An Exploration of the Effect of Family Interaction within the Treatment and Aftercare Programme of Addiction

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The thesis is submitted to the
Higher Education and Training Awards Council (HETAC) for
the B.A. (Hons.) degree in Counselling and Psychotherapy
from Dublin Business School, School of Arts

19th April 2013

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Declaration

I declare that this thesis is my own work, and it has not been submitted as an exercise for a degree in any other University. I agree that the library at Dublin Business School may lend or copy this thesis on request.

Signed: _____ Date: _____

Aiveen Farrelly

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Acknowledgements

Words cannot express my love and thanks to my wonderful husband,

Partner-in-crime, best friend and fellow parent in the trenches, Neil.

Without your unwavering love and support this never would have been possible,

I love you with all my heart.

To my two boys, Jack and Samuel, what can I say?

You are the loves and light of my lifexx

To my mother, who taught me that you cannot save another and how to accept choices.

Heartfelt thanks to the tough love of my amazing supervisor, Siobáin O'Donnell

You kept me on the straight and narrow and gave me those special words of encouragement

when I needed them most, thank you for believing in me.

To my besties, night out is definitely on order, thank you for four years of patience

Come away, O human child!

To the waters and the wild,

With a faery hand in hand,

For the worlds more full of weeping

Than you can understand.

W.B Yeats, Collected Poems.

Abstract

The dark shadows of the soul can only be illuminated by understanding, for it is in the understanding of the shadow held inside the Self which frees the potential to flourish and live life to our best ability. In exploring the effect of family interaction within the treatment and aftercare programme of addiction, the main aim is to gain understanding. Not only for the individual suffering the addiction, but also for the family in their attempt to support or mitigate the consequences of their loved ones addiction. Therefore, this research seeks to explore the opinions of those working in the field of addiction on what effect they feel such interaction can bring. The sample chosen was three therapists presently working within a treatment centre and two aftercare facilitators who work in an aftercare group. The process of thematic analysis was applied to the data gathered from semi-structured interviews. Three salient superordinate themes emerged from such analysis 1) Gift of Truth, 2) Hindrance or a Help and 3) Human Fallibilities. These themes were then each divided into three separate subordinate themes which were discussed extensively. The understanding gained from this research shone light on how the families can contribute both negatively and positively to the substance user's engagement with the treatment and aftercare programmes of addiction. The findings also showed the influence of the professional's opinion of family interaction within the treatment setting, and its potential effect on all parties involved. Understanding towards each other and a consequential emerging awareness proved to have profound positive effect for all involved. Conversely, dysfunctional entrenched and habituated ways of inter-relating and communicating to another had an equally negative influential effect on the outcome of recovery.

Chapter 1: Introduction

1.1 Awareness

The field of psychotherapy and addiction treatment share one inalienable truth, a belief that influences and shapes their theories, ideologies and methods of application, that before the individual can change maladaptive behaviour, they must first be aware of it. One could say that they both strive for this awareness of Self through the dissipation of illusion, delusion and denial. The unconscious holds the aetiology of all seemingly illogical, irrational and potentially damaging behaviours, thoughts and defence mechanisms. It is only with the illuminating light of self-knowledge that the dark shadows held within are dissipated. One cannot address man's maladies of the soul without addressing his environmental experience and his beliefs of the world he lives in. Our earliest environment can hold the earliest learning experience in relation to who a person is, how they relate with others, and where a sense of personal worth was acquired

1.2 Dynamics and Effects

If this where acknowledged, study can then take place in defending the importance of this thesis, this exploration of the effect of family interaction within the treatment and aftercare programme of addiction. Such examination, through a comprehensive literature review, interview methods and analysis of gathered data shall bring forth concepts and themes for further discussion. This discourse shall provide a deeper understanding of the dynamics and cyclical nature of addiction and the family system. The validity of this study is contained in the devastating emotional, psychological, mental, spiritual and social effects of addiction and all those who experience it, either personally or through a loved one, and also as a society at large.

1.3 Validity

Conceding this, we then move to argue that research in this area is continually evolving and adapting. Improvement of understanding in the area of family interaction is still needed, for those working in the field admit that addiction works within a social context and as such, the inclusion of those in the substance abusers environment is imperative (Keene, 2010). Recognising this, part of this research shall include gathering information by a means of interviewing those working in the treatment and aftercare programme of addiction. Common themes and concepts shall be extrapolated from the analysis collected and shall become part of this discourse.

1.4 Nature versus Nurture

The nature of addiction is complex and intrinsically layered, some subscribe to the theory that addiction is an inherited genetic disease that is both chronic and progressive that without successful intervention will lead to criminality and/or death (Edwards & Steinglass, 1985, Stanton & Todd, 1982). Others view the nature of addiction to lie in highly dysfunctional patterns of relating, only taking place in a social context and a form of self-medication that can be alleviated by interaction with family and peer support where appropriate and learning new skills for coping with life and all that experience can hold (Copello & Oxford, 2010, Rassoll, 2011). Both of these theories shall be addressed as part of this exploratory research, for although the treatment and aftercare programme of addiction is no longer focused solely on the individual, there is still much controversy and conflict around the extent of the family's role in addiction treatment (Gifford & Humphreys, 2007).

1.5 Conclusion

Discussion shall take place in relation to the marrying of findings from both detailed analysis of the data garnered from interviewing those who work in the field of treatment and aftercare of addiction, and the research gathered from extensive research of relevant literature. Ethical considerations shall be considered in relation to possible issues that may come to light when working with addiction in the family setting, and a clear and concise explanation shall be given on the methodologies implemented and inclusion/exclusion criteria for this dissertation. To begin, we turn to our broad study of seminal and contemporary literature in the field of family interaction within the treatment and aftercare programme of addiction.

Chapter 2: Literature Review

2.1 Introduction

In the exploration of the effect of family interaction within the treatment and aftercare programme of addiction, the intervention, treatment, aftercare and relapse prevention in conjunction with a brief discussion of the argument for family inclusion shall be discussed. In addition, the ethical considerations of family interaction within addiction treatment shall also be part of this discourse. This thesis is inclusive of all addictions and for the sake of constraint; individuals receiving treatment for active addiction shall be referred to as 'substance user' throughout. With this understanding in place, an argument for family inclusion within addiction treatment shall be made.

2.2 Family Inclusion

Early work in the field of addiction considered the individual suffering substance use issues primarily from a biomedical/behavioural point of view. The Disease Model focused mainly on addiction being an inherited, chronic and progressive disease, and for those born into families with generational addiction patterns, to some extent, an unavoidable fate unless intervention was applied (Edwards & Steinglass, 1995). Contemporary views, however, are inclusive of the treatment of the individual's environment, understanding that there is a clear and distinct recommendation for a systemic perspective based on the Family systems model to be integrated into any treatment plan (Carr, 2005, Copello&Oxford, 2010, Edwards & Steinglass, 1995). Theories of causation have been compared to the elusive chicken and egg argument, with much controversy and opposing opinion still active in the field of addiction treatment (Keene, 2010). Conversely, one point that is agreed on is the importance of place that the bio psychosocial model has in the treatment of addiction. This concerns the place that

the individual's environment, family dynamics and emotional and psychological patterning has in the treatment and aftercare programme (Cmokovic & Delcampo, 1998, Isaacson, E. 1991, Miller& Wilbourne. 2002, Vellerman & Templeton. 2003).

