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Addiction and the Family: Substance Use as a Symptom of the Larger Emotional System

Alexis Mercado

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Addiction and the Family:

Substance Use as a Symptom of the Larger Emotional System

By

Alexis Mercado

An Applied Clinical Project Presented to the

College of Art, Humanities, and Social Sciences of Nova Southeastern University

in Partial Fulfillment of the Requirements for the Degree of

Doctor of Marriage and Family Therapy
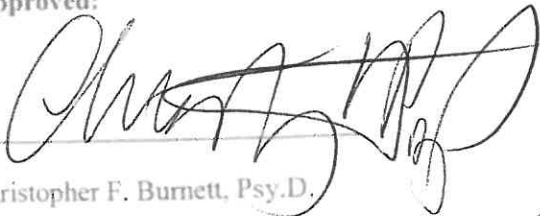
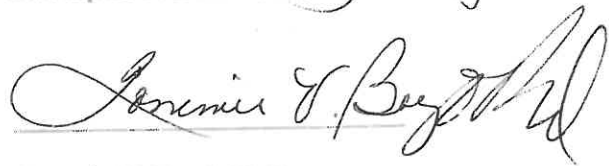**Nova Southeastern University**

July 2019

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

This Applied Clinical Project was submitted by Alexis Mercado under the direction of the chair of the Applied Clinical Project committee listed below. It was submitted to the College of Arts. Humanities, and Social Sciences and approved in partial fulfillment for the degree of Doctor of Marriage and Family Therapy at Nova Southeastern University.
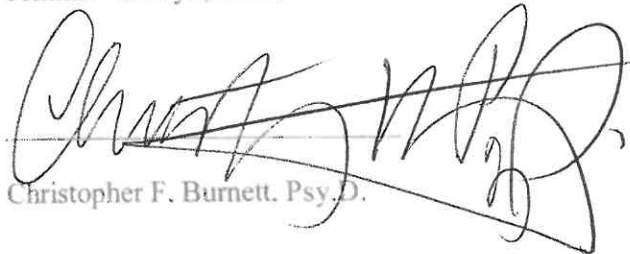
Approved:

7/3/19

Date of Defense

Christopher F. Burnett, Psy.D.

Tommie V. Boyd, Ph.D.

7/10/19

Date of Final Approval

Christopher F. Burnett. Psy.D.

Dedication

With infinite love in my heart and immense gratitude, I dedicate this work to all the individuals that are aware of their family system patterns and have the courage to choose again. To all the men and women in this world who sit and wonder why they think differently from their nuclear family. To those individuals who question their need to differentiate and have different opportunities in life. For every person who has felt sad, upset, or lonely because they chose to step out of the generational family patterns. To all the individuals who create boundaries with their family and develop a loving family outside of their nuclear system. This work is a testament to what is possible when you take a close look at yourself and your family system. It is a physical manifestation of the steps needed to become individuated while also loving your nuclear family and the tools they have given you. This is for everyone who is ready to stop blaming others, take personal responsibility, and make new choices. I dedicate this to you, who have chosen to step into the work and continue to move forward with your lives.

Acknowledgements

I extend special thanks to Dr. Burnett, my Applied Clinical Project chair, for without your teachings, guidance, and unconditional support, I would not have had the knowledge to spread awareness to the field of addiction in this way. You have constantly shown me the importance of working through my own family system to help others differentiate from theirs. This gift has assisted me personally and professionally for that I am beyond grateful. I would also like to thank Dr. Boyd, my committee member, for your loving wisdom and everlasting support. You have shown me so much grace and consistently believed in my ability to work through any obstacle that came my way during the writing phases. I appreciate all your suggestions, time, and effort that was taken to help me achieve this in time!

I would like to thank Gus Crocco, as I am grateful for the opportunities provided to use my education with the staff and clients. To the amazing friends that have supported me on this entire journey, Marty Waddington, Alana Bartlett, and James Musgraves, you have all been the best soundboards anyone could ask for and the unconditional support provided energetically and emotionally truly helped this dream come to fruition. I love you and I am so blessed to have you all in my life.

Last but certainly not least, to my sister, whom I love dearly. I am grateful for our ongoing commitment to strengthen our bond and relationship in healthy ways. To my niece and nephew, who constantly show me the importance of breaking generational patterns so they can benefit from the choices made and differentiate even further. To my Wellness family, thank you for providing me with unconditional love and always reinforcing my potential to give back to the world!

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Abstract

Traditional family therapy in the field of addiction primarily focuses on relapse prevention and psychoeducation. The lack of systems thinking in residential treatment facilities led to my desire to apply Bowen Family Therapy to a focus group in a residential treatment center. I used the following Bowen concepts: anxiety, differentiation of self, emotional cutoffs, and triangulation as a means to explore how addiction is a symptom of the larger emotional system of the family. I, co-facilitated a three hour group therapy session over 7 weeks with individuals in a treatment center. I addressed the following questions: RQ 1: What impact, if any did this program have on their life? RQ 2: What were the long-term effects of being in the program? RQ 3: Did participating in the group help to better understand resiliency? RQ 4: How does education on the family system impact an individual's recovery process and relationships in life? Through interviews, I followed up with clients three years later to look at the long-term effects of being in the 7-week program. This Applied Clinical Project focused on understanding resiliency and long-term effects on sobriety through a Bowenian lens. The themes that emerged focused on communication, boundaries, resiliency, relationships, and anxiety. The findings demonstrated that a multigenerational element in the study helped participants develop a way to maintain the Family Dynamics curriculum in their day to day life. The overarching theme is that healthy relationships with open communication lead to better anxiety management, resiliency, and boundaries which shows a foundation of which new approaches to substance abuse treatment can be found.

CHAPTER I: INTRODUCTION

Personal Background and Experience

As a Latina born and raised in the Bronx, NY in a single parent home with my mother, I am aware of the patterns that can be present in the family system. I graduated high school in 2002 and was the first grandchild in my family to achieve a high school diploma. I was also the first person in my immediate family to be accepted into college in the Fall 2002. I entered SUNY Purchase College with the hopes of becoming a lawyer and helping individuals fight for their rights in the court system. However, there was a different plan in store for me that semester as I was in a near fatal car accident.

