2) Whose idea was it for your loved one to get help?
- 3) Sometimes when people make a momentous decision, such as to begin the process of recovery, that choice is preceded or accompanied by other changes. What differences have you noticed recently in what your family has been doing or thinking or feeling?
- 4) What do we need to work on together during family weekend so that when you leave, you can look back and say, "This was worth our time and involvement?"
- 5) What do you anticipate being different in your family's life two or three months after you complete treatment? What will each of you be doing differently?

Appendix C

Brochure

Regaining Connections: Because families recover too

Treatment Philosophy

Families typically experience many emotions—from anger and relief, to confusion and fear—while their loved one is going through recovery. Family members want what’s best for him or her, but both addiction and addiction treatment are complex and multi-faceted, so they aren’t always sure how to be helpful. The family program at Sober Heaven offers guidance and support, built on the foundational recognition that encouragement and connection can improve the quality of family life and enhance the resilience of recovery. Sober Heaven recognizes that all families have their own unique strengths, some of which have developed from hardships and adverse life circumstances. We also know that all families are capable of growth and change. Families can act as tremendous resources for their addicted loved one’s recovery because they know not only more about his or weaknesses than anyone else, but also more about hidden potentials and possibilities. An effectively supportive family and social environment can be crucially important for the entire recovery process, from first steps through ongoing maintenance. The addiction has had serious consequences for the addicted loved one and the family alike; it only makes sense, then, that everyone may have something valuable to contribute to the solutions and resolutions involved in recovery.

In keeping with Sober Heaven’s general treatment philosophy, the Family Program is committed to incorporating “new leading edge evidence based treatment,” emphasizing the healing potentials in each family.

Treatment Approach

The Family Program involves a family weekend at Sober Heaven, tailored to each individual family and their needs. This treatment approach offers a different way of looking at families, one that respects the intensity, complexity, and unique qualities of each family’s struggles, while also discovering and highlighting their unique reparative potentials. The program invites and promotes family change through behavioral, emotional, and communicational alterations in the way members relate to each other. Families learn how to let go of ineffective ways of interacting and how to establish and hold onto effective alternatives and workable solutions. They are guided through an exploration of previous ways they have coped with the addiction and also of new ways they can address and resolve the negative consequences the addiction has had on their family. By discovering and practicing strategies for the effective handling of problems related to the addiction, they learn skills they can take home with them and maintain in the future, promoting ongoing family recovery.

The Treatment Experience

While your family and addicted loved one are with us during the family weekend, you will be working directly with a licensed family therapist dedicated to creating the most viable courses of action to strengthen family bonds and enhance overall family functioning. Prior to the weekend starting, your family therapist will begin exploring the needs of your family by conducting a one-on-one assessment with each family and addicted loved one. During the family weekend, your family and addicted loved one will join other families for two full days, engaging in a series of enriching therapeutic exercises designed to address the concerns that caused your family to seek professional help. You will be given the opportunity to interact with other families who are experiencing similar problems, as well as finding ways to improve connections and enhance communication skills within your own family. Therapeutic exercises will be undertaken by individual families, as well as by the group as a whole. Families will gain greater clarification about what they can do for themselves and their loved one, participating in conversations that move cautiously but steadfastly towards optimism, rather than despair. Families will conclude their weekend with a new sense of direction and hope for themselves and their addicted loved one.

About the Therapist

Sandra DiMarco is a licensed family therapist who has been focused on helping individual, couples, and families overcome the negative effects of addiction. Earlier in her career, she facilitated family workshops on dysfunctional and functional family patterns. Inspired by a deep desire and curiosity to find ever more effective ways to make a difference, she approaches all individuals and families with compassion and a commitment to their best interest. Sandra received her family therapy education and training at Nova Southeastern University.

Appendix D

Family Weekend Invitation

Please Join Us for Family Weekend; Regaining Connections

Where:

Sober Heaven

84 NW St, Waves Beach, FL 33333

When:

Sunday, August 27 & Monday, August 28

Time:

8:30am-4:00pm, Sunday & Monday

Suggested hotels:

Sunburn Motel

(833) 571-9826

4584 SW 80th Ave

Waves Beach, FL 33333

(1.2 miles away)

The Lowkey Resort

(833) 905-9223

5770 Center St.

Waves Beach, FL 33333

(2 miles away)

The Sand Tide Inn

(833) 195-1336

558 NW 89th Blvd

Waves Beach, FL 33333

(3.6 miles away)

**Please contact Sandra DiMarco (833) 321-2593 for questions
Breakfast & Lunch will be provided!**

*Regaining
Connections:
Because Families
Recover Too*

Appendix E

Weekend Evaluation Surveys

Family Weekend Survey

- 1) Did your experience meet your expectations? Did you get what you hoped for and/or needed?
- 2) What did you find most meaningful or significant about what happened?
- 3) Do you anticipate that what you experienced or learned here will make a difference for you and/or your loved one(s) in the future? How so?
- 4) Anything the facilitator could or should have done differently? Any additional comments or suggestions?



Appendix F

Staff Evaluation Survey

- 1) Have you received any feedback from family members who participated in the most recent family weekend? If so, how did they describe their experience?

Please provide specific details.

- 2) On a scale from 1-10 (with 1 = very dissatisfied, and 10 = very satisfied), how would you rate your client's (or clients') overall experience of the family weekend?

- 3) What did you consider most significant in what you heard about the weekend?

- 4) If you participated in the family weekend, please describe your perception of the clients' and families' experiences. What about your experience? What did you consider most significant in what you observed?

- 5) Based on the feedback you heard from clients/families and/or your participation in the family weekend, do you have any suggestions for what could be changed or improved?

Appendix G

Weekend 1 Family Agenda

Sunday, August 27, 2017

8:30 am- 9:00 am: **Breakfast**

9:00 am- 10:30 am: **Introduction**

- Group facilitator introduces herself, explains the structure of the weekend, and reiterates issues of confidentiality

Icebreaker: Getting to know each other

- *Purpose:* To help families join, establish trust, promote safety, and vulnerability with each other.
- *Group Discussion:* “None of you would be here today if, at the heart of your experience, you weren’t deeply caring people. You care about the well-being of the person who is here getting treated, you care about the well-being of your family, and you care about your own well-being. You sought out help for yourself or your loved one, or you supported this reaching out. Form groups of 3 and go meet with someone you don’t know and find out about the strengths and skills they have to care. None of the three of you should be in the same family. Take some notes, because when we come back together, you will be introducing this person to the group, describing briefly the heart of his or her caring”
- *Methods:*
 1. Allow participants to go off in groups and answering the following questions: “What does this person care about?” “What matters to him or her?” “How has he or she brought commitment to caring into making the world a better place?”
 2. Facilitate interactive group discussion, allowing participants to introduce themselves and get to know each other
- *Tip:* If one group member is too loquacious, use empathy skills to summarize what they say and move on. Other people will become restless when a person dominates. Participants will look at the group facilitator’s competence to stop this kind of dynamic, which must be done in a respectful way.