If one is to treat the individual, one must look to where they first learnt the skills of interactional navigation and structured coping and defence mechanisms to gain greater understanding of their current behaviours (Winnicott, 1965). The circular nature of addiction can also be observed in the reciprocal patterns of addictions and families. Dysfunctional family systems can often produce addictive behaviours; these behaviours can then affect family interactional dynamics, which can then create a family system that allows addictive or otherwise damaging ways of relating to flourish (Lewis, 1989, Roessler & Rubin, 1982). Having argued the need for family inclusion, discussion of the intervention stage of addiction treatment and explore the effect of family interaction within it shall proceed.

2.3 Intervention

For families suffering patterns of trans-generational addiction, an intervention can hold great opportunity for learning, not only about addiction itself, but also how family dynamics and behaviour can contribute to engagement. In order to change behaviour, awareness must first be acquired, for there are beliefs still held that it is only the individual who suffers from addiction, not the family. Through interaction with an intervention process, families are provided with an opportunity to educate themselves on how some of their own behaviours are contributing to the problem, not causing it, but contributing to it. In acknowledging this the family members can then be involved in a cohesive treatment and aftercare programme of addiction for their family member. The family holds a recognised powerful influence on the continuation or recovery of addiction (Copello & Oxford, 2002). However, the family system does not need the substance user to become clean and healthy in order for other individual

members to receive help. For some it is in the very act of involvement within the intervention process that enables them to break the silence around the substance abusers behaviour and effect on others. This can be the first step in breaking the dysfunctional bonds of fear and collusion (Doweiko, 2002).

However, it should be noted at this point that "if the family environment…is not conducive to adapting old negative behaviours into new and healthier behaviours, family therapy may not be appropriate." (Cmokovic & Delcampo, 1998:25). There are situations where it is not appropriate or safe for the individual to be treated alongside their family, but in our exploration of family interaction, we have found that in most cases it is of benefit to all involved. In the final argument for family interaction within the intervention process, we look to the effect it can have on the most vulnerable family members. In family dynamics, children's voices can struggle to be heard (Minuchin, 1982). In working with a treatment team however, the children's needs could be "monitored and addressed while working within the family unit." (Copello & Oxford, 2002:47).

2.4 Treatment

In researching relevant literature on the subject of family interaction within the treatment programme of addiction, there is evident conviction that those treatments that incorporate a social component, either that of family or peer environment, are the most efficacious. (Copello, 2010; Miller & Wilbourne, 2002, Rassoll, 2011) For some individuals entering treatment, there can still be a distinct lack of motivation for change, not all enter because of a desire to stop active addiction, and some enter treatment in order to avoid jail or debt. However, having the family involved can provide a compelling incentive for the substance abuser to engage with the treatment programme. When this happens, further family interventions can be implemented. Even in the case where the substance abuser withdraws

from the treatment, the family can still continue to engage with and receive support from the treatment programme (Copello, 2002). The emotional connection that the family has with the substance abuser can be crucial for engagement in the early stages of treatment, and its strength can help secure the continuing engagement of the individual with the programme itself (Psychology Today, 2012). In working with those who do not wish to continue engaging with a treatment programme, intervention with family involvement can encourage and motivate the individual to stay (O'Farrell, 1992). For those who are highly motivated to change, it is an unique opportunity for engagement with their family in a safe and supportive environment for both. (Templeton, L.; Velleman, R.; Copello, A.; Orford, J., 2008)

Indeed, the efficacy of such interventions may lie in the family's developing awareness that they too are in need of care and attention as a result of their involvement with the effect of addiction and its devastating consequences, physically, emotionally and spiritually (Gomez, 1997). In this new treatment environment, the family are encouraged to be open and honest with both the therapist and family member about how they have been affected. Such honesty then in turn has an effect on the substance users awareness of the fallout of their addiction and its influence in their families. (Copello, 2002; Rassoll, 2011) By engaging on this level the family's interaction can be felt in the system in two ways; by talking and change, as "change was seen primarily through the adoption of attentive ways of coping but also through reduced stress and strain and improved support." (Templeton, 2007:41).

Historically there was little room for the family in the treatment of addiction (Stanton & Todd, 1982). Some may interpret older models of treatment of having attitudes towards the family and their coping methods and as blaming and accusatory (Copello, 2002). Indeed, there has been what some have called a 'cultural shift' within the field of addiction treatment in relation to family interaction (Orford, J.; Templeton, L.; Copello, A.; Velleman, R.; Ibanga, A.; Binnie, C., 2009). With their inclusion in this process, family members were

shown that although the active abuse and behaviour of addiction was the responsibility of the individual, it always took place in the context of a relationship, and it "can be influenced by family of origin dynamics or as part of a restricted communication process within a current relationship." (Flynne, 2010:585).

It is accepted that "untangling the effects of genetic tendencies and environmental triggers is a complex business." (Gerhardt, 2004:45). By working inclusively with the family the therapists gain a great opportunity for greater understanding in the analysis of the individual's relationship with their addiction. One accepted premise in the field of addiction is that if the fundamental family function does not re-adjust to the dynamics of recovery, then the individual is more likely to continue and be active in their addiction (Cmokovic, 1998). In the 'family days' part of treatment, the therapist is able to apply some family intervention, by doing so the therapist is enabling the family to interact more honestly with each other. This may result with the family gaining greater understanding of each other, and what they may each bring that could contribute to dysfunctional relating. By doing this in the treatment environment, this challenging dynamic piece can be done without the family then assuming responsibility for the substance abusers addiction, but rather "help mitigate psychological and physical strain that may result from long-term interaction with those struggling with alcohol or drug dependence." (Rotunda & Doman, 2001:257).

An emerging issue from the study of the literature relating to the effect of family interaction within the treatment of addiction was that it was often a struggle to get family members to focus on their own needs and issues, that they were primarily drawn to focusing on the substance abusers behaviour and treatment instead (Copello, 2010; Keene, 2010; Templeton, L.; Zohhadi, S.; Velleman, R, 2007). Denial, enabling and co-dependency are terms that have been used to describe family member's coping mechanisms by those in the field, paradoxically, the main ways in which change occurred for family members was by an

increased understanding of their own needs, this could be seen manifesting by an increased focus on themselves, an increase in confidence and strength, and by doing so, increasingly being able to remove themselves from the situation." (Templeton et al, 2007).

A more contemporary understanding of these coping mechanisms is the 'stress-strain-coping-support" model (Copello, 2002). This model of treatment very much includes the family members and has developed a deep understanding of the family and the way they may have been attempting to handle their interactions with another's addiction. It holds within it a 5-step plan for the family which is structured around the following steps; to listen un-judgementally, to provide relevant information, to explore ways of responding and interacting with the substance abuser, to discuss the family members available and potential social support and finally, to establish with the family member the need for further help. (Copello, 2010; Oxford et al, 2009, Templeton et al, 2008) As discussed by Flynne, the most effective way of extracting maximum effect of family interaction within the treatment of addiction, is to apply the systemic reflective approach, and by doing so altering entrenched and embedded beliefs, views and attitudes of all parties involved (Flynne, 2010).