After the accident, I moved onto campus and found that being a lawyer no longer fit into my life plan. I found myself enthralled with the foundational teachings established in my intro to psych course. It was from that moment, I knew I wanted to be a therapist and to better understand the ways things work in a family system. This was the beginning of my curiosity to understand how one change can affect the course of someone's life.

In my senior year, I applied to Long Island University, Westchester Campus, as it was on campus of my then current school location and would allow me to be near friends. This was a significant step individually and in my family system as no one in my immediate family had ever received a bachelor's degree, let alone apply for a master's degree. I recall my family members asking me why I needed further education and yet attempting to support me in their own way. My friends were a system of great support during my college years, as my family was not as understanding of the importance of education and there were significant family health issues occurring throughout my family system.

When I saw that LIU (Long Island University) had a Marriage and Family therapy program, it was an opportunity to work with others and learn more about the dynamics in my own family.

I claimed it as an opportunity to repair relationships, to discover roles, and improve communication, all while making myself a better professional in the field. I firmly believe we can only take our clients and support them in a way that we have been willing to do for ourselves.

The last semester of the program, we were required to complete a practicum for graduation. I had been considering my plans for practicum way in advance and had my heart set on interning at a domestic violence center. However, that placement fell through and I was faced with a decision to pass the semester with no placement and wait until the following semester to graduate or to take a placement at a residential treatment center for addiction. At this point, a treatment center was the last place I ever wanted to intern; however, I did want to complete my degree. I applied for the placement and was immediately accepted as an intern for the family program in their residential program.

After a few weeks at this placement, I realized I was meant to be there. I loved spending time with the families twice a week and watching them support their family members in treatment. I enjoyed working on the Men's unit and facilitating group therapy with them three days a week. I interned under two Licensed Clinical Social Workers and truly credit my gentle and compassionate presence as a therapist in the field of addiction to them.

At the end of internship, I was offered a full-time therapist position at this facility to continue working with the family program and on the men's unit. However, I was already accepted into a doctoral program in Miami and moved to South Florida two months after graduation.

When it came time to find employment, I knew I wanted to work at a treatment center, but my experience was limited. I was able to start employment as a dual diagnosis counselor. In this program, I witnessed clients having no family involvement in their treatment. This was a significant contrast from my internship site, and I began to take notice of the differences I witnessed. Clients had minimal remorse for their actions, their relapses, and oftentimes would attend services under the influence, as there were no significant consequences or directives provided to alter this course of action. Employed at this facility for three years, the monotony of the schedule, minimal new clientele, and limited opportunities to expand my knowledge, led me to seek employment elsewhere.

Fully aware that group therapy and family therapy were my strengths, I looked to a company that would provide these services to their clients. I quickly started to notice that despite offering group therapy three times a week to men in the criminal system, (many on probation or parole) the system had failed them, as they were only afforded individual therapy once a month, no family involvement, and if they could not get an appointment due to high caseloads carried (30-45 men per group) in a month then they would not have a session for another month. The system focused more on the assessments of the client, deeming them acceptable to detox, placement in a residential program, or halfway house, or the outpatient program. The outpatient program was short staffed and limited in what we were able to provide in terms of therapeutic services.

However, I did notice that when I was able to advocate to work with the adolescents, this is where all the family work was being directed. The facility prided themselves on completing weekly family therapy with adolescent clients and their family in a 12-week period. I started to receive outpatient adolescent clients in which we discussed the family system and the roles all individuals played in the emotional system. Unfortunately, my experience facilitating these sessions was short lived, as the adolescent program was cut after three months.

In the Fall of 2012, I enrolled into Nova Southeastern University, as a member of the Doctor of Marriage and Family Therapy program, and I am so grateful for the education I have received. I was learning that "a person's family of origin has the potential to be both a resource and a support system". (Kerr & Bowen, 1988, p. 275) This led to a yearning to learn more in the field of family therapy, I started to work at another treatment center. At this facility, there were licensed mental health counselors and social workers. The interns varied in the certifications and licensure status, which included marriage and family therapists like me. We would meet for supervision once a week to discuss cases and receive feedback. In addition, the facility boasted their family services and it peaked my interest. We were mandated to facilitate calls for clients to their family members 2-4 times a week, pending their level status. Each client was in the facility for a maximum of 30 days and had to pass a level to get more privileges. On the first level, they could call family 2 times a week and on the next level they could have their cell phone to call family members 3 times a week.

Furthermore, if the client lived locally, the family was invited to attend weekly family sessions at the discretion of the therapist. If the client was from out of state, which most were, the family was encouraged to attend a monthly family program facilitated by a couple who were certified addiction professionals.

During this time, they would learn about boundaries, triggers, and engage in a family sculpting exercise. However, Kerr and Bowen (1988), state:

> Drugs are another major binder of anxiety. Alcohol, tranquilizers, and illegal drugs can bind anxiety for an individual and within a family. The more the family can focus on alcohol as the problem, the more other potential problems are overlooked. Excessive alcohol use, of course can also threaten a family and be a source of anxiety. (p. 119)

Again, the common theme demonstrated was a lack of family systems theory, blaming the client for their addiction, or blaming the parents for their lack of ability to control the client's behaviors as opposed to understanding that substance use is an attempt to control and manage the anxiety in the family.

Degree Application

Since Fall 2013, I have worked as a full-time therapist at an inpatient residential treatment center for co-occurring disorders in Broward County. My current credentials are: Licensed Marriage and Family Therapist, Masters Certified Addiction Professional, Internationally Certified Drug and Alcohol Counselor, and Advanced Certified Clinical Hypnotherapist.

The philosophy of the treatment center I was employed, focused on weekly family sessions for therapy sessions (and to attend family therapy for 2-3 days while in treatment). This process was different, as in other facilities, "family therapy" was separated from the community in the facility. The schedule included clients attending primary group three times a week in the mornings with their primary clinician and two large group sessions in the mornings with the CEO, a licensed clinical social worker.

In the afternoons, clients would attend step study groups, gender groups, relapse prevention, and either HIV or nutrition education. Regarding family involvement, the families were invited to attend group therapy sessions that clients attended with their "primary" group and large community group process.

It was during this time, I decided to start applying the education I was receiving to the field of addiction. "Approaches based on systems principles allow the therapist to be in contact with the problem, but not part of it. This type of contact can reduce symptoms but without replicating the patient's unresolved emotional attachments". (Kerr & Bowen, 1988, p. 110) Utilizing the philosophy of the treatment center and systems principles, I invited family members to attend therapy with clients. I observed that as the only Marriage and Family therapist present at the facility and working with professionals solely focused on addiction, there was a significant difference in treatment results and experiences.