Pre-treatment change questionnaires: How you got here

- *Purpose:* To begin orienting the families to change.

- *Group Discussion:* “Those of you that are here for treatment and this may be your first time participating in a facility such as this, some of you may have been at this facility or others, nevertheless coming here marks a change from prior to coming here. You each made a decision and your family is somehow supporting that decision in coming here to make a significant change. What have you noticed, if anything, that is really subtle, just slight changes interactions between you and your family or the way you are feeling about yourself or your family?”

Now for the families, now that your loved one has been in treatment for some time, what are you noticing that is going on with your family now and what are you anticipating being different once the person gets out of treatment?”

- *Method:*
 1. Facilitate interactive group discussion allowing participants to discuss differences
- *Tip:* Distinguish time now from time which use to be. What is going on now, how that transitioned and how what is unfolding currently could set up for something to being different in the future.

10:30 am: **Break**

10:45 am- 12:00 pm: **Making Sense of Addiction**

Ted Talk: Johann Hari

- *Purpose:* To help families join, establish trust, and promote safety and vulnerability with each other. Additionally, to place the idea of addiction in a larger context.
- *Methods:*
 1. Instruct participants to get into groups with two or more people they don't know, and watch the video together. The group facilitator tells the participants there will be questions at the end of the video.
 2. After the video, instruct group participants to discuss the following questions with their other group members:
 “What stood out for you?” “What did you conclude?” “Did you come to any sort of consensus with each other in terms of what you agreed with? Didn't agree with?” “If there is no consensus, what are the variety of answers?”

3. Instruct them that one of the people in their group will be reporting on what their group came up with.
 4. Once the groups are done discussing these questions, invite them back together.
 5. Ask each individual group one of the three questions, and process answers in the context of the larger group.
- *Tip:* When people are watching the video, look around for people who look impatient, having side conversations, and so on. If this kind of group dynamic is occurring, cut the video short and ask, “Ok, so far, he said the following 3 things. What are you thinking?”

When participants are in their groups, walk around and listen to assess the degree to which they are engaged in the exercise. If they are not, do not directly intervene with individual groups, but cut it short.

Codependency: Making Sense of Family Relationships around Addiction

- *Purpose:* To talk about codependency in a way that endorses change, rather than prevents it. Use codependent discussion to uncover natural strengths rather than negative identities that need to be eliminated.
- *Group Discussion:* Group facilitator asks participants about their thoughts on what codependency is, what it isn't, and so on, in an effort to explore their realities about it. The group facilitator mentions the following definitions of codependency if not brought up in the group discussion:
 “Trying to rescue or fix the damage caused by someone else's irresponsible behavior.” “Trying to change someone else at the detriment of your own physical, emotional and spiritual well-being.” “Tendency to put others' needs ahead of one's own.” “Reliance on others for approval, identity and self-esteem.” “Trying to control the other's behaviors and feelings.”
- *Methods:*
 1. Group facilitator facilitates discussions about the above definitions of codependency in a resource-oriented way, utilizing metaphor and story. Exceptions and differences are explored.
 2. “Trying to rescue or fix the damage caused by someone else's irresponsible behavior.”
 Resource-oriented discussion is orientated around the ideas of protecting the other in an exhaustive, all-encompassing manner. A metaphor can be used about parents' love for their young child with parents' whole being wrapped up in preventing them from falling or being rude to others. So,

the parental hovering is about protection and staying safe, which is not an element of their love to be taken away. Participants are encouraged to not think about how to care or protect less, but rather how to protect more effectively

3. "Trying to change someone else at the detriment of your own physical, emotional and spiritual well-being."
Resource-oriented discussion about this definition is oriented in the idea of helping the other in a way which undermines them and the other person. Group facilitator tells a story about this idea. An example, a wife who would sit home constantly in efforts to change her husband's problem. As a result, she became isolated and began feeling depressed. After the telling of the story, the group facilitator poses questions about what the wife could have done differently.
4. "Tendency to put others' needs ahead of one's own."
Resource-oriented discussion about this definition is oriented in the idea about anger as a way to set a boundary. Group facilitator tells another story about a man who constantly put everyone else before himself, then would become resentful and explode on others. As a result, he utilized anger as a way of setting a boundary to stand up for himself and his own needs. After telling the story, the group facilitator poses questions about setting boundaries but not having to do it through anger. Furthermore, the difference between, "I can't do it" and "I won't do it" is processed. The easier thing to do with someone you love is to say, "I can't do it because I am too sick or too tired" rather than won't. Discussions are processed around the ability to establish a safe boundary, one that is not built into "I have to establish this as my own inability, rather than, I am taking this as a position of strength." Also, exceptions are explored about times participants stood up for themselves without using anger to do it.
5. "Reliance on others for approval, identity and self-esteem."
Resource-oriented discussion about this definition is about how others around you can think your worthwhile but you are not so sure. Then, others continue to try and convince you, but you don't believe them or protect yourself from the ideas they are trying to convince you of. Ideas are explored about what has made it possible in their lives to know that they have an outsider who sees something in them, and they discover that it is legitimate and see something that is an actual reflection for what is going on for them?
6. "Trying to control the other's behaviors and feelings."
Resource-oriented discussion about this definition brings in the serenity prayer, "Accept the things I cannot change, the courage to change the things I can and the wisdom to know the difference." The idea of ordering another person around to control their unstable situation is processed.

However, then the other person has to protect themselves from other people telling them what to do. The way they do that is to counter what the other person is saying. It may feel like the other person is unwilling to accept their advice; however, individuals are self-determining. It is a natural human need to feel the power to control our own lives. Furthermore, if you are only doing what the other person is telling you to do then you no longer exist and lose yourself. If clients only do what others tell them they will find sobriety by losing themselves, which doesn't make for a stable sobriety.

12:00 pm- 1:00pm: **Lunch**

1:00 pm- 2:30 pm: **Discovering and Exploring Family Resources, Part 1**

Exploring Resources

- *Purpose:* To endorse family members' positive views of each other. Furthermore, to endorse a conversation based on abilities rather than deficits. Family members planting seeds for clients to think differently, more optimistically, about their capabilities and vice versa
- *Methods:*
 1. The group facilitator poses the following question to the family members, "What do they know about their loved one that keeps them in recovery?"
 2. The group facilitator poses the following question to the clients, "What do you see in your family that helps you keep going, that they provide that has made it possible for you to enter into recovery and for you to have the courage and strength to make this tremendous effort?"
 3. Answers are processed in the context of the group.
 4. Family members and clients discuss what they discovered about each other.
- *Tip:* If participants are unable to answer these questions and instead start to complain, steer the conversation by acknowledging their feelings with empathy and then becoming curious about what made it possible for them to be present in the family weekend, despite their deep sense of frustration for the other.