The efficacy of this approach, Flynne observes, can be felt in the contemporary narratives and treatment applications in the present prevailing dogma in the clinical field. In exploring this evolving approach, the author could extrapolate that some theorists felt that it was not only the substance abuser and their families that need to change their views on addiction and the family, but perhaps also some of those presently working in the field. (Addiction, 2010; Copello &Oxford, 2002; Copello, 2010; Oxford *et al*, 2009; Psychology Today, 2012) Undeniably, therapists who work in this field are drawn to the methods that best reflect their own "views on the course of alcoholism." (Lawson & Lawson, 1998:43). For many of those working within treatment centres, they have personally been through the struggle of overcoming addiction themselves; this cannot but influence their own attitudes, consciously

or unconsciously towards family interaction (Kahn, 1991). Considering this, we must then also acknowledge that in "working with families, therapists need to further examine their feelings and thoughts…therapists who have not examined their perspectives are at risk of joining the family system of their clients and impeding change. They can become rescuer or persecutor of alcoholics and other family members." (Lawson & Lawson, 1998:189).

If Freud was correct, and all pathological behaviour is at its root self-explanatory (Freud, 1901), then the family must be part of the treatment programme if those that work with the substance abuser are to fully explore the individuals addiction for, "family therapy represents an outlook regarding the origin and maintenance of symptomatic or problematic behaviour, as well as form a clinical intervention directed to changing dysfunctional aspects of the family system." (Corsini & Wedding, 2000:398). This would be particularly relevant in family systems that contain generational addiction. Throughout our lifespan those who are in our environment and our interaction with them have untold influence in the construction of our structure's, defences and coping mechanisms (Gomez, 1997, Yalom, 2002). Taking into account the undeniable influence the yet scientifically unproven Disease Model (Nathan, 1991) has had in the field of addiction treatment, that genetics shall prevail; one must also then acknowledge that "most genes are expressed in response to environmental triggers and in combination with each other." (Gerhardt, 2004:105). Some theorists go so far as suggesting that the root of the individual's choice of addiction can be grounded in the individual's interactional parental relationship saying that "their choice of addiction may be influenced by their parent's influence-the person who chooses to self-medicate when feeling distress is attempting to restore some sort of internal equilibrium." (Gerhardt, 2004:105). Here again we can observe how powerful the effect can be with the interaction of the family within the treatment setting.

In this exploration, we then see that not only is family inclusion within the treatment of addiction powerfully effective and influential in the individuals continuing engagement with the treatment process, it can also be incredibly effective in discovering possibilities of causation. The concept of the individual alone needing treatment for addiction, apart from their family, is losing hold in the treatment setting. One can understand some families reluctance in participating in such treatment programmes, one traditional view that families were somehow to be blamed and kept apart still held ground not so long ago. Even going back only 30 years we see such opinions as "anyone working with addicts families for the first time is impressed with the tremendous defensiveness most of them show." (Stanton & Todd, 1982:124). The lack of compassion is hard to deny. The concepts of enabling and co-dependency have been both enlightening and punitive. Such concepts do have their place within the treatment of addiction, and the aetiology of the addiction can be less important at this time then how it is being maintained, at times even providing a homeostasis within the family system (Lawson & Lawson, 1998).Having discussed at length the effect of family interaction within the treatment of programme of addiction, and found it to invaluable where appropriate, we now move to explore our findings on the effect of family interaction within the aftercare setting.

2.5 Aftercare

It is commonly accepted that the aftercare programme and relapse prevention of addiction is vital (Addiction, 2010; Copello &Oxford, 2002; Keene, 2010; Oxford et al, 2009) For some individuals re-entering life sober, they feel alienation from their peers and feel tempted to return to their old social circle, however admittance to this circle would depend on the continuation of drug use. Socially speaking, while drugs cause problems on one level, in this regard they can also solve others (Keene, 2010). In some cases the substance user's

relationships have completely broken down or have become quite ill in their function. But where possible, the involvement of family in the aftercare programme of addiction has a powerful effect as "the main precursors of relapse have been identified as psychological and social, the main influence being social, whether personal relationships with friends or partners or wider issues such as homelessness and unemployment." (Keene, 2010:67).

The main focus of aftercare and relapse prevention is to create new coping mechanisms for the substance user to utilize as he faces life anew, the effect of family interaction in this stage of recovery can be powerful, in both positive and negative ways equally. If there are unaddressed underlying issues of hereditary emotional patterns of a maladaptive nature, and the family refuses to accept any ownership or responsibility of their part in these patterns, or how they may be contributing to the maintenance of the individual's addiction, then perhaps their absence in the aftercare programme would be more beneficial. For some substance users, they need to extract themselves from the family systemic dynamics in order to get themselves 'better' (Rassool, 2011). Such refusal is explained in part by studying certain literature on the reciprocal nature of addiction within the family system as it shows that "the chronic relapsing nature of addiction can be explained from a family systems viewpoint. The addiction cycle is part of a family patterning involving a complex homeostatic system of interlocking feedback mechanisms, which serve to maintain the addiction and, consequently, the overall family system." (Stanton & Todd, 1982:30).

The concepts of enabling and co-dependency show that enabling means to knowingly behave in such a way that makes a substance user be in the active addiction without facing the natural consequences of their behaviour, and co-dependency being described as a maladaptive seeking of identity, self-worth and fulfilment outside the self (Doweiko, 2002). With these concepts explained, we can clearly see how such maladaptive ways of relating to another would have an untold detrimental effect on the aftercare and relapse prevention in the

early recovery of the individual recovering from substance use. As discussed by Keene (2010), the two year aftercare programme of addiction following treatment is seen as the most critical stage for maintaining and developing on the changes achieved in the intervention and treatment period. For the individual in recovery it is about recognizing the people, places and things that may trigger old using coping mechanisms. For the family in recovery, it is about accepting the challenging truth that we can 'love' someone to death, to take responsibility for what they own in the possible maintenance of addiction, and by doing so being able to let go and relinquish the illusions of control over what they are not responsible for. To fully integrate the challenging truth that they cannot control, cure or save their loved one from their addiction. Having explored the effect of family interaction within the aftercare and relapse prevention programme of addiction, it is left to note one final aspect of working with family dynamics and systems in the treatment of addiction and that is the ethical considerations.

2.6 Ethical Considerations

In the exploration of family interaction within the treatment and aftercare programme of addiction there is a possibility of emerging ethical issues. Those working with families had expressed concerns about what may surface from working with substance users and their families in light of the possible high levels of dysfunction held within the family system (Copello, 2010). By the very act of attending these services, there is also an aspect of diagnosis or possible labelling that may engage the whole family with such challenging feelings as guilt, shame, profound sadness or anger. There may also be a perceived risk of stigmatization and objectification of both the substance user and their families within their community. Such objectification can be quite damaging and the paradox lies in the fact that nothing in our behavioural actions of utilised defences is practiced without cause, our actions,

no matter how seemingly irrational and potentially self-harming, are functioning and fulfilling a need of the Self (Gillett, 1999). There may also be breaking of silences around such devastating issues of sexual abuse, violence in the home and incest, and these are matters that therapists must always be alert for and sensitive to (Lawson & Lawson, 1998). Part of a comprehensive treatment plan must incorporate procedure for such matters and include referral to the necessary services. There can be no shirking from this responsibility of care, as for some families, this intervention and treatment period may be the only chance for their most vulnerable members to speak out and receive help and support. This point alone defends completely the argument for the need for the family interaction within the treatment and aftercare programme of addiction, and how it can powerfully affect the outcome.