Some professionals would think that coming from a system thinking perspective would lead to disconnect from the client however it is important to note:

> Systems based therapy is not an emotionally sterile or a mechanical process. The therapist-patient relationship always has some influence on therapy, but it is not necessary to foster, consciously, or unwittingly, much transference for the relationship to be useful to the patient. (Kerr & Bowen, 1988, p. 111)

Client's feedback informed me that they loved having family participate in their treatment, they enjoyed discussing their role in the family system, the evolution of addiction as a symptom of the family system, and becoming an individual while being separate from the larger emotional system.

Applying my degree and education made me a better therapist. "The ability to be in contact with a problem but not part of it relates to emotional neutrality and detachment" (Kerr & Bowen, 1988, p. 111). Working in the field of addiction, I have experienced that this ability can be difficult at times due to clients relapsing, having multiple admissions in a short period of time, or passing away due to drug overdoses, suicide, and alcohol poisoning. However, a component of this Applied Clinical Project is to express that "major problems arise when the therapist loses sight of his part in the process and responds to the patient's transference by diagnosing it as the patient's problem," which often occurs at treatment centers. (Kerr & Bowen, 1988, p. 111)

By practicing systems thinking, I was able to create distance and separation from my clients without falling into my own family pattern of fusion in relationships. Relationships were maintained in a neutral stance and I used my role as therapist to discuss generational patterns triggered by life events for clients.

"Neutrality is reflected in an ability to be calm about what goes on between others, to be aware of all the emotionally determined sides of an issue, and to be aware of the influence of subjectivity on one's notions about what "should" be. (Kerr & Bowen, 1988, p. 111)

Furthermore, bringing in my degree set me apart from other professionals in the field whom were solely focused only on the twelve-step process and education. This led to a review of common problems in the treatment of addiction and incorporating the family to the course of treatment. Upcoming is an outline of the common problems and themes discovered based on my experience in the field and my knowledge of family systems.

Statement of the Problem

Taking notice of what clients responded to or not was a significant step in the process. While other professionals provided "homework assignments [to] help the client understand spirituality, find a home group, learn from recovery role models, work with a sponsor, and get the most from work on each of the 12-steps in the recovery process". (Jack, 2005, p.73) I spent time listening, not being anxious to fix their situation, and challenging their view of the family system and addiction.

I witnessed coworkers provide group therapy sessions focused on a "range from topics related to expectations of a 12-step group, problems and solutions in early recovery, the nature of 12-step work, and relapse prevention tools" (Jack, 2005, p. 73). While my group therapy sessions focused on "The emotional system itself [operating] as a unit, each one affecting all the other members" and "one [becoming] aware of being a

small part of something much larger than self-one's family in all of its generations".
(Gilbert, 2004, p. 2)

In my opinion, the attitude and approach of my coworkers appeared to be "intent on getting others to do things their way" and "frustration with the resistance of others to their efforts often leads to disappointment and anger; sometimes even to giving up and withdrawing". (Kerr & Bowen, 1988, p. 122) The above describes. the burnout process of therapists in the field of addiction, as they refrain from neutrality and become fused with the client and the perceived problem. So, when engaging in family therapy, not addressing the component of substance use as emotional management to the family system and instead addressing the behavior or the client as the problem leads to frustration from the client and the family

The process of drinking to relieve anxiety and increased family anxiety in response to drinking, can spiral into a functional collapse or become a chronic pattern (Bowen, 1978). Given my background, the clients I worked with received knowledge of systems theory and were able to bring it into their recovery process. I observed their ability to manage tensions and anxieties that arise in early recovery with more awareness, sense of developing self, and incorporate the relationships in their lives. Clients who had an education on systems theory, relationships, and the management of anxiety were also able to build relationships with peers in an easier manner, as evidenced by their ability to quickly find a sponsor and support group.
If they observed themselves having higher anxiety, they would often be observed discussing how it related to their relationships with their immediate family.

Other clients at the facility focused on spirituality and the traditional 12-step model. They concentrated on themselves but appeared to have greater difficulty managing relationships in early recovery especially with their family.

The above-mentioned clients continued to struggle with fusion to their families or complete emotional cutoff. They fell into these black and white categories of attempting to pursue similar relationships with their family or maintain the cutoff by not speaking to their family and using the geographical relocation as a way to uphold the distance and separation.

Purpose of the Study

It became clear in reviewing the literature that family systems theory is often left out in the discussions of family therapy with clients. Professionals are certified as addiction professionals and have minimal understanding or limited experience engaging in systemic family therapy. Family therapy with clients and their families are often composed of an individual session and repeating the same jargon of: just say no, have clear boundaries, and kick them out of the house if they relapse.

According to Kerr and Bowen (1988):

the problem of a therapist [reacting] to a family's anxiety by telling people what to do, the resources of the family will quickly become submerged. If a therapist does not react, but just helps a family define the nature of the problem with which it is confronted (especially the relationship process that create and reinforce it), the resources of the family will resurface. (p. 283)

As opposed to blaming clients or their family members, we must begin to treat not just the individual but the family. Therefore, the purpose of this study: 1) help clients understand their role in the larger system, thereby, decreasing the assumption and expectation that upon completion of treatment, the "diseased individual" would be "cured" by the treatment center; 2) to increase understanding of a lifelong engagement in practicing tools and new patterns to ease anxiety and tension as a member of the larger emotional system while also defining their sense of self, and 3) to examine the long-term effects of resiliency and coping mechanisms though a Bowenian lens.

Significance of the Study

This Applied Clinical Project explores the stance Bowen Family Systems Theory takes on explaining addiction as a symptom of the larger emotional system. While also discussing the importance of educating clients on family systems theory as part of building a foundation in their recovery process. Furthermore, increasing clients own understanding of personal family patterns through differentiation of self, emotional cutoff, and triangles in participation of family dynamics group co-facilitated by me using Bowen Family Systems Theory.

Summary

I outline the inquiry to bring Bowen Family Systems Theory into a focus group. Bowen Family Systems Theory in a focus group would be educating and helping clients gain an understanding of anxiety, their family relationships, and how substances are used as binders to manage the family system. In addition, addiction counselors who are primarily instructed to focus on the 12-steps and spirituality-based education would need to learn a new model. In Chapter Two, I discuss how addictions have been addressed in past studies, the primary focus on adolescent family therapy, and the gaps in the research.