2:30 pm: **Break**

2:45 pm- 3:45 pm: **Discovering and Exploring Family Resources, Part 2**

Being Resourceful for Each Other

- *Purpose:* Open up possibilities for family members to help each other effectively, increasing their confidence in their ability to deal with future problem.
- *Methods:*
 1. The group facilitator instructs families to ask the following questions to another person in recovery aside from their family member, “If you were our son, husband, brother, wife; what could we do differently than we been doing that would help you maintain your sobriety? If you had to give us your best advice in how to be most helpful, if you were our family member—what can you tell us that we could benefit from, from your experience, what would be most helpful?”
 2. The group facilitator emphasizes that this is a brainstorming activity and discusses brainstorming as ideas in which no one has to be wrong or agree. They can decide later if the idea fits for them.
- *Tip:* Reassure clients that if they do not know, it is okay. They can begin by talking about what their family did that wasn’t helpful. Then, together everyone can talk about what would have happened if things were done differently.

Surprisingly Positive Benefits of Difficult Emotions

- *Purpose:* Address families’ feelings of isolation and stigmatization surrounding addiction while increasing possibilities.
- *Group Discussion:* The group facilitator discusses negative emotions not as a long-term solution. Rather, a long-term way of managing a relationship with themselves which doesn’t work very well. Furthermore, ideas are endorsed about these emotions as a tool to protect themselves. Participants are encouraged to think about some other way of having a relationship with themselves that doesn’t depend on profound disappointment.
- *Methods:*
 1. Group facilitator connects themes across participants and processes answers between all participants within the context of an interactive group discussion.

3:45 pm- 4:00 pm: **Evaluation Surveys**

4:00 pm: **Adjournment**

Monday, August 28, 2017

8:30 am- 9:00 am: **Breakfast**

9:00 am- 10:30 am: **Inching Towards Change**

Getting From What Doesn't Work to What Does

- *Purpose:* To explore the context in which families do not have addicted relationships, and alter interactional patterns organized around the addiction. The group facilitator encourages the sharing of similar or divergent experiences to create a context for direct and indirect leaning among multiple families
- *Methods:*
 1. Hand all the participants a pencil and piece of paper
 2. Instruct families to think about the following questions:
 “What happens during periods of addictive behavior?” “Who was talking to whom and who wasn’t talking to whom?” “What were the different ways stressors/hurt about the addiction were handled?” “What is going on during times of non-addictive behavior?” “Who was talking to whom and who wasn’t talking to whom?” “What were the different ways stressors/hurt about the addiction were handled?”
 3. Give participants five to ten minutes to processes questions on a piece of paper
 4. Ask volunteers to share their experience. On a flip chart, the group facilitator will draw a line down the center, one side representing abstinence and the other representing non- abstinence
 5. The group facilitator facilitates a discussion that connects family members’ experiences about differences; behaviors during periods of abstinence vs. periods of non-abstinence. The group facilitator is encouraged to utilize SFBT questioning within the discussion to elicit what worked before and what failed to work.

Getting a Feel for Change

- *Purpose:* To establish the first smallest steps in assisting the family to move toward desired changes in an experiential way. Furthermore, to honor and respect multiple perspectives of family relationships and find a common ground within their experiences to promote possibilities for change.

○ *Methods:*

1. The group facilitator lets the group know that this exercise involves asking people to stand as if they were in a sculpture. Furthermore, the group facilitator tells the participants the exercise could involve being gently touched or “put” into a position, and that anyone is welcome to say they do not want to be put into position.
2. Ask a participant to volunteer to sculpt their family’s response to them being an addict.
3. Ask the participant to choose people from outside her family to play the role of the characters in their family. Remind them to remember to select a volunteer who will represent their addiction. Essentially, the participant will personify their addiction.
4. The group facilitator provides the instructions, “You can move people in any position to show us what it is like to be in your family. You can tell them with words how to stand or sit, or, if they give you permission, you may move them gently with your hands. You may even tell them how to position their eye contact.”
5. Then, instruct the participant to change positions of the volunteers, who are playing the role of their family members to reflect positions representing what they want in their relationships.
6. The group facilitator facilitates a discussion with the participant who is sculpting their family about the effects the changes in position have upon them.
7. After the sculpting exercise is complete, the group facilitator opens up the discussion to the entire group. Participants who volunteered to play family roles are asked about what it was like for them to play that role. Participants who were observers are asked what it was like for them to witness the sculpting exercise, and so on.

10:30 am: **Break**

10:45 am- 12:00 pm: **Keeping Change Going**

Inching Forward

- *Purpose:* Promoting family empowerment to utilize the resources within them, endorsing families to interact in support manner with each other. Additionally, to endorse families’ supportive interactions with each other and perspectives about a hopeful family recovery future.

○ *Methods:*

1. The group facilitator asks the group to brainstorm a few desirable characteristics of family recovery (family activity, doing chores together, fewer arguments) from their own experience, expectations, and hopes.
2. Then, she will ask the group to separate into their individual families and choose two or three items that would make a big difference within their families if family members were to follow through their ideas. Additionally, the families are asked to answer the following questions: “What is the first smallest step your family has to take to implement these ideas?” “What would each of you notice that would tell you the family was moving in a positive direction?”
3. Ask the group to come back together and promote a group discussion with the families about the ways they decided the three items from the list were important to them. Then, how it was different than the way they would have made a family decision before attending the weekend.
4. The group facilitator concludes the discussion by asking each family to decide what they must do to keep the positive changes going over the next few weeks.

12:00 pm- 1:00pm: **Lunch**

1:00 pm- 2:30 pm: **Learning from Slips, Part 1**

- *Purpose:* To end the weekend by encouraging families to utilize their internal resources for any potential problems in the future. Furthermore, to encourage sensitivity to the potential for a relapse. By altering the language into a slip, relapses are made to be less horrific, placing families in a position to possibly behave differently if one occurs.
- *Group Discussion:* “A slip can be anywhere from questioning whether you can maintain your sobriety, ‘Wow, I am really struggling today.’ It can be a slip in confidence. It can be a slip in hope, in positive attitude or behavior. And the earlier you identify there is a slip, before it becomes a behavior, the easier it is to address it and do something about it. So, identifying non-behavior slips is an essential part in maintaining your sobriety. Instead of taking it as evidence of failure, take it as evidence of learning. The more committed you are to learning from slips, the less dangerous they need to be. I’ve had clients who get freaked out by dreams of using. Instead of freaking out, it is a gift that can be learned from. Slips begin so small that other people may not notice them. And if they do, bring it to the family and the family as a whole can be helpful in addressing it. It is not the worst thing; it may be the

very essential thing for you to learn what you need to learn in order for you to stay sober. It doesn't have to be you actually using. It can be afraid of you using. Or scoping out where you typically score or looking up the phone number for people you typically use with. And when you identify it, it becomes a point to be different.