2.7 Conclusion

The effect of family interaction within the treatment and aftercare programme of addiction has been examined, the need for family inclusion, the intervention process, treatment stage, aftercare and relapse prevention aspects respectively. It has been found that each of these stages can be hugely influenced by family interaction and indeed benefit greatly from such inclusion, where appropriate. In addition, the author has also discussed the various challenges that may arise from such involvement and the possible ethical issues that may emerge. The evidence for the necessity of family interaction was clear in the findings of the literature research, though opposing opinions have been voiced. Our family of origin and earliest environment is where we first laid the tentative foundations of our personality structure and defence mechanisms (Winnicott, 1965). Our understanding of who we are and estimation of our worth was reflected to us in the dynamic with our first primary objects (Gomez, 1997). The truth of such reflection was not always accurate but had ineffable influence in our ability to make sense and meaning of the world that surrounded us and our place in it. Greater understanding is gained of where we are on the road of life when we can explore where we began.

Chapter 3: Methodology Chapter

3.1 Purpose

The purpose of this study was to explore the effect of family interaction within the treatment and aftercare programmes of addiction. In doing so, investigation of any themes and concepts that arose out of such exploration could take place, and a deeper awareness of the family dynamic affected by addiction and how it may affect the outcome of recovery could evolve. The seriousness of addiction and its far reaching effects gives validity to this research. This chapter shall explain and define which instruments and tools have been employed by the author in order to attain maximum knowledge on this theme, given the limitations of time, space, location and scope of this thesis.

3.2 Research Method

The research method utilised is one of a qualitative nature. Qualitative methods were chosen due to the focus on "depth more than breadth and, insight rather than generalisation." (Ulin, Robinson & Tolley, 2005:54). By its nature, qualitative research can illuminate some of the underlying behaviours, perceptions and attitudes that may influence approaches and outcomes of treatment in the chosen field. It offers tools which can be used to gain insight into why specific methods of intervention are used as opposed to others (Ulin et al, 2005). In aiming to write an exploratory piece, it was found that the inductive qualitative method to be the best suited for the author's needs as it enables an exploratory, investigative and enquiring thesis.

3.3 Interview Style

Considering that the aim was to obtain the participants own experiences and viewpoints, inductive semi-structured interviews were chosen as the data gathering method of enquiry. This allowed the participants to contribute in their own understanding, their first-hand experience of working with addiction, while also being gently focused by the researcher. This type of interviewing style allowed further flexibility on the course and direction of the discussion, the author being willing to explore any concepts or themes that may emerge that she may have previously been unaware of.

3.4 Open Questions

The semi-structured interview was based around six open-ended set questions (see appendix A). The objective of using such open-ended questions was to gather knowledge of the phenomenological experience of working with those seeking treatment for addictions and those in their environment that have been affected. Use of this method can then allow the respondent to share more clearly and perhaps introduce issues that the researcher had not thought of. The respondents can be perceived as the experiential expert on the subject and should therefore be allowed maximum opportunity to tell their own story (Smith & Osborn, 2003).

3.5 Sample Criteria

Purposive sampling was employed to ensure the participants suitability for the research involved. This was to ensure that a theoretical framework was constructed in regard to the validity of the gathered research. The author retained three treatment therapists who had been working for longer than five years in the field respectively, and two aftercare group facilitators with similar experience, this was the inclusion criteria. Experience of less than

five years or working in any other application in the field was the exclusion criteria. The group was of mixed gender. All individuals were given an information sheet which they were asked to sign to show their informed consent. (See appendix B). All participants were also informed about the nature of the research and given the opportunity to cease or withdraw any co-operation at any time.

3.6 Thematic Analysis

In keeping with the explorative nature of the thesis, the author has chosen the realist and experiential method of qualitative analysis over one which stems from a theoretical or epistemological position. With such a view, thematic analysis is then to be used to extrapolate possible strands, themes and concepts from the interview data. By employing this method of data analysis, there is potential for a rich, detailed and complex emergence of issues that can be extracted from the respondent's experience of working with those in addiction and their families (Braun & Clarke, 2006). Indeed, one of the objectives in utilising inductive qualitative analysis to explore the effect of family interaction within the treatment and aftercare programme of addiction was to defend against relying on hypothesis or theoretical pre-conceptions. By such un-reliance, a fresh and comprehensive exploratory piece was made possible.

3.7 Belmont Principles

In regard to ethical issues, the author adheres to the Belmont Principles of Ethics (1979) and guidelines for the protection of Human Subjects of research. These principles ensure the protection of any participants employed in the name of research. The author has complied with the role of assessment of risk-benefit and appropriate guidelines for inclusion and exclusion criteria. In relation to the basic ethical principles held within the Belmont Report, respect has been afforded to the respondents as they have received adequate information on

the research and have entered into it voluntarily. All effort has been made to maximise the possible benefits and minimise any possible harm in regard to beneficence. Each respondent has also given written consent for their views and opinions to form part of this thesis with the understanding that they can withdraw consent at any time. The offer was also made to provide each respondent with a copy of this work if requested.

3.8 Conclusion

The purpose of this chapter has been to outline the research methodology employed by the author in exploring the effect of family interaction within the treatment and aftercare programme of addiction. In doing so, explanation and reason was given to the choice of inductive qualitative nature of the research methods, the tool of the semi-structured interview and purposive sampling. Thematic analysis has been put forward as the choice of data interpretation and ethical considerations were also given attention and the Belmont Principles were adhered to.

Chapter 4: Findings

4.1 Introduction

In this chapter, findings extracted from the inductive semi-structured interviews shall be outlined and discussed. The participants involved were encouraged to share extensively on their experience of working with substance users and their families in the attempt to explore the effect of family interaction in these programmes. The process of thematic analysis has enabled the author to use raw data to illustrate the various superordinate and subordinate themes found in the interview research. Throughout this section the two facilitators interviewed shall be referred to as FD and FE, the three therapists as TA, TB and TC respectively. Extracted data shall be coded numerically from within the transcriptions, for example, FD: 10 would signify the tenth interactive piece of script being used from the interview with facilitator D.

Table 1: Superordinate and Subordinate Themes

<table>
<tr><td></td><td colspan="3">Superordinate Themes</td></tr>
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Gift of Truth</td><td>4.3

Hindrance / Help</td><td>4.4

Human Fallibilities</td></tr>
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Keeping it Honest</td><td>4.3.1

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4.2 Theme One: Gift of Truth

The theme of the family bringing the 'gift of truth' has been divided up into three separate subordinate themes. This was a prominent and significant theme that ran through the interviews; with participants all noting that this theme would have a huge effect within the aspect of family interaction within the treatment and aftercare programme of addiction.

4.2.1 Keeping it Honest

The expression of the family 'keeping it honest' was one that was repeated by several different participants.

> TA: 2 "...often the family needs to be the camera and replay to the person what their behaviour is like when they are in active addiction, particularly with alcohol or drugs where they may not have the memory of what they said or did."

In further discussing the importance of honesty and the potential harm of its absence therapist A expressed;

> TA: 8 "The main obstacles are that they may not be upfront, they may not be prepared to give what we call 'the gift of truth'. I think there might be things that they might be holding back, whether they are afraid of the persons reactions or there may be some shame issues that they have, just that they are not prepared to go the whole hog."

With therapist C, elaboration was given on the importance of family interaction and them 'keeping it honest'.

> TC:1 " The reason we feel so strongly about it is that the family, of course has been affected by the addiction, and not only in the treatment process can the family offer..um, clarity around some of the specifics in terms of behavioural changes or experiences that the person is having in active addiction, the family may not be in quite so much denial as the actual client...so the effect the family has is crucial, I think, in helping the client see what the addiction has done."