CHAPTER II: REVIEW OF THE LITERATURE

Definition of Addiction

The American Society of Addiction Medicine (www.asam.org, 2011) provides the following definition of addiction:

Addiction is a primary, chronic disease of brain reward, motivation, memory and related circuitry. Dysfunction in these circuits leads to characteristic biological, psychological, social and spiritual manifestations. This is reflected in an individual pathologically pursuing reward and/or relief by substance use and other behaviors. Addiction is characterized by inability to consistently abstain, impairment in behavioral control, craving, diminished recognition of significant problems with one's behaviors and interpersonal relationships, and a dysfunctional emotional response. Like other chronic diseases, addiction often involves cycles of relapse and remission. Without treatment or engagement in recovery activities, addiction is progressive and can result in disability or premature death. (www.asam.org, 2011)

The American Society of Addiction Medicine (ASAM) also developed forms labeled as ASAM criteria, which addiction professionals and therapist providing addiction services are required to complete for each level of care that insurance companies require as criteria for treatment admittance. The forms range from the detox level of care through the outpatient level of care.

In addition, the American Psychiatric Association defines addiction as "a complex condition, a brain disease that is manifested by compulsive substance use despite harmful consequence. People with addiction (severe substance use disorder) have an intense focus on using a certain substance(s), such as alcohol or drugs, to the point that it takes over their life. They keep using alcohol or a drug even when they know it will cause problems. Yet, a number of effective treatments are available, and people can recover from addiction and lead normal, productive lives" (www.psychiatry.org, 2017) Furthermore, the American Psychiatric Association describe individuals struggling with addiction as "people with a substance use disorder. . . [they] have distorted thinking, behavior and body functions. Changes in the brain's wiring are what cause people to have intense cravings for the drug and make it hard to stop using the drug. Brain imaging studies show changes in the areas of the brain that relate to judgment, decision making, learning, memory and behavior control." (www.psychiatry.org) While the American Psychiatric Association continues to define individuals in this manner, it is appearing to be grounded in the concept of a "diseased" individual with minimal hope for the future which is relevant if they fail to stop using substances. However, if an individual can find other methods to manage and understand their cravings then the prospect of their future becomes more hopeful.

As a Certified Addiction Professional (CAP) it is protocol to discuss the pathology of the individual in staff meetings and supervision sessions. In clinical discussions, clinicians share that diagnosing the client with a label was an effort to describe their personality, problems, and behavior in life.

However, it has been my experience in working with clients, that two options can emerge when pathologizing an individual: 1) some will wear it as a badge and label in which they define all their decisions, while 2) others will reject the label and fight it, as opposed to understanding the behaviors and learning how to make new choices or develop new patterns in their life. Either way pathologizing the individual is a task I worked on to stray from, which was difficult in a field where pathologizing an individual allows them to get the services needed. In the following section, I review the traditional models utilized to treat addiction and the philosophies demonstrated by each.

Traditional Models of Addiction and Family Treatment

Motivational Interviewing

Motivational Interviewing (MI) is a foundational form of addiction counseling. MI is often used to motivate clients in treatment and help them become aware of the current motivation level and the resistance present to accepting help with their addiction. According to Miller and Rollnick (2002),

> The goal of MI interventions is to evoke self-motivational statements, referred to as "change talk." Change talk can manifest in four different ways: 1) recognizing disadvantages of the status quo (e.g., "I guess there's more of a problem here than I realized"), 2) recognizing the advantages of change (e.g., "my boys would like it; they are always after me to quit"), 3) expressing optimism about change (e.g., "I did quit smoking a few years ago, that was tough and took a few tries, but I did it"), and 4) expressing either a direct or implicit intention to change (e.g., "I definitely don't want to keep going the way I have been"). (p. 561)

Change talk is a great tool to helping clients see the reality of their situation,

The following five general principles of motivational interviewing are expected practices

of a counselor using motivational techniques during client intervention.

1. Express empathy through reflective listening,

2. Develop discrepancy between client's goals or values and their current behavior,

3. Avoid argument and direct confrontation,

4. Adjust to client resistance rather than opposing it directly,

5. Support self-efficacy and optimism". (Madukwe, 2013, p. 188)

Furthermore, motivational interviewing is primarily used with individuals during

an individual session. However, "there is limited research about the transfer of

motivational techniques from individual to group treatment". (Malat et al., 2011, p. 561)

Madukwe (2013) shares "Faith/hope effect plays a major role in one's potential to

change. A person's perception of how likely it is that he/she can succeed in making a

particular change is a good predictor of the likelihood that actual change will occur (p.

182). With spiritual based treatment being an accepted form of treatment, including

Alcoholics and Narcotics Anonymous, I present research focusing on these practices

being the primary way to address addiction in a treatment setting.

Spirituality Based Addiction Therapy

O'Brien and Abel (2011) cite (NIDA, 2009), "Addiction treatment must be

individualized; not all treatments work for all clients" (p. 123). To provide individualized

treatment, facilities instruct helping professionals to work with clients to build a concept

of spirituality of their own understanding.

According to Juhnke et al. (2011), "Spirituality has been acknowledged within existing literature and the helping professionals as important to clients successful recovery from substance abuse and addictions" (p. 21). Furthermore, Juhnke et al. (2011) recommend that helping professionals "have used prayer as a means to help client identify overall treatment goals, initiate and conclude individual sessions, and respond to cravings and stressors" (p. 21). In reviewing the literature, I believe there is evidence to support the implementation of spiritual based treatment however I also believe it is important to include Bowen Family Systems theory, as a clients' spirituality has the potential to be influenced by their family system, thereby creating resistance to the process or complicating their own understanding of developing a connection due to anxiety present in the family system around spirituality.

The incorporation of a spiritual based approach to addiction treatment is further explored in the literature. We discover the world of 12-step principles and recovery which occur outside of a treatment setting. In the next section, 12-step recovery and the research aligned with supporting it are outlined below.

12-Step Recovery

The twelve step principles of recovery are well known and highly recommended in the addiction field. According to Martino (2013), citing Daley et al. (2011), "the twelve-step principles of recovery and interventions to prepare and link clients to community twelve-step programs are commonly used in addiction treatment settings and are highly regarded by clinicians" (pp. 273-274).