It is like walking along ice. You slip but you do not fall if you maintain your balance. And you learn how to walk on ice by maintaining your balance. Slipping does not necessarily mean falling. It is all about finding and maintaining your balance. And you don't find balance by not living. If you are walking on ice and slip, you learn to regain your balance even before falling. Now if you fall, you learn from your falling but if you have been learning successfully during your slips, you can negotiate ice very well."

- *Methods:*

1. After the group facilitator facilitates a group discussion about slips, instruct individual families to separate into groups.
2. Then, pose the following questions to the families:
 "What would be the first sign that a slip is on the horizon before the slip actually happened?" "What could each of you do to prevent it from making it all the way to the loved one in the family?" "What do they need to notice to notice when things are starting to be more challenging for them?" "When this happens, what are you going to do?" "How are you going to communicate about it differently?"
3. After the families process these answers in the context of their group, invite families back together in the larger group and process the families' discussions.

- *Tip:* If you are working within a facility abiding by 12-Step principles, check with the administrators to ensure they agree with utilizing the language of a "slip."

2:30 pm: **Break**

2:45 pm- 3:45 pm: **Learning from Slips, Part 2**

- *Purpose:* To end the weekend by encouraging families to utilize their internal resources for any potential problems in the future. Furthermore, to encourage sensitivity to the potential for a relapse. By altering the language into a slip, relapses are made to be less horrific, placing families in a position to possibly behave differently if one occurs.

- *Methods:*

1. The group facilitator instructs everyone to close their eyes in the context of the group. Then, they facilitate a guided imagery exercise oriented in the idea of a relapse as a slip. The goal is to create a shift in future family behaviors about relapses by utilizing language that endorses change, such as story and metaphor.
2. After guiding participants through the guided imagery exercise, the group facilitator invites participants back into the group to briefly process what just occurred for them during the guided imagery.

3:45 pm- 4:00 pm: **Surveys**

4:00 pm: **Adjournment**

Appendix H

Weekend 2 Family Agenda

Saturday, October 28, 2017

10:00 am- 10:30 am: **Breakfast**

10:30 am- 12:30 pm: **Introduction**

- Group facilitator introduces themselves, the structure of the weekend and reiterated issues of confidentiality

Icebreaker: Getting to know each other

- *Purpose:* To help families join, establish trust, and promote safety and vulnerability with each other.
- *Group Discussion:* “None of you would be here today if, at the heart of your experience, you weren’t deeply caring people. You care about the well-being of the person who is here getting treated, you care about the well-being of your family, and you care about your own well-being. You sought out help for yourself or your loved one, or you supported this reaching out. Form groups of 3 and go meet with someone you don’t know and find out about the strengths and skills they have to care. None of the three of you should be in the same family. Take some notes, because when we come back together, you will be introducing this person to the group, describing briefly the heart of his or her caring”
- *Methods:*
 1. Allow participants to go off in groups and answering the following questions: “What does this person care about?” “What matters to him or her?” “How has he or she brought commitment to caring into making the world a better place?”
 2. Facilitate interactive group discussion, allowing participants to introduce and get to know each other.
- *Tip:* If one group member is too loquacious, use empathy skills to summarize what they say and move on. Other people will become restless when a person dominates. Participants will look at the group facilitator’s competence to stop this kind of dynamic which must be done in a respectful way.

12:30 pm: **Break**

12:45 pm- 1:30 pm: **Making Sense of Addiction, Part 1**

You Tube Video: Gabor Mate

- *Purpose:* To help families join, establish trust and, promote safety and vulnerability with each other. Additionally, to place the idea of addiction in a larger context.
- *Methods:*
 1. Instruct participants to get into groups with two or more people they don't know and watch the video together. The group facilitator tells the participants there will be questions at the end of the video.
 2. After the video, instruct group participants to discuss the following questions with their other group members:
 "What stood out for you?" "What did you conclude?" "Did you come to any sort of consensus with each other in terms of what you agreed with? Didn't agree with?" "If there is no consensus, what are the variety of answers?" "New revelations?"
 3. Instruct them that one of the people in their group will be reporting on what their group came up with.
 4. Once the groups are done discussing these questions, invite them back together.
 5. Ask each individual group one of the three questions, and process answers in the context of the larger group.
- *Tip:* When people are watching the video, look around for people who look impatient, having side conversations, and so on. If this kind of group dynamic is occurring, cut the video short and ask, "Ok, so far, he said the following 3 things. What are you thinking?"

When participants are in their groups, walk around and listen to assess the degree to which they are engaged in the exercise. If they are not, do not directly intervene with individual groups but cut it short.

1:30 pm- 2:30 pm: **Lunch**

2:30 pm- 4:00 pm: **Making Sense of Addiction, Part 2**

Codependency: Making Sense of Family Relationships around Addiction

- *Purpose:* To educate participants about codependency utilizing relational concepts. Furthermore, to promote codependency as occurring in relationships, rather than a phenomenon occurring within one individual.
- *Methods:*
 1. Group facilitator facilitates a psychoeducational group with a PowerPoint to explain what codependency is.
 2. Codependency is presented as a way person deals with people in relationships and the way they deal with themselves. Furthermore, codependency is framed as an attempted solution to behaviors in the families but fails to be effective.
 3. Common characteristics of codependency are listed. The list is meant to be exhaustive, to normalize codependent behaviors and assist participants in recognizing that almost everybody will experience a codependent behavior at one point or another—for example, mothers who parent a young child. The point is made that while being completely codependent can have negative effects, codependency does not constitute a diagnosable mental health condition.
 4. Codependency vs. interdependency is processed.
 5. A family definition of codependency is explained: “A dysfunctional pattern of living which is nurtured by a set of unwritten rules within a family. It is these unwritten rules which affect our approach to living. Each family has their own set of unwritten rules.” Unwritten rules are defined, and participants are asked if any of these rules occurred in their families while growing up.
 6. Enabling is discussed as shielding the addict from experiencing the consequences of their behavior. The enabler is defined as the one who is emotionally closest to the addict and protector of the family.
 7. Letting go of control is discussed as, “letting go of what you cannot control is hard. However, holding onto these uncontrollable things and trying to manage them is much harder.” A hand-out is distributed to further explain this idea. Then the following questions are presented in the context of the group:
 “If you knew that you had no power to control a particular person, how would you behave differently? What would you stop saying or doing? What would you say instead? What would you be doing differently in order to enjoy your own life?” “What is the most loving and nurturing thing available to you right now that you can use to take care of yourself and begin enjoying life?”