This sentiment was again experienced with facilitator E when he articulated that;

> FD: 1 "...it's very important for a lot of reasons; you're getting the truth about the addict or the alcoholic when the spouse is there. They will tell you what it was really like, and in that it is supportive to them, a lot of people can be in denial about the amount of drink or the behaviour with drink, it's very helpful when there is somebody from the family there."

4.2.2 Finding a Voice

The second subordinate theme under the 'gift of truth' reflects the difficulty experienced by the family to be able to speak about the addiction, some for the first time.

> TA:4 "...with the client in treatment, but for the family member they may never have had the opportunity to voice this and be heard in that type of environment...the client really needs to hear it and the family really need to say it."

The family's attempts to be honest and speak out can be thwarted by the silence that can accompany active addiction.

TC: 2   "As the treatment progresses I think clients are more able to hear what families are saying in spite of the fact that they may have heard what they are saying over and over again around the kitchen table or in the sitting room, because there is, they are in a different place."

Acknowledging this, it was also noted that there would be strong boundaries around the expression of opinions and feelings. These structured boundaries being vital to the ability to listen to whatever was being expressed, both for the substance user and the family member.

TC: 9   "...if you have, I suppose, a sort of, what's the word I'm looking for, an element of acting out, inappropriate behaviour, an expression of feeling is one thing, an inappropriate expression of feelings , depending on the words that are chosen, the way things are said it, we would certainly have called behaviour. I think that it is inappropriate, absolutely, absolutely and challenge it. And it wouldn't matter if it was coming from family or coming from the client, you know, we would need to contain, there is a need for containment."

4.2.3 Safety

The imperative need for safety was heard throughout the interviews.

TB: 26   "You have to work with what you have, so how safe? I couldn't answer; it depends on how safe it was going in in the first place.

Another therapist explained:

> TC: 2   "...once you remove the chemical or you cease the activity, the addictive activity that has brought the person into treatment, you create a safe environment where the families can actually be open about what their experience of your addiction has been like. Then I think you create an atmosphere where perhaps, um, the client is not going to be clouded by alcohol or distracted by gambling and they can actually listen in a very different way to what is being said."

The level of honesty appeared to be directly linked to the creation of a safe therapeutic environment.

> TC: 2   "But there must be a level of honesty that you wouldn't have at home because you would not have the safety of a treatment centre."

In regard to the aftercare setting:

> FE: 2   "...you get to see the truth, you get to see what it was like living with the addict or the alcoholic, you know, in a lot of cases you get the truth. In some cases, they are afraid to say it...over time you would try and encourage them...and when you're in a safe environment, like in an aftercare group, I think that's the time to bring it out, when someone can have their say as opposed to having a row, that's the beauty of aftercare I find."

The necessity for such safety was very explicit, for both sides need the freedom to be able to share their experiences.

> FE:3   "You have to make aftercare a safe environment for the partner, and also the person in recovery, the addict or the alcoholic to say what it was like for them, because it's not always about the addict or the alcoholic.

4.3 Theme Two: Hindrance or a Help

This section of findings is dedicated to the behaviours that family interaction can bring that can contribute to the outcome of successful addiction treatment. With the second superordinate theme of 'Hindrance or a Help', three subordinate themes were found.

4.3.1 Denial

The theme of denial was commented on by all participants.

> TA: 2 "...with addiction, we also see that they [substance user] are blinded to the impact of their addiction on other people in the family."

Here again in another interview observation can be made on how vital the family interaction can be in relation to denial.

> TC:5 " Oh, I think there can be denial on the part of the client, you know, denying the severity of their condition...certainly in the early days and weeks of treatment there will be a level of denial present in the treatment process. It's about chipping away at that denial. The family are here expressly to help with that chipping away process by saying, 'well, this is what I remember', and sometimes you can meet resistance in this area."

The following excerpt is a particularly striking and poignant description of denial.

> FE: 5 "Well, people are faced with what it was like; they are not getting away with anything. Maybe that's a bit harsh? You know, denial is a powerful thing...denial is not a conscious lie...I don't think it's a conscious act. I've seen people in aftercare, they see their partners pulling their hair out and they are like, 'I don't know'. It's like they don't understand that

they were like that. I think in a lot of cases and I firmly believe this, that they are not able to cope with it, they blot it out...I've seen denial literally nearly kill somebody."

4.3.2 Enabling

Another persistent theme throughout the findings was the issue of enabling and how, when active, it can work against the treatment of addiction.

FD: 17 "...the main obstacles...are enabling really, that would be the big one. Enabling and not being honest, still trying to cover up, still trying to make it alright, making excuses and covering up. That would be a big obstacle."

In speaking of addiction being a family disease, participants explained:

TA: 6 "...we encourage the family to get help for their end, for their need to recover every bit as much as the person they are here for."

In discussing the need for family dynamics to be recognised, one therapist, defending his position on the necessity for family interaction to be heavily restricted and structured reported that;

TB: 5 "...because of the chaos they have come from, and the chaos is never entirely caused by the person with the addiction problem...the family is important but it must be structured and controlled while in treatment. You have to keep the family out of that stuff."

In terms of enabling and how it can prevent a substance user from having to deal with the natural consequences of the behaviour held in addiction, one therapist shared;

TC: 1 "But the family, because they have been affected by, um, the addiction, would also I think need to get some clarity around how their behaviour has changed in tandem with the person coming into treatment...sometimes the behaviour of family members will actually mirror the addiction in terms of their preoccupation with the person...totally preoccupied with controlling the addiction or preventing the next crisis."

4.3.3 Understanding

In exploring the effect of family interaction within the treatment and aftercare programme of addiction, understanding – or lack of it, showed itself to be a huge part in effective treatment.

TB: 19 "I suppose the first obstacle and the biggest one is understanding. That the family do need to understand some little bit about what addiction is...because again, with addiction the behaviours of alcoholism or addiction, they don't exist in a vacuum."

This therapist went on to say;

TB: 20 "...it's probably the norm, not the exception (lack of understanding). They understand the effects, they understand what they are seeing, but they don't understand what's driving it. Unless they are totally brain-dead they will understand what's happening to them as in the physical effects, but not the emotional effects, they are not very good at understanding that as people."

Another therapist explained the struggle that families can sometimes have in reaching an understanding of what addiction is.

TC: 4   " I think for families it is very challenging to have to accept that they are powerless over this addiction., but that doesn't mean that you sever your connection. You just change your approach and it is very important that the supportive approach is present. Encouragement, listening, everybody listening."

4.4 Theme Three: Human Fallibilities

In this final section of the findings chapter, attention shall be given to the themes covered by human fallibilities. This includes those belonging to the family, the substance user and also the professional in the service.

4.4.1. Anger/Resentment

While the family interaction within the treatment and aftercare programme of addiction has been found to be potentially beneficial, it can also evoke varying degrees of underlying anger and resentment.

FD: 18   "Anger and resentment just gets in the way and until somebody starts dealing with it, it can be a huge obstacle, like 'you never supported me'. Bringing up the past and spouses bringing up the past. Because they are still hurting and angry and that would be an obstacle."

Another viewpoint on anger and resentment was;

TB: 1   "...there are different types (families), some are where they are very in your face where the families, you know, the people who have been hurt by the addictive behaviour we would say, sit around in a circle and attack the person in the middle. Personally I don't go for that you know. By the

time the person gets to go for help they are usually pretty aware of the mess

they are in."