The utilization of 12-step programs may be highly regarded by clinicians as one may discover that many professionals working in treatment centers are former addicts and alcoholics. I use the term "former" as when one enters the fellowship of alcoholics anonymous or one of its affiliates such as: narcotics anonymous or cocaine anonymous to name a few, some may consider themselves recovered or cured from a hopeless state of mind. I would agree that it has been my professional experience in observing therapists, counselors, and addiction professionals emphasizing participation in 12-step programs upon treatment completion. This course of practice is heavily recommended by treatment centers and many times the only recommendation that professionals are required to make in their discharge summaries. Furthermore, insurance companies, probation officers, and employers are demanding to see a discharge plan including 12-step participation upon treatment completion, often as a contingent to their probation, family medical leave, or claim for insurance to pay for treatment.

In a study completed by Martino (2013), citing Dennis et al. (2013), "the most credible clinicians were very experienced addiction counselors who had less formal education and more twelve-step principle knowledge" (p. 274). This study based the credibility of clinicians based on the report of clients. It is no surprise to me that clients would rather have a clinician whom they are aware of having struggled with addiction in the past as well and now can be seen as an example and "hope" for the client. However, I have seen this path backfire on clinicians, therapists, and counselors that are not mindful of the boundaries they keep with their clients. They ended up divulging too much personal information and develop significant transference with their clients.

The fusion between the two and the triangulation that can occur between the pair and a clinician that does not report being in recovery can lead to an increase in anxiety for all the relationships.

A 12-step participation may be the primary recommendation at this moment however it is with this Applied Clinical Project in mind, I am recommending a look into how family systems theory can change the future of addiction treatment. In the upcoming section, I will discuss family-based addiction treatment, the focus on adolescents, and the fellowship of Adult Child of Alcoholics (ACOA) working to bring family into the recovery process in their own practice and means.

Family Based Addiction Treatment

Family Therapy is incorporated to addiction treatment however the extent varies based on facility and services rendered at the specified treatment level. Stanton (1979) as cited by Liddle and Dakof (1995) express:

> Family therapy rests on the connection between family relationships and the formation and continuation of drug abuse. Within this paradigm, family relationships, because of their presumed causative role in the creation of the disorder, are the primary target of intervention. (p. 512)

Liddle and Dakof (1995) report:
> In the family-involved or family-based treatment models, families are not afforded the same place at conceptual or intervention levels. Family, including marital interaction, may be regarded as one of many target areas of intervention. (e.g., McLellan, Amdt, Metzger, Woody, & O'Brien, 1993)

Furthermore, involvement of the family does not mean that the practitioner attempts to change family interaction or relationships directly. One may instead involve the family in adjunctive or information-providing ways only". (p. 512) This is where the necessity of my project comes into account, as I planned to work with the client not only to address their addiction but also to see their interactions with their family members, how they can begin to bridge the relationships, and work on defining a strong sense of self to be a part of the family system without allowing anxiety to trigger a need to use substance due to inability to function in the larger emotional system that is their family.

In addition,

Interventions have been constructed to test classic and integrative family therapy approaches and include family therapy as part of a broader array of interventions to reduce or eliminate drug use and abuse with adults and adolescents. Nonetheless, the number of completed studies are relatively few compared to the number of treatment studies in the drug abuse field overall. This is consistent with the relatively low frequency with which family therapy has been studied in psychotherapy as a whole. (Liddle & Dakor, 1995, p. 513)

According to Malat etal. (2011), "the traditional focus on interactive group process and personality has been preserved to address the multitude of psychological vulnerabilities that may predispose patients to relapse (Khantzian, et al., 1990). At the same time, abstinence is prioritized in these integrative models in accordance with the disease concept". (p. 558) Family therapy is an opportunity for individuals to be in a safe, structured environment to address their point of view and have the family communicate in a more effective manner.

The reality is that "the experience and lifestyle of active addiction is, in and of itself, traumatizing and lays each struggling person open to a variety of additional traumas, including interpersonal violence, accidental injury and the like". (Morgan, 2009, p. 5) Given that not only the addict is suffering but also the family system as a unit, it would be beneficial to include this discussion into the process. However, a common issue in the literature is the primary focus being on adolescent family treatment. Morgan (2009) states it is "particularly challenging [as] the emerging research point[s] to widespread development of SUDs among adolescents as well as earlier ages of onset". (p. 7)

Family Therapy

Family therapy should not be made a priority for adolescents in the addiction field. It should be made available in more than a phone call or visitation for one day, as is common practice in treatment facilities. According to Stanton and Shadish (1997) as cited by Morgan and Crane (2010), "family therapy impacts not only substance-abusing individuals, but health care insurers and families as well, because of its increased effectiveness over individual treatment, family psychoeducation, and peer group therapy". (Morgan & Crane, 2010, p. 486)

Morgan and Crane further state:

> Conducting cost-effectiveness studies on family-based substance abuse treatment will not only demonstrate effective family-based treatments but also those that are competitive in terms of costs. (Morgan and Crane, 2010, p. 496)

I do believe it is important to acknowledge that adolescents need to have treatment and it is more cost effective based on literature reviewed however:

> when a child is wounded, the pain and negative long-term effects reverberate as an echo of the lives of people they grew up with-and then they grow up, at risk for taking on similar characteristics and behaviors-thereby sustaining the cycle of abuse, neglect, violence, substance abuse, and mental illness. (Anda, 2008, p. 16)

If we do not address the adults that are struggling with addiction and how their addiction is a symptom of the larger emotional system then they are on track to repeating the same behavioral patterns and symptoms that they learned from their family. This will then lead to the generational pattern being passed down to their children until someone in the family system is given an opportunity or is motivated enough to differentiate outside of their family system. "The experiences of childhood-specifically stressful or traumatic experiences that can negatively affect childhood development-are fundamental and often 'hidden' underpinnings of the occurrence of multiple health and social problems". (Anda, 2008, p. 4)

By addressing these experiences in a group setting where individuals can be supported by others who can relate and encouraged to see patterns they may not have been awakened to before, is how we break the generational patterns, differentiate from the family system, and build a stronger sense of self, all while attempting to rebuild emotional cutoffs and becoming de-triangulated from other family members.