4:00 pm: **Break**

4:15 pm- 5:15 pm: **Discovering and Exploring Family Resources**

Exploring Resources

- *Purpose:* To endorse positive family members' positive views of each other. Furthermore, to endorse a conversation based on abilities rather than deficits. Family members planting seeds for clients to think differently, more optimistically, about their capabilities and vice versa
- *Methods:*
 1. The group facilitator poses the following question to the family members, "What do they know about their loved one that keeps them in recovery?"
 2. The group facilitator poses the following question to the clients, "What do you see in your family that helps you keep going, that they provide that has made it possible for you to enter into recovery and for you to have the courage and strength to make this tremendous effort?"
 3. Answers are processed in the context of the group.
 4. Family members and clients discuss what they discovered about each other.

Tip: If participants are unable to answer these questions and instead start to complain, steer the conversation by acknowledging their feelings with empathy and then becoming curious about what made it possible for them to be present in the family weekend, despite their deep sense of frustration with the other.

5:15 pm- 5:30 pm: **Surveys**

5:30 pm: **Adjournment**

Sunday, October 29, 2017

10:00 am- 10:30 am: **Breakfast**

10:30 am- 11:30 am: **Inching Forward Towards Change**

What are our strengths?

- *Purpose:* To encourage motivation for change in the families by supporting their strengths.
- *Methods:*
 1. The group facilitator hands out a piece of paper to all the participants and poses the following questions:
“Name one strength about their family they are grateful for. If no strengths, what strength would they like to see in their family?” “Name a strength they see in the other family, but never told them.” “Name a strength the family has used in the past to overcome a problem related to addiction?”
 2. After participants are done writing their answers, the group facilitator goes around to each family group and instructs them, if they feel comfortable enough, to read what they wrote out loud.
 3. Responses are processed in the context of the larger group.

Getting a Feel for Change

- *Purpose:* To establish the first smallest steps in assisting the family to move toward desired changes in an experiential way. Furthermore, to honor and respect multiple perspectives of family relationships and find a common ground within their experiences to promote possibilities for change.
- *Methods:*
 1. The group facilitator lets the group know that this exercise involves asking people to stand as if they were in a sculpture. Furthermore, the group facilitator tells the participants the exercise could involve being gently touched or “put” into a position, and that anyone is welcome to say they do not want to be put into position.
 2. Ask a participant to volunteer to sculpt their family’s response to them being an addict.
 3. Ask the participant to choose people from outside her family to play the role of the characters in their family. Remind them to remember to select a volunteer who will represent their addiction. Essentially, the participant will personify their addiction.
 4. The group facilitator provides the instructions, “You can move people in any position to show us what it is like to be in your family. You can tell them with words how to stand or sit, or, if they give you permission, you

may move them gently with your hands. You may even tell them how to position their eye contact.”

5. Then, instruct the participant to change positions of the volunteers who are playing the role of their family members, to reflect positions representing what they want in their relationships.
6. The group facilitator facilitates a discussion with the participant who is sculpting their family about the affects the changes in position has upon them.
7. After the sculpting exercise is complete, the group facilitator opens up the discussion to the entire group. Participants who volunteered to play family roles are asked about what it was like for them to play that role. Participants who were observers are asked what it was like for them to witness the sculpting exercise, and so on.

11:30 am- 12:00 pm: **Guest Speaker, alumni of the facility**

12:00 pm: **Break**

12:15 pm- 1:30 pm: **Keeping Change Going**

Being Resourceful for Each Other

- *Purpose:* Open up possibilities for family members to help each other effectively, increasing their confidence in their ability to deal with future problem.
- *Methods:*
 1. The group facilitator instructs participants to break off in their own individual family groups.
 2. Clients answer the following questions and discuss them with their family members:
 3.
 - “How do you know when you want your family to help you? How will they know you want their help?” “What do you suppose, up until now, your family would say all they have done to try and be helpful to you?” “If they could help in a way that works for you, what will they do differently? What difference would that make in your relationship?”
 4. Families answer the following questions and discuss them with clients:
 - “When have you known when your loved one needs help? How do you know they want your help?” “What do you suppose would say, up until

now, all that you have done to try and be helpful to him/her?” “What have you learned that can tell you differently they may be struggling? Knowing what you learned now, what difference would that make in the relationship?”

5. The group facilitator invites individual family groups back into group to process what they learned about each other in the context of the group.

1:30 pm- 2:00 pm: **Lunch**

2:00 pm- 3:45 pm: **Learning from Slips, Part 1**

- *Purpose:* To end the weekend by encouraging families to utilize their internal resources for any potential problems in the future. Furthermore, to encourage sensitivity to the potential for a relapse. By altering the language into a slip, relapses are made to be less horrific, placing families in a position to possibly behave differently if one occurs.
- *Group Discussion:* “A slip can be anywhere from questioning whether you can maintain your sobriety, ‘Wow, I am really struggling today.’ It can be a slip in confidence. It can be a slip in hope, in positive attitude or behavior. And the earlier you identify there is a slip, before it becomes a behavior, the easier it is to address it and do something about it. So, identifying non-behavior slips is an essential part in maintaining your sobriety. Instead of taking it as evidence of failure, take it as evidence of learning. The more committed you are to learning from slips, the less dangerous they need to be. I’ve had clients who get freaked out by dreams of using. Instead of freaking out, it is a gift that can be learned from. Slips begin so small that other people may not notice them. And if they do, bring it to the family and the family as a whole can be helpful in addressing it. It is not the worst thing; it may be the very essential thing for you to learn what you need to learn in order for you to stay sober. It doesn’t have to be you actually using. It can be afraid of you using. Or scoping out where you typically score or looking up the phone number for people you typically use with. And when you identify it, it becomes a point to be different.

It is like walking along ice. You slip but you do not fall if you maintain your balance. And you learn how to walk on ice by maintaining your balance. Slipping does not necessarily mean falling. It is all about finding and maintaining your balance. And you don’t find balance by not living. If you are walking on ice and slip, you learn to regain your balance even before falling. Now if you fall, you learn from your falling but if you have been learning successfully during your slips, you can negotiate ice very well.”