The effect of such anger and resentment was illustrated by another participant.

> TC: 7   "Or, you know, another obstacle in the process, or a strange one in
> the family interaction, you may have a really really angry family member,
> and they are just not able to see, and they are justified of course in being
> angry because they have been put through the mill. But you can see that
> maybe in an assessment and see a great deal of anger from the spouse and
> then they come in and are not shifting either...they can have such a level of
> anger from family members that your thinking, gosh, if the client goes back
> out to this level of anger what are they going to do...and I think that that can
> be an obstacle, to everybody's recovery, to the families recovery and
> particularly to the clients recovery."

Anger from the substance user was also part of the dynamic.

> FE: 10   "Anger is an awful obstacle I think. Anger is a big one, you know.
> And often times it's themselves, and they are lashing out at everyone else,
> you know. I've seen people blowing the top in aftercare and as soon as the
> group is over, they're fine...they didn't want to know, their carry on, they
> didn't want to be told. So anger is a big one, a huge obstacle."

4.4.2 Control

While those in active addiction have been accused of being controlling and manipulative, the
findings showed that family members could be accused of the same.

TC: 1 "Sometimes the behaviour of family members will actually mirror the addiction in terms of preoccupation with the person coming into treatment. They will become totally preoccupied with controlling the addiction or preventing the next crisis, em, they will find that, em, you know, in their day to day life they will lose a certain amount of focus in terms of their own life."

This belief was further compounded later in this same interview.

TC: 3 "...and it can be very difficult for families to shift that gear from wanting to control that addiction to stepping back a bit. It's hard for them to understand that control is not receiving support. Support is more when you notice that somebody is changing, support is more that they know that you are in their corner, without trying to get them to do anything in particular."

Such need for control in the face of active addiction is understandable said one participant as;

TC: 4 "...because I think, you know, with a chronic problem in the home, the family really wants to control the situation, where possible to mitigate some of the things that are happening."

Such focus and energy spent on the attempt to mitigate the effect of such a 'sick' member can have unforeseen consequences.

TC: 8 "I think a 'sick' member causes great diversion, because, you don't have to attend your stuff, your outlook is over there at them, and your energy goes into fixing them, and maybe even getting a sense of wellbeing with the 'fixing piece'...there can be all kinds of interesting dynamics that are part of that process there...I think the opening statement that I made of

families often 'mirroring' in a way what's happening with the 'sick' person

is valid, and can really be an obstacle."

As another participant put it;

FE: 2   "People who have lived with this, their behaviour can be tough at

times too."

4.4.3 Professional's Attitude

Data extracted from the semi-structured interviews by thematic analysis also inferred that the

professional's own personal attitude toward family interaction played a part in the effectiveness of

such involvement.

FD: 33   "I think for families the benefit can really be brought home and can

really help the kids and the whole family."

An opposing opinion suggested;

TB: 15   "When they are back in the real world and they are interacting with

family, a lot of it is new for them. The aftercare meetings...are a chance for

them to get away and often their patience and tolerance is tested to the limit

by family members. You know, the person is having trouble enough just

adjusting to reality...you want to keep the family out of that stuff."

Considering that addiction is defined by some as a 'family disease' only one of the participants was

a representative of the family member, an aftercare facilitator. But no therapist came from a family

background, all had been through treatment for addiction themselves and 'came up through the

system'. It was also noticeable to the author that many times the participant would slip into the first

tense, reflecting that their own personal experience of treatment was very near the surface, for example;

> TC: 9   "This is not an opportunity to stick the knife in and turn it, nor is it another opportunity to have another go at the family like I have always done before."

Another participant shared that;

> FE: 11   "In some cases, a lot of people can come in the door and get it unbeknownst to themselves, they discover change over time, they start to see maybe it is better, I'm not so sick or there is not so many rows...but sometimes we fight that too, do you know what I mean?"

Later in the same semi-structured interview the participant went on to say;

> FE: 12   "I'm not going to hammer myself with the past, nor will I let anyone else, but I do have a responsibility not to repeat it...and if I feel a need to share a bit about myself with the group then I would feel comfortable about doing that."

4.5 Conclusion

In this chapter discussion took place in regard to the data collected from the semi-structured interviews carried out with both aftercare facilitators and therapists in the treatment centres for addiction. Three main superordinate themes emerged from the extracted data, each of these then contained another three separate subordinate themes respectively.

Chapter Five: Discussion

5.1 Introduction

The primary research question in this study is one of an explorative nature, to ascertain the effect of family interaction within the treatment and aftercare programme of addiction. Thematic analysis was applied to the narratives of five participants, three therapists in treatment centres and two aftercare facilitators working within the field of addiction treatment. In-depth views were explored and three superordinate themes emerged from such study. The participants shared with the author what their experiences of working with substance users and their families were and the findings indicate the complex nature and challenging issues that such interaction can bring to the therapeutic setting.

5.2 Gift of Truth

One effect consistently reported throughout the narratives was, that family interaction helped 'keep it honest'. Therapist A spoke of the family acting like a camera, replaying to the substance user their behaviours and the effects of their addiction on others. For some receiving treatment for addiction, their memory of their behaviour while active was absent due to alcoholic blackouts or the effects of drugs (Roessler & Rubin, 1982). Those who work with substance users encourage the families to be as open and honest as possible in order in order for the substance user to become aware of the effects of their addiction (Copello, 2002; Rassoll, 2011). Possible blocks to such honesty, fear or shame for example, could be magnified due to the potential stigmatization of addiction held in society (Lawson & Lawson, 1998). Indeed, in order for an individual to receive 'treatment', they must first receive a diagnosis of some fashion; in order to receive a diagnosis then something must first be thought to be wrong, sick, or broken in the individual (Gillet, 1999).

The silence that can surround addiction can be dispelled by the clarity the family can bring (Keene, 2010). By confronting the substance user on the effects felt by the family as a result of the behaviour while active, such collusion can cease. Indeed, by their very involvement within the treatment programme such honesty is encouraged and enabled by the therapists (Doweiko, 2002). Facilitator D spoke of the importance of the spouse being present in the aftercare programme due to the level of denial the substance user can possibly have in relation to the depth of their addiction. In this way, the family member can hold a powerful influence on the continuation with and engagement of the individual in their recovery programme (Copello & Oxford, 2002).

Therapist A spoke of the importance of the family 'finding their voice' within the programme, that the client really needs to hear it and 'the family really need to say it'. For some, this programme may provide the first opportunity ever to speak about how this has affected them personally and the how it has really been to live with addiction and what that can entail (Templeton et al, 2007). Therapist C shared about how the client, while in treatment can hear things differently, due to it being said in a safe and supportive environment. This unique opportunity therefore allows the family and client to engage in a new way with each other (Templeton et al, 2007). In circumstances where this new setting is not enough to create a contained and safe environment for all, then restricted communication must be put in place by the treatment centre (Carr, 2005, Flynne, 2010).

Such safety is vital to the successful interventions applied to the substance user and their family. Part of the therapeutic work is the initial assessment of the appropriateness of family inclusion; in certain circumstances this may not be recommendable (Cmokovic & Delcampo, 1998; Velleman & Templeton, 2003). Therapist B expanded on this by putting forward the question 'how safe was it for the client going in?' Such safety can be heavily affected by the families' awareness of what they themselves may be bringing in terms of dysfunctional

relating, a safe environment is imperative if the substance user and the family are to begin to be honest with each other (Templeton et al, 2007). Two of the participants elucidated on how the different setting (treatment/aftercare) can increase the level of safety felt by those involved (Rassoll, 2011). What truths and honesty can then emerge from all parties when this safety is in place break the silence on what has previously been implicitly held in secret (Doweiko, 2002).