This is further explored by Felitti (2003), in which he states:

> Our findings indicate that the major factor underlying addiction is adverse childhood experiences that have not healed with time and that are overwhelmingly concealed from awareness by shame, secrecy, and social taboo. . . . The ACE Study provides population-based clinical evidence that unrecognized adverse childhood experiences are a major, if not the major, determinant of who turns to psychoactive materials and becomes "addicted. (p. 8)

Morgan (2009) states "Recovery is a path of transformation; it allows one to acknowledge and live from deeper aspects of life and awaken to the call of spirit or a higher power". (p.11) I agree with Morgan (2009) and reviewed the literature on family, recovery, and spirituality.

This was further explored in Morgan and Crane (2010), "when a clients system (i.e., his or her family, siblings, spouse/partner, etc.) is treated, it becomes healthier, and the client then has a stronger support network to aid him or her in the recovery process" (p. 486). Adult Children of Alcoholics, a 12-step recovery-based group, works to address an individual and their family system. Their program is geared towards helping individuals maintain their sobriety, heal from childhood wounds, and define their sense of selves. This program is further explored in the next section.

Adult Children of Alcoholics

As mentioned above, there is another fellowship that starts to hit a bit closer to home for the purposes of this study, Adult Children of Alcoholics, also known as ACA. "The ACA fellowship is also focusing on the family system, which means inventorying parental behavior in addition to inventorying one's own self.

The ACA is not blaming the parents, but this is a unique Twelve step approach that is necessary to get at chronic loss at its roots" (ACA, 1990, p. xxi). The fellowship of Adult Children of Alcoholics was developed to address addiction, the family system, and old trauma.

Participants in the ACA fellowship, "believe that each of us is born with a True Self that is forced into hiding by dysfunctional parenting. A false self emerges that protects the hidden True Self from harm, but at a heavy price. Without help, the destructive false self is too much for most adult children to separate from" (ACA, 1990, p. xv). This is where the ACA fellowship begin to conflict with family systems theory, in that the parenting is not labeled as dysfunction but instead reviewed in their levels of differentiation and ability to define the self from their family of origin. The language is not necessarily in alignment with one another however the message at its core is similar. For example, "As part of our recovery process, many ACA members take a "blameless inventory" of their parents to understand and stop the generational nature of family dysfunction" (ACA, 1990, p. xvi). Bowen family systems therapy works with clients to engage in this "blameless inventory" by completing a genogram with their family. It is recommended to complete the genogram outlining a minimum of three generations going back from the client. This task allows the client to begin observing and identifying generational patterns that have been passed down in the family system due to the anxiety and lack of differentiation level completed by their parents and their parents' parent and so on. Furthermore, the ACA fellowship has a book that they have used since its development in 1990.

The ACA fellowship states, "This book is not a call to rally against dysfunctional families, parents, or family systems that many would consider problematic. In ACA, we learn to focus on ourselves and live and let live" (ACA, 1990, p. xvii). The recovery process for the individual and their family is outlined in the ACA fellowship introduction.

According to ACA (1990), "Most people recovering from addiction and other disorders can recover more successfully by first stabilizing these for a time...we call this stabilization period Stage 1 recovery work . . . come to a recovery perspective because they are hurting or even "bottoming out" from emotional pain and having a desire to change. These can usually enter directly into ACA and trauma effects recovery work, which we call Stage Two . . . . The goals of Stage Two work include: 1) realizing our True Self, 2) grieving our ungrieved hurts, losses, and traumas, 3) finding and fulfilling our healthy needs, and 4) working through our recovery issues.
The final one, Stage Three recovery, is refining our relationship with self, others, and God from a spiritual perspective". (p. xxix)

The format and purpose for the ACA fellowship is one of good-natured intentions. However, as a licensed marriage and family therapist who has specialized in trauma, addiction, and certified in these specialties, I consider the ethical implications that can occur during these meetings and in working this recovery-based program. In the recovery process, individuals are sponsored by another individual whom has undergone the 12-steps. These sponsors are not trained in grief counseling, trauma counseling, or family systems. The assistance they provide someone working these steps of recovery is based on their own life experiences.

There may be some situations that are out of their scope and they would need to refer the individual hopefully to a therapist or counselor who specializes in family systems theory and addiction. However, according to Gilbert (2006), "The therapy professions have been characterized by a tendency to *blame parents* for emotional ills of individuals. When people do not do well, or became symptomatic, somehow, parents were to blame. This was and continues to be, an extremely destructive force to families, putting parents on the defensive and leaving them confused and inept in their roles as leaders of the family". (p. 107)

It is with this understanding and experience that I developed a therapy group for individuals in a residential treatment center geared towards family systems theory and addiction. My focus was on helping clients understand that their addiction was a symptom of the larger family system, that it was not solely their responsibility to treat their addiction, and that distancing or cutting themselves off from their family members would only hinder them moving forward.

In the upcoming section, I further outline the development of the group for this Applied Clinical Project, the theoretical framework, the inclusion criteria, and the curriculum for the 7-week program. It was my aim and purpose through this project to emphasize the importance of including family systems theory to help individuals understand the involvement of their family in the symptom development of addiction.

Theoretical Framework: Bowen Family Systems Theory

According to Kerr and Bowen (1988), "family systems theory links all clinical symptoms to the emotional system. A disturbance in the balance of the emotional system, both within an individual and within his relationship system, can trigger the development of symptoms". (p. 256) The purpose of the study was to demonstrate how addiction is a symptom of the larger emotional symptom and not simply perceiving the individual struggling with alcoholism or addiction as someone that is diseased.

Kerr and Bowen (1988) also stated, "acute symptoms are associated with short-term disturbances in the balance of a system. Chronic symptoms are associated with long-term disturbances". (p. 256) Substance misuse and abuse are examples of acute symptoms while substance dependence is an example of chronic symptoms. Furthermore, addiction can be expressed through family systems theory as:

> a factor or factors that trigger the initial disturbance in system balance that ultimately leads to symptoms in an individual [that] may be in the biology or psychology of that individual or in his relationship system. If the individual or family fails to adapt effectively to the initial disturbance, the disturbance may become self-perpetuating and provide the impetus or "energy" for the full expression of whatever pathogen or defect may be present. (Kerr & Bowen, 1988, pp. 258-259)

Often in family therapy, "much of what is done in the name of helping others, such as getting others to "express their feelings," reflect the inability of the "helper" to tolerate his own anxiety" (Kerr & Bowen, 1988, p. 124).