- *Methods:*

1. After the group facilitator facilitates a group discussion about slips, instruct individual families to separate into groups.
 2. Then, pose the following questions to the families:
 “What would be the first sign that a slip is on the horizon before the slip actually happened?” “What does your family need to notice when things are starting to be more challenging for you?” “When this happens, what are you going to do?” “How are you going to communicate about it differently?”
 3. After the families process these answers in the context of their group, invite families back together in the larger group and process the families’ discussions.
- *Tip:* If you are working within a facility abiding by 12-Step principles, check with the administrators to ensure they agree with utilizing the language of a “slip.”

3:45 pm: **Break**

4:00 pm- 5:15 pm: **Learning from Slips, Part 2**

- *Purpose:* To end the weekend by encouraging families to utilize their internal resources for any potential problems in the future. Furthermore, to encourage sensitivity to the potential for a relapse. By altering the language into a slip, relapses are made to be less horrific placing families in a position to possibly behave differently if one occurs.
- *Methods:*
 1. The group facilitator instructs everyone to close their eyes in the context of the group. Then, they facilitate a guided imagery exercise oriented in the idea of a relapse as a slip. The goal is to create a shift in future family behaviors about relapses by utilizing language which endorses change, such as story and metaphor.
 2. After guiding participants through the guided imagery exercise, the group facilitator invites participants back into the group to briefly process what just occurred for them during the guided imagery.

5:15 pm- 5:30 pm: **Surveys**

5:30 pm: **Adjournment**

Appendix I

Weekend 3 Family Agenda

Saturday, January 27, 2018

10:00 am- 10:30 am: **Breakfast**

10:30 am- 12:30 pm: **Introduction**

- Group facilitator introduces themselves, the structure of the weekend and reiterated issues of confidentiality

Icebreaker: Getting to know each other

- *Purpose:* To help families join, establish trust, and promote safety and vulnerability with each other.
- *Group Discussion:* “None of you would be here today if, at the heart of your experience, you weren’t deeply caring people. You care about the well-being of the person who is here getting treated, you care about the well-being of your family, and you care about your own well-being. You sought out help for yourself or your loved one, or you supported this reaching out. Form groups of 3 and go meet with someone you don’t know and find out about the strengths and skills they have to care. None of the three of you should be in the same family. Take some notes, because when we come back together, you will be introducing this person to the group, describing briefly the heart of his or her caring”
- *Methods:*
 1. Allow participants to go off in groups and answering the following questions: “What does this person care about?” “How has he or she brought commitment to caring into making the world a better place?”
 2. Facilitate interactive group discussion, allowing participants to introduce and get to know each other
- *Tip:* If one group member is too loquacious, use empathy skills to summarize what they say and move on. Other people will become restless when a person dominates. Participants will look at the group facilitator’s competence to stop this kind of dynamic which must be done in a respectful way.

Pre-treatment change questionnaires: How you got here

- *Purpose:* To begin orienting the families to change.

- *Group Discussion:* “Those of you that are here for treatment and this may be your first time participating in a facility such as this, some of you may have been at this facility or others, nevertheless coming here marks a change from prior to coming here. You each made a decision and your family is somehow supporting that decision in coming here to make a significant change. What have you noticed, if anything, that is really subtle, just slight changes interactions between you and your family or the way you are feeling about yourself or your family?”

Now for the families, now that your loved one has been in treatment for some time, what are you noticing that is going on with your family now and what are you anticipating being different once the person gets out of treatment?”

- *Method:*
 1. Facilitate interactive group discussion, allowing participants to discuss differences
- *Tip:* Distinguish time now from time which use to be. What is going on now, how that transitioned and how what is unfolding currently could set up for something to being different in the future.

12:30 pm: **Break**

12:45 pm- 1:30 pm: **Making Sense of Addiction, Part 1**

You Tube Video: Gabor Mate

- *Purpose:* To help families join, establish trust, and promote safety and vulnerability with each other. Additionally, to place the idea of addiction in a larger context.
- *Methods:*
 1. Instruct participants to get into groups with two or more people they don't know and watch the video together. The group facilitator lets the participants know there will be questions at the end of the video.
 2. After the video, instruct group participants to discuss the following questions with their other group members:
“What stood out for you?” “What did you conclude?” “Did you come to any sort of consensus with each other in terms of what you agreed with? Didn't agree with?” “If there is no consensus, what are the variety of answers?” “New revelations?”
 3. Instruct them that one of the people in their group will be reporting on what their group came up with.

4. Once the groups are done discussing these questions, invite them back together.
 5. Ask each individual group one of the three questions and process answers in the context of the larger group.
- *Tip:* When people are watching the video, look around for people who look impatient, having side conversations, and so on. If this kind of group dynamic is occurring, cut the video short and ask, “Ok, so far, he said the following 3 things. What are you thinking?”

When participants are in their groups, walk around and listen to assess the degree to which they are engaged in the exercise. If they are not, do not directly intervene with individual groups but cut it short.

1:30 pm- 2:30 pm: **Lunch**

2:30 pm- 4:00 pm: **Making Sense of Addiction, Part 2**

The Neurology of Addiction: Scientifically-based Hope

- *Purpose:* To utilize new research based on the learning theories of addiction and neuroplasticity, in order to promote a greater sense of hope that their loved ones can change. Furthermore, to endorse ideas from research that prove brains are not permanently impacted from having an addiction.
- *Methods:*
 1. Group facilitator facilitates a psychoeducational group utilizing a PowerPoint, to explain the complexities involved in the development of addiction and broaden the context in which the etiology of addiction is viewed.
 2. Addiction is presented involving the following variables: family, cultural, psychological, biological, environmental, and developmental timing.
 3. The “thinking” brain, prefrontal cortex, is differentiated from the “survival” brain, limbic system. Dopamine produced from drugs versus natural reinforcers are explained. Ideas are emphasized about drugs elevating dopamine so far out of its natural range that it compels people to see the repeated experience far more than natural rewards, such as sex or sugar. “When the brain pathways intended to promote eating, social connection, reproduction and parenting are diverted into addiction, their blessings can become curses”

4. After explaining the detrimental effects drugs can have on the brain, the facilitator will introduce the concept of neuroplasticity and ask participants to share their thoughts about whether the brain can ever go back to the way it was prior to someone abusing drugs.
5. Then, research is cited on neuroplasticity. The group facilitator explains that studies show the reduction of gray matter (decision-making and self-control) in an addicted person return to normal within 6 months to a year of abstinence. Furthermore, after remaining abstinent for a year or more, studies show increased grey matter beyond the levels found in human beings who never struggled with an addiction problem.