5.3 Hindrance or a Help

All participants spoke extensively on the theme of denial, both in regard to the substance user and the family. Its influence on the ability to engage with the treatment and aftercare programme of addiction was experienced as profound. When Therapist C spoke of the substance user being blind to the impact of their addiction on the family, the benefit of family interaction became clear; this could be a unique opportunity for the client to learn from their family how their addiction has affected them (Copello et al, 2005). Another reason was given by Therapist C who reasoned that the family's presence in the treatment of addiction was expressly to chip away at such denial. Therefore, such family interaction proves to be the most efficacious in breaking down the denial of the substance user (Copello, 2010; Miller & Wilbourne, 2002; Rassoll, 2011). Reflective systemic therapy has been utilised by those working in the field in order for those affected to break through the powerful unconscious act of denial (Cmokovic, 1998; Flynne, 2010). As Facilitator E expressed it -he believed it was an inability to 'cope with it, they blot it out, I've seen denial literally kill somebody.'

Enabling was another theme extracted from the raw data, all participants noting it as a huge obstacle for everybody's recovery. Facilitator D spoke of enabling being the 'main obstacle' in her opinion when working with substance users and their families. In the treatment and aftercare programme of addiction one of the main aims of the professionals is to work with

those who enable the user in order to decrease or eliminate this dynamic (Rotunda & Domen, 2001). If enabling is seen as an action or behaviour that prevents the user from dealing with the natural consequences of the behaviour in active addiction, understanding must also be given to how this dynamic was fostered by those living with a family member in active addiction. Therapist A spoke of how the family needs to see that they need recovery every bit as much as the individual in treatment. By engaging with the treatment and aftercare programme of addiction, the families are afforded an opportunity to discern between supportive and enabling behaviour (Copello, 2002; Rotunda & Domen, 2001). In cases where the substance user has come from a generationally affected family with addiction, there may be many complex and potentially damaging interrelating patterns of communication. Therapist B stated, in circumstances such as these, that the family interaction would need to be carefully structured and contained. In working with those deeply affected by addiction, such entrenched patterns of relating behaviour may actually work against potential recovery, there are times when family interaction has been deemed inappropriate (Cmokovic & Delcampo, 1998; McGoldrick, Genson & Shellenberger, 1985).

The last subordinate theme under the heading of 'Gift of Truth' is that of understanding. The depth of understanding the family has of the dynamics of addiction itself can contribute or negatively affect the substance user and their family's engagement with the treatment and aftercare programme. Due to the complexity of working with the family members and the individual in treatment, acknowledgment is made to the fact that addictive behaviours do not exist in a vacuum, they are always in the context of a relationship (Copello, 2010). Contemporary understanding of such workings has recognised that it is the application of a systemic perspective based on the family systems model that achieves the optimum results (Copello & Orford, 2010; Edwards & Steinglass, 1995). Therapist B reflected that it would 'be the norm not the exception' for there to be a distinct lack of understanding by the family

in relation to addiction. The circular and dysfunctional nature of an untreated system (Minuchin, 1974) affected by addiction can explain how this lack of understanding can flourish (Lewis, 1989). The family may also find it very hard to integrate the understanding that they are totally powerless over another's addiction. Therapist C argued that such powerlessness does not then translate to a severing of connection, but rather an implementation of a supportive way of relating instead, where everybody listens to each other. A challenge to this understanding may be the initial reluctance of the family members to acknowledge their own needs and issues, preferring to instead concentrate on the substance user's treatment and behaviours (Copello, 2010; Templeton et al, 2007).

5.4 Human Fallibilities

Unprocessed anger and resentment was flagged as an almost overwhelming obstacle in working with substance users and their families in the treatment and aftercare programme of addiction. There are some family systems that are so affected by addiction that they can cause a damaging pattern of relating to flourish (Lewis, 1989). There are circumstances where it is neither advisable nor appropriate to invite the family to interact with the substance users treatment plan (Cmokovic & Delcampo, 1998). However, where appropriate, these settings can provide an ideal opportunity to facilitate new ways of relating and communication within the family system (Templeton et al, 2007). Therapist B spoke negatively of the families that attack the individual in treatment. This behaviour can potentially block recovery, not only for the substance user, but for the family also (Gomez, 1997). Whilst the attempt to untangle the genetic tendencies from the environmental influence can be complex (Gerhardt, 2004), it is a worthwhile venture. While addiction continues to be mainly addressed as a family disease, it needs to incorporate family systems interventions in order to better deal with the consequences of active behaviours (Cmokovic, 1998).

Therapist C explained the powerful influence a really angry family member who seems to be unable to shift from this position, can have in the recovery process. In stating that such levels of unwavering anger can be a block to everybody's recovery, (Kahn, 1991) validation was given to the argument that the individual is more likely to continue using if the fundamental family functions cannot readjust to the required dynamics of recovery (Cmokovic, 1998). Understanding such levels of anger can be challenging if one is not mindful of the sometimes extreme consequences that addiction can bring to affected family members. However, interaction with the treatment and aftercare programmes may contribute towards mitigation of emotional, psychological and physical strains in the family members (Rotunda & Dowen, 2001). Facilitator E spoke of the anger and vitriol directed by the substance user to those who attempt to confront him on his addiction. With these two aspects in mind, the therapists and facilitators may be dealing with individuals unable to relate to each other in any healthy or meaningful ways for the beginning of treatment (Keene, 2010).

Control was another theme contained in the superordinate theme of Human Fallibilities. Such a coping method can be partially explained by the sometimes extreme and dangerous situations that active addiction can bring to a family system. Therapist C spoke of coping mechanisms like control sometimes developing in tandem with the substance user's addiction. Part of the programme in dealing with family interaction is to get the family members to be able to look at their own behaviours and how they may have become preoccupied with the substance users addiction and behaviours at the cost of focus in their own lives (Templeton et al, 2007). The journey to acceptance that control and support are not the same dynamic can be an uphill battle. Ironically, it is in stepping back and withdrawing from the situation, in refocusing on the self, which can allow the family to be more supportive to each other (Templeton et al, 2007). Maladaptive coping mechanisms such as control are understandable in the face of the pain and suffering that addiction can bring, by

interacting with the programmes of treatment and aftercare, the family gain an opportunity to heal therapeutically that may otherwise have been impossible (Copello, 2010).

Attention must also be given to the concept of the 'sick' member of the family ensuring homeostatic balance in the family system. Bearing this in mind, part of the family interaction can be used to investigate the possibility of this dynamic being present (Edwards & Steinglass, 1995). With encouragement given to both the substance user and the family to explore their way of relating to each other, all individuals can improve their situations, regardless of their relatives (Templeton et al, 2007). In accepting that addiction can be a chronic and relapsing disease, the cycle of addiction may have become entrenched in the pattern of relating within the family system (Copello & Oxford, 2010; Stanton & Todd, 1982). Facilitator E reflected on those who live with addiction, that their 'behaviour can be tough at times too'. Contemporary opinion illuminates understanding of such 'tough behaviour' with the strain-coping-support model (Copello, 2010; Oxford et al, 2009). Change could be seen primarily through adapting to alternative ways of coping and through the ensuing reduced stress and strain, the support that such adaptation could bring (Templeton et al, 2007).