In my own experience, my intention has always been to work with clients on their family dynamics and assisting them in understanding the generational patterns present without trying to fix them. "The family of origin is a resource for learning more about oneself. A person's relationships with parents, siblings, and other relatives during childhood and adolescence are the primary influences on the way he manages himself in his marriage, with his children, and with others important in his life" (Kerr & Bowen, 1988, p. 275).

According to Kerr and Bowen (1988), "Family systems theory assumes the existence of an instinctually rooted life force (differentiation or individuality) in every human being that propels the developing child to grow to be an emotionally separate person, an individual with the ability to think, feel, and act for himself". (p. 95) This theory is the opposite of traditional 12 step model and literature, as the 12 step model encourages addicts and alcoholics to look for a spiritual solution to their problem, rely on other addicts and alcoholics to guide them through step work to alleviate their "cravings" to use substances again, and attend meetings when the desire to use a substance or in family systems theory when the anxiety is too high and needs to be de-escalated. Furthermore, Kerr and Bowen (1988) state: "The principal generators of chronic anxiety are people's reactions to a disturbance in the balance of a relationship system" (p. 113), which in my opinion points to the fact that if family dynamics are full of anxiety that is chronic and ongoing where an individual is looking for relief then an option would be to utilize substances in order to decrease the anxiety.

According to Kerr and Bowen (1988), "people manage anxiety and reactivity with relationships and with a variety of activities. The activities include such things as. . . drinking. . .When most of the anxiety is bound in a stable arrangement of relationships and activities, the emotional system is said to be "in balance". If the balance is associated with clinical symptoms, the symptoms are fairly stable. If the balance is disturbed, new symptoms may appear and/or chronic symptoms may worsen". (p. 264) However, initially individuals are not always aware or believe that the use of substances creates a dependence not only on the substance but also on the substance's ability to decrease anxiety anytime the individual encounters it. Hence leading to increased substance use to manage anxiety as a result of destabilized relationships in the family system.

In addition, "family systems theory attempts to bridge. . . compartmentalization of disorders into categories such as "medical" or "psychiatric" by conceptualizing *all* clinical dysfunctions as linked to the *same* basic patterns of emotional functioning in a nuclear family". (Kerr and Bowen, 1988, pp. 163-164) The above mentioned led to the development of the framework used in the facilitation of a Bowen family systems theory group format. Facilitators led discussions once a week for three hours in a 7-week time frame on differentiation of self, emotional cutoffs from family members, and the triangles evident in each client's family system. The focus of the "therapists [were to] begin [seeing] the multigenerational process of which all of us are a part. . . [remove] the blame factor and gives [clients] and others a way to understand a way of changing self in [their] families that is realistic and effective". (Gilbert, 2006, p. 107)

The following is brief overview of the eight concepts to Bowen's family system theory:

1) Differentiation of Self: "As people work on getting to a better level [of functioning], they carry less anxiety, which is at the base of most symptoms. They make better decisions, often at issue in human difficulties. They are more effective in relationships and relationship systems". (Gilbert, 2006, p. 44)

2) Triangles: "The triangle describes the dynamic equilibrium of a three-person system. The major influence on the activity of a triangle is anxiety". (Kerr & Bowen, 1988, p.135)

3) Nuclear Family Emotional Process: "In Bowen family systems theory, the nuclear family, rather the individual, is the emotional unit. This concept changes the way one thinks about everything relational, and perhaps the way one thinks about everything". (Gilbert, 2006, p. 5)

4) Family Projection Process: Bowen (1978) states that the family projection process "is so universal it is present to some degree in all families". . . ."the pattern in which parents operate as a we-ness to project the undifferentiation to one or more children". (p. 379)

5) Emotional Cutoff: "Emotional cutoff is a concept in systems theory that describes the way people manage the undifferentiation (and emotional intensity associated with it) that exists between the generations. The greater the undifferentiation or fusion between the generations, the greater the likelihood the generations will cutoff from one another". (Kerr & Bowen, 1988, p. 271)

Furthermore, Bowen (1976) describes cutoff as a "*process of separation, isolation, withdrawal, running away, or denying the importance of the parental family.*". (p. 383) This process of emotional cutoff can be "enforced through physical distance and/or through various forms of emotional withdrawal". (Kerr & Bowen, 1988, p. 271)

6) Multigenerational Transmission Process: "family systems theory assumes that individual differences in functioning and multigenerational trends in functioning reflect an orderly and predictable relationship that connects the functioning of family members across generations". (Kerr & Bowen, 1988, p. 224)

7) Sibling Position: "The research showed that, all things being equal, people would show certain characteristics, depending on where they landed in their families' constellations, according to the mix of rank and genders there". (Gilbert, 2006, p. 86)

8) Societal Emotional Process: "The concept of societal emotional process describes how a prolonged increase in societal anxiety can result in a gradual lowering of the functional level of differentiation of a society". (Kerr & Bowen, 1988, p. 334)

In reviewing the literature, Valkov (2018) completed a study on birth order and its relation to the development of substance use disorder. Valkov (2018) stated: "study is to investigate the significant relationship between substance use disorder (SUD) and ordinal birth order". (p. 154) The study was inspired by research from Adler (1927) where he theorized that the last-born individual never has to share or change position within the family and, therefore, never has to deal with dethronement (in contrast to firstborns)". (p. 155)

The study reports that last born children are likely to develop substance use disorders because "last-born children are less likely to be forced to separate from their parents, and they are often spoiled and pampered" (Pakov, 2018, p. 155). In addition, Eckstein and Kaufman (2012) report "numerous empirical studies have found that the youngest children have the highest social interest and agreeableness, are most rebellious, most empathic, most likely to abuse alcohol and are overrepresented among psychiatric populations" (as cited by Pakov 2018, p.155). These findings are further emphasized after "analyzing the data from the National Longitudinal Survey of Youth, Argys, Rees, Averett and Witoonchart (2006) found that last-born persons are much more likely to use substances as cited by (Pakov, 2018, p. 155)

Furthermore, "Barclay, Myrskylä, Tynelius, Berglind, and Rasmussen (2016) found that later born siblings were hospitalized for alcohol use at a higher rate than first-borns, and there is a monotonic increase in the risk of hospitalization with later birth order" (as cited by Pakov, 2018, p.155). However, Pakov (2018) identifies that "the correlation between birth order and substance use disorder does not necessarily imply causation – that birth order causes substance use disorders". (p. 157) Instead he shares that in "substance use disorder is a result of biological, psychosocial and spiritual factors, contributing to the variation in the risk for and severity of the disorder. Birth order is only one part of a complex combination of etiopathogenic factors" (Pakov, 2018, p. 157).