Codependency: Making Sense of Family Relationships around Addiction

- *Purpose:* To educate participants about codependency, utilizing relational concepts. Furthermore, to promote codependency as occurring in relationships, rather than a phenomenon occurring in an individual.
- *Methods:*
 1. Group facilitator facilitates a psycho-educational group utilizing a Power Point to explain what codependency is.
 2. Codependency is presented as a way person deals with people in relationships and the way they deal with themselves. Furthermore, codependency is framed as an attempted solution to behaviors in the families but fails to be effective.
 3. Common characteristics of codependency are listed. The list is meant to be exhaustive to normalize codependent behaviors and assist participants in recognizing that almost everybody will experience a codependent behavior at one point or another—for example mothers who parent young children. The point is made that while being completely codependent can have negative effects, codependency does not constitute a diagnosable mental health condition.
 4. Codependency vs. interdependency is processed.
 5. A family definition of codependency is explained, “A dysfunctional pattern of living which is nurtured by a set of unwritten rules within a family. It is these unwritten rules which affect our approach to living. Each family has their own set of unwritten rules.” Unwritten rules are defined, and participants are asked if any of these rules occurred in their families while growing up.

6. Enabling is discussed as shielding the addict from experiencing the consequences of their behavior. The enabler is defined as the one who is emotionally closest to the addict and protector of the family.
7. Letting go of control is discussed as, “letting go of what you cannot control is hard. However, holding onto these uncontrollable things and trying to manage them is much harder.” A hand-out is distributed to further explain this idea. Then the following questions are presented in the context of the group:
 “If you knew that you had no power to control a particular person, how would you behave differently? What would you stop saying or doing? What would you say instead? What would you be doing differently in order to enjoy your own life?” “What is the most loving and nurturing thing available to you right now that you can use to take care of yourself and begin enjoying life?”

4:00 pm: **Break**

4:15 pm- 5:15 pm: **Discovering and Exploring Family Resources**

Exploring Resources

- *Purpose:* To endorse positive family members’ positive views of each other. Furthermore, to endorse a conversation based on abilities rather than deficits. Family members planting seeds for clients to think differently, more optimistically, about their capabilities and vice versa
- *Methods:*
 1. The group facilitator poses the following question to the family members, “What do they know about their loved one that keeps them in recovery?”
 2. The group facilitator poses the following question to the clients, “What do you see in your family that helps you keep going, that they provide that has made it possible for you to enter into recovery and for you to have the courage and strength to make this tremendous effort?”
 3. Answers are processed in the context of the group.
 4. Family members and clients discuss what they discovered about each other.
- *Tip:* If participants are unable to answer these questions and instead start to complain, steer the conversation by acknowledging their feelings with empathy and then becoming curious about what made it possible for them to

be present in the family weekend, despite their deep sense of frustration for the other.

5:15 pm- 5:30 pm: **Surveys**

5:30 pm: **Adjournment**

Sunday, October 29, 2017

10:00 am- 10:30 am: **Breakfast**

10:30 am- 12:00 pm: **Inching Forward Towards Change**

Inching Forward

- *Purpose:* Promoting family empowerment to utilize the resources within them, endorsing families to interact in support manner with each other. Additionally, to endorse families' supportive interactions with each other and perspectives about a hopeful family recovery future.
- *Methods:*
 1. The group facilitator asks the group to brainstorm a few desirable characteristics of family recovery (family activity, doing chores together, fewer arguments) from their own experience, expectations, and hopes.
 2. Then, they ask the group to separate into their individual families and choose two or three items that would make a big difference within their families if family members were to follow through their ideas. Additionally, the families are asked to answer the following questions: "Choose two or three items that would make a big difference if your family was to follow through with their ideas?" "What is the first smallest step your family has to take to implement these ideas?" "What would each of you notice that would tell you the family was moving in a positive direction?"
 3. Ask the group to come back together and promote a group discussion with the families about the ways they decided the three items from the list were important to them. Then, how it was different than the way they would have made a family decision before attending the weekend.
 4. The group facilitator concludes the discussion by asking each family to decide what they must do to keep the positive changes going over the next few weeks.

12:00 pm: **Break**

12:15 pm- 1:30 pm: **Keeping Change Going, Part 1**

Getting a Feel for Change

- *Purpose:* To establish the first smallest steps in assisting the family to move toward desired changes in an experiential way. Furthermore, to honor and respect multiple perspectives of family relationships and find a common ground within their experiences to promote possibilities for change.
- *Methods:*
 1. The group facilitator lets the group know that this exercise involves asking people to stand as if they were in a sculpture. Furthermore, the group facilitator tells the participants the exercise could involve being gently touched or “put” into a position, and that anyone is welcome to say they do not want to be put into position.
 2. Ask a participant to volunteer to sculpt their family’s response to them being an addict.
 3. Ask the participant to choose people from outside her family to play the role of the characters in their family. Remind them to remember to select a volunteer who will represent their addiction. Essentially, the participant will personify their addiction.
 4. The group facilitator provides the instructions, “You can move people in any position to show us what it is like to be in your family. You can tell them with words how to stand or sit, or, if they give you permission, you may move them gently with your hands. You may even tell them how to position their eye contact.”
 5. Then, instruct the participant to change positions of the volunteers who are playing the role of their family members to reflect positions representing what they want in their relationships.
 6. The group facilitator facilitates a discussion with the participant who is sculpting their family about the affects the changes in position has upon them.
 7. After the sculpting exercise is complete, the group facilitator opens up the discussion to the entire group. Participants who volunteered to play family roles are asked about what it was like for them to play that role. Participants who were observers are asked what it was like for them to witness the sculpting exercise, and so on.

1:30 pm- 2:00 pm: **Lunch**

2:00 pm- 3:15 pm: **Keeping Change Going, Part 2**

Being Resourceful for Each Other

- *Purpose:* Open up possibilities for family members to help each other effectively, increasing their confidence in their ability to deal with future problem.
- *Methods:*
 1. The group facilitator instructs participants to break off in their own individual family groups.
 2. Clients answer the following questions and discuss them with their family members:
 3.
 - “How do you know when you want your family to help you? How will they know you want their help?” “What do you suppose, up until now, your family would say all they have done to try and be helpful to you?” “If they could help in a way that works for you, what will they do differently? What difference would that make in your relationship?”
 4. Families answer the following questions and discuss them with clients:
 - “When have you known when your loved one needs help? How do you know they want your help?” “What do you suppose would say, up until now, all that you have done to try and be helpful to him/her?” “What have you learned that can tell you differently they may be struggling? Knowing what you learned now, what difference would that make in the relationship?”
 5. The group facilitator invites individual family groups back into group to process what they learned about each other in the context of the group.