The last area to be addressed is the professional's own opinion and attitude, towards addiction, those who suffer it and the families affected by it. Facilitator D expressed her heartfelt opinion that family interaction within the treatment and aftercare programme of addiction was hugely beneficial as it affected the most vulnerable family members, the children. So often in family dynamics, children's voices can struggle to be heard, with family members interaction, a unique opportunity is created for them to be able to talk about their feelings in a safe environment (Copello & Oxford, 2002).

It has been reported that a cultural shift has taken place within the field of addiction treatment (Edwards & Steinglass, 1995). However, in the course of gathering research for this thesis, some evidence was found to the contrary. In particular Therapist B was against family involvement, reporting that their influence was felt very negatively. In one instance this therapist stated that the substance users 'patience was tested to the limit by the family members....you want to keep family out of that stuff'. Similar attitudes towards family involvement can be found in the older models of addiction treatment that could be construed as blaming and accusatory towards the family members and their coping methods (Copello, 2002). If addiction takes place in the context of a relationship then so too must its treatment. All parties involved must look at their own entrenched and deeply held beliefs as they hold influence on the ability to engage with the treatment and aftercare programmes, including those in a position of power (Flynne, 2010).

The final piece addressing potential blurring of boundaries and professional position was that all participants' shared personal experience of addiction in their interviews, that they had all individually been 'successfully through the programme'. The unspoken inference was that this proved that the programmes worked, and more importantly, you need to have gone through it to be able to successfully work with these programmes. Therapist C spoke of the treatment setting not 'being an opportunity to have at the family like I have always done'. Facilitator E shared that substance users can get better unbeknownst to themselves saying, 'they discover over time, start to see maybe it is better...but sometimes we fight that too'. Facilitator E later went on to say that 'I'm not going to beat myself up about the past, nor will I let anyone else, but I do have a responsibility not to repeat it.' This gave example to the need for those working in the field of addiction treatment to attend to their own feelings and thoughts, for those who wield potential power and influence over vulnerable people (substance users and their families in early treatment) have to be held accountable for their

professional ethical conduct. The professionals who do not attend to their possible biases and transferential issues in an aware manner run the risk of taking on the rescuer or prosecutor of the substance user or their family (Lawson & Lawson, 1998).

5.5 Conclusion

Addiction has the potential to destroy individuals, the families they belong to and the community they live in. It is a cunning and baffling disease that continues to evade conclusive definitions of aetiology or explanation as to why some people continue on its path toward the inevitable conclusion of recovery, prison or death. Historically there has been an accusatory and blaming relationship between those treating the disease and those who live with it, with its presence still being felt in some quarters today. However there has been a recognised need for the potential successful outcome of recovery to be attained, where appropriate, the family to be now involved within the treatment and aftercare programmes of addiction (Winnicott, 1965). In this way, family members and substance users have the opportunity to recover in a way that is not dependent on the other (Orford et al, 2002).

One cannot address man's maladies of the soul without addressing the environment in which he grew up. Within the treatment programmes, those working in the field recognise that the environment the substance user returns to can have untold influence on the individuals chance of recovery. At times this was felt to still be the main focus, the family being used as a tool to break down denial, to cease maladaptive behaviours that may damage the recovery of the substance user, the spouse to keep the substance user honest in aftercare. When the Disease Model was first established in the 1950's it focused solely on the individual rather than looking at the interpersonal dynamics held in their environment (Keene, 2010). Although it is now commonly known as a family disease, the treatment still is overwhelmingly directed towards the recovery of the individual.

In exploring the effect of family interaction within the treatment and aftercare programme of addiction, the author found it to be a potentially valuable tool for those working in the field. The effect would be challenging to quantify. In the optimum position, the interaction of the family in addition to their willingness to look at their own maladaptive behaviours would prove to be invaluable. Within family systems it is accepted that it need only take one member of the family to change, its effects will be felt throughout the branches of the family tree. The roots of a family run deep and dark and exist outside the realm of the human eye, but its ability to adapt to its environment effect the strength of the trunk and the reach of its branches. The disease of addiction has the ability to infect from a root level; its psychological and emotional scarring can be felt down through generations of a family. The effect of such a family interacting with the treatment of addiction essentially safeguards those in the family environment and the children they will bring into the world against the poison of addiction.

5.6 Limitations

As in all explorative studies, there are both strengths and limitations attached to the work. The semi-structured interviews gathered a wide scope of opinion and experience from the participants. This data gave forth strong themes and findings, but the word count and time limit constrained exhaustive thematic analysis, leaving the researcher to decipher which excerpts had to be left on the cutting room floor. At times it was felt that the participants may have given forth the socially acceptable and politically correct answer as opposed to their individual opinion, particularly when it addressed the issue of safety within the programmes. A more evenly balanced sample of those working in the field may have offered different data, but the sample was reflective and indicative of the representation of substance users and family members who are working in the field. All therapists were in recovery in addition to one of the facilitators; only one facilitator was representing the family, which was as a result

of it being an aftercare group with predominantly married or long-term partnerships as clients. The inquiry was one of an interpretative nature and so is constrained by the researcher's ability; it is not offered as a definitive interpretation of the data and does not claim there were no other possible viewpoints to be deciphered.

5.7 Recommendations

The recommendations would be a compulsory attendance in outside supervision by those working in the field of addiction. It needs to be a transparent and open environment, with more influences felt in the treatment than just those who have been successfully through the programme. Although the aftercare period was two years following treatment, only spouses or partners were allowed to attend, further support could possibly be offered to the more vulnerable members of the family, the children.

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Appendix A: Questions for Treatment Therapists and Aftercare Facilitators

1. How important do you feel family interaction to be within the treatment/aftercare programme of addiction?

2. What effect do you feel family interaction has within the treatment/aftercare programme of addiction?

3. What influence do you feel such interaction has on the outcome of recovery?

4. What are the main obstacles you find in working with substance users and their families?

5. What happens when it is not appropriate to work with the families/substance user?

6. How safe do you find the treatment/aftercare setting to be when working with emerging issues?

Appendix B: Informed Consent Form

An exploration of the effect of family intervention within the treatment and aftercare programme of addiction.

To Whom It May Concern

I am a fourth year student on the BA Counselling and Psychotherapy course with Dublin Business School. As a requirement of this course I am undertaking a research project and the area of interest to me is the effect of family intervention within the treatment and aftercare programme of addiction.

This study shall include an in-depth analysis of the material gathered through semi-structured interviews. These interviews shall be conducted with treatment therapists and the facilitators of aftercare programmes. The purpose of these interviews is to ascertain the effect that is felt by those working within the treatment of addiction on those accessing the services.

The process involves an interview which should take no more than 30-40 minutes and will be recorded. Participants will remain anonymous and any references to actual clients, places or recognisable events will be replaced or removed.

Under data protection the author is required to keep the transcripts from the interviews for a period of 7 years. These will be stored electronically and encrypted during this time.

Participation in this study is completely voluntary and you may stop the interview at anytime or withdraw your participation. If you would like to read the finished thesis please do not hesitate in contacting me at the above number/e-mail and l will make a copy available to you.

The purpose and process of this study has been explained to me.
I agree to participate.

Participant's Signature: _____ Date: _____

Participant's Name in print: _____