3:00 pm- 4:30 pm: **Learning from Slips, Part 1**

- *Purpose:* To end the weekend by encouraging families to utilize their internal resources for any potential problems in the future. Furthermore, to encourage sensitivity to the potential for a relapse. By altering the language into a slip, relapses are made to be less horrific placing families in a position to possibly behave differently if one occurs.
- *Group Discussion:* “A slip can be anywhere from questioning whether you can maintain your sobriety, ‘Wow, I am really struggling today.’ It can be a slip in confidence. It can be a slip in hope, in positive attitude or behavior.

And the earlier you identify there is a slip, before it becomes a behavior, the easier it is to address it and do something about it. So, identifying non-behavior slips is an essential part in maintaining your sobriety. Instead of taking it as evidence of failure, take it as evidence of learning. The more committed you are to learning from slips, the less dangerous they need to be. I've had clients who get freaked out by dreams of using. Instead of freaking out, it is a gift that can be learned from. Slips begin so small that other people may not notice them. And if they do, bring it to the family and the family as a whole can be helpful in addressing it. It is not the worst thing; it may be the very essential thing for you to learn what you need to learn in order for you to stay sober. It doesn't have to be you actually using. It can be afraid of you using. Or scoping out where you typically score or looking up the phone number for people you typically use with. And when you identify it, it becomes a point to be different.

It is like walking along ice. You slip but you do not fall if you maintain your balance. And you learn how to walk on ice by maintaining your balance. Slipping does not necessarily mean falling. It is all about finding and maintaining your balance. And you don't find balance by not living. If you are walking on ice and slip, you learn to regain your balance even before falling. Now if you fall, you learn from your falling but if you have been learning successfully during your slips, you can negotiate ice very well."

○ *Methods:*

1. After the group facilitator facilitates a group discussion about slips, instruct individual families to separate into groups.
2. Then, pose the following questions to the families:
 "What would be the first sign that a slip is on the horizon before the slip actually happened?" "What could each of you do to prevent it from making it all the way to the loved one in the family?" "What do they need to notice to notice when things are starting to be more challenging for them?" "When this happens, what are you going to do?" "How are you going to communicate about it differently?"
3. After the families process these answers in the context of their group, invite families back together in the larger group and process the families' discussions.

- *Tip:* If you are working within a facility abiding by 12-Step principles, check with the administrators to ensure they agree with utilizing the language of a "slip."

4:30 pm: **Break**

4:45 pm- 5:15 pm: Learning from Slips, Part 2

- *Purpose:* To end the weekend by encouraging families to utilize their internal resources for any potential problems in the future. Furthermore, to encourage sensitivity to the potential for a relapse. By altering the language into a slip, relapses are made to be less horrific placing families in a position to possibly behave differently if one occurs.
- *Methods:*
 1. The group facilitator instructs everyone to close their eyes in the context of the group. Then, they facilitate a guided imagery exercise oriented in the idea of a relapse as a slip. The goal is to create a shift in future family behaviors about relapses by utilizing language which endorses change, such as story and metaphor.
 2. After guiding participants through the guided imagery exercise, the group facilitator invites participants back into the group to briefly process what just occurred for them during the guided imagery.

5:15 pm- 5:30 pm: Surveys**5:30 pm: Adjournment**

Appendix J

Informed Consent for the Family Weekend

Informed Consent

Sandra N DiMarco, M.S. Marriage & Family Therapist

This purpose of this agreement is to identify the nature of confidentiality and expectations for multiple family group therapy. As a client participating in multiple family group therapy, you have certain rights and responsibilities that are important for you to understand. There are also legal limitations to those rights that you should be aware of. As a licensed therapist, I have corresponding responsibilities to you. These rights and responsibilities are described in the following sections.

I. Benefits and Risks

Multiple family group therapy has both benefits and risks. Risks may include experiencing uncomfortable feelings, such as sadness, guilt, anxiety, anger and frustration because the process of multiple family group therapy may bring up unpleasant past experiences or feelings. However, multiple family group therapy has many benefits. Multiple family group therapy can lead to positive changes in family relationships, enhance communication skills and provide the opportunity to meet other families experiencing similar problems. However, there are no guarantees this will happen.

II. Confidentiality

a. Legal limits of confidentiality

You have rights to confidentiality when participating in multiple family groups. I cannot tell anyone else what you tell me without your prior written permission. I will always act to protect your privacy even if you release me in writing to share your information. However, when participating in multiple family groups, other group members are not obligated to the same legal obligations of confidentiality. It is imperative to avoid sharing experiences shared by other families and never talk about them outside the group setting.

You are also protected under the provisions of The Health Insurance Portability and Accountability Act (HIPAA). This law insures the confidentiality of all electronic transmission of information about you. Whenever I transmit information about you electronically (for example, any follow up e-mails post-family weekend), will be done with special safeguards to insure confidentiality.

b. Exceptions to confidentiality

- If I believe that you are in immediate danger of killing yourself, I will have to break confidentiality and call the county crisis team. However, before taking such measures,

I will explore all other options with you. If at that point, you were unwilling to take the required steps to guarantee your safety, I will have to ensure your safety and call the crisis team.

- If I have good reason to believe that you will harm another person, I must attempt to inform that person and warn them of your intentions. I must also contact the police and ask them to protect your intended victim.
- If I have good reason to believe that you are abusing or neglecting a child or vulnerable adult, or if you give me information about someone else who is doing this, I must report this to the Florida Abuse Hotline.

III. Other Rights

You have the right to ask questions about anything that happens during group and are free to leave the group at any time if topics become too overwhelming for you. There will be another therapist available in the building to address your concerns if you decide to walk out of group. If a group member leaves and does not come back, I will call you after the group process and follow up with you.

IV. Format

Family involvement is crucial to the recovery process and negative family support can be a factor contributing to relapse. With my goal to promote positive family support and connection, there will be a range of exercises occurring over the course of the weekend involving talking with your own family, with other families, reflecting as a group and reflecting in small group exercises. There will be minimal lecture and more experiencing and brainstorming about possibilities to be different. Group sessions will be 7 ½ hours long with breaks for breakfast, lunch and other small breaks provided throughout the duration of the day. I encourage everyone to avoid walking in and out during group exercises due to issues of confidentiality since other non-group members could be outside the room. Additionally, if group members continuously walk in and out, it can become disruptive to the group process. I am committed to making this weekend the best it can be for clients and families who participate in the weekends. My plan is to continue to improve the weekends based on your feedback. At the end of each day, I will provide you with an evaluation survey. However, you are not obligated to complete the survey.

V. Complaints

If you're unhappy with what's happening in group therapy, I encourage you to pull me aside and talk with me so I can address your concerns. I will take such criticism seriously, and with care and respect.

Client Signature: _____