In reviewing treatment protocols, I observed there are common themes and problem areas that arise among clients undergoing addiction and mental health treatment in a residential setting.

Some of these key themes and areas are struggling with chronic anxiety, lack of self-awareness, and strained relationships with their family and loved ones. Given my understanding of Bowen's family concepts, I believed the following concepts: chronic anxiety, defining the self, triangles, emotional cutoff and differentiation of self, play an integral part to the development of a Family Dynamics Group to address these common themes and problem areas.

Development of the Family Dynamics Group

By creating a group and curriculum centered around these patterns, clients were provided an opportunity to discuss these topics from a different perspective and one that appeared to be more relatable. I outline the development of the Family Dynamics Group.

Three years ago, a coworker and I discussed the importance of developing smaller breakout groups to work with clients who had multiple relapses and re-entrance into our program, more specifically clients whom were "bored and tired" of the traditional curriculum. I took this as an opportunity to consider what the clients in our community were responding to and what they were not. Using my knowledge in family systems theory presented by Kerr and Bowen (1988),

> a person who develops a symptom frequently reacts anxiously to having the symptom and that reaction can make the symptoms worse" and "Anxious family members may become overinvolved with the symptomatic person in a frenzied way or they may become underinvolved in an equally reactive way. (p. 177)

I developed this group as a unique approach to addiction treatment. It was viewed as a way for clinicians to be of greater service in the treatment of addiction, assisting clients in differentiating from their families, and developing a way to manage their anxiety.

Therefore, I could assist clients in managing:

> an event, or more likely a series of events, [that could] disturb the balance of a relationship system and trigger symptoms [in early recovery]. The events may be the addition of something new that has to be dealt with or the loss of something old that was relied on. Both types of events can increase anxiety in the system: the first by giving the system more anxiety to manage, the second by depriving the system of an old way of managing its inherent anxiety. (Kerr & Bowen, 1988, p. 265)

With this intention in mind, it was an easy decision that lead to the development of this group. I stepped into the group co-facilitating with a coworker whom was also trained in Bowen Family Systems Theory and held a degree in Marriage and Family Therapy.

My underlying thoughts on utilizing these concepts is that if clients could begin to view their circumstances from a different perspective then they could gain a greater understanding of their patterns in life and ultimately of themselves. In early recovery, clients struggle to face themselves and by providing them with a gentle look into not only themselves but their family, they could perhaps be more honest in their self-reflections and realizations obtained during this seven-week group dynamic.

Family Dynamics Group Curriculum- 7 weeks

Developing a well thought out curriculum was significant to the co-facilitator and me. We were aware of the significance of having a thorough and comprehensive outline for each week. The center of the curriculum was founded on the use of three main concepts of Bowen family systems theory: differentiation of self, emotional cutoff, and triangles.

Differentiation of self was utilized as a descriptor centering on "the different degrees of adaptiveness of people to disturbance in their emotional environment". (Kerr & Bowen, 1988, p. 263) Emotional Cutoff was revered to describe how the "average family situation in our society today is one in which people maintain a distant and formal relationship with the family of origin, returning home for duty visits at infrequent intervals". (Bowen, 1976, p. 383)

While triangles were described as "the dynamic equilibrium of a three-person system. The major influence on the activity of a triangle is anxiety" (Kerr & Bowen, 1988, p. 135). Furthermore, clinicians discussed that "when anxiety increases, a third person becomes involved in the tension of the twosome, creating a triangle. This involvement of a third person decreases anxiety in the twosome by spreading it through three relationships" (Kerr & Bowen, 1988, p. 135).

The curriculum was developed for a 7-week program. Due to therapist recommendations for clients and length of stay varying for each client, the guarantee of an individual attending all seven weeks was not feasible. However, client's feedback after each group for the most part was positive and demonstrated a desire to return the following week if permitted and if they were still in attendance of the treatment facility.

The following 7-week curriculum established was to assist clients in understanding addiction, their family system, and ability to maintain their goal of sobriety through anxiety management.

Week 1: Resistance, Traditional Concept of Addiction, Anxiety

Resistance is a common occurrence when working with clients in addiction. The resistance around discussing addiction and the family system is even higher. Many common statements heard while working as an addiction professional were "it's my problem, not my family's, I did this to myself, and I don't need to talk about my family to recover from addiction".

According to the ACA (1990), "First is the issue of betrayal. . .people of all ages are so afraid of betraying their parents. Speaking your truth, owning your reality is not an act of betrayal with your parents. . .to not own your reality or to not speak your truth is the ultimate act of betrayal to yourself" (p. xxiii). The second form of resistance is that "people want recovery, but they prefer it to be pain free...people are afraid they are too fragile and will fall apart. . .but feelings are cues and signals to tell you what you need. It is the repression or distorted expression of them that gets people sick or into personal difficulty" (ACA, 1990, p. xxiii). In other words, the second form of resistance occurs when individuals do not want to discuss their emotional cutoffs, triangles engaged with family members, or defining the self as it would mean taking a closer look at the system which can increase anxiety. Clients may be afraid that by discussing these areas and increasing their anxiety levels that they may not have the tools or skills to alleviate their anxiety levels without returning to old patterns utilized to manage anxiety such as

substance use. The third form of resistance is "people want to heal and live in the present, but they prefer to do it alone. This is often based in rigid self-sufficiency. Self sufficiency is valued in our culture. The rigidity of self-sufficiency is based in mistrust of others and the fear of letting go of control" (ACA, 1990, p. xxiii).

By addressing resistance, rebellion, addiction and an understanding of anxiety, a foundation was laid between the clients and facilitators. We were able to set up ground work and parameters in how we would be discussing addiction, the family system, and anxiety.

Week 2: Development of Symptoms, Substance Use as a Symptom of Family Anxiety

According to Gilbert (2006), "the emotional system itself operates as a unit, each one affecting all the other members. In thinking systems, one is aware of being a small part of something much larger than self" (p. 2). By helping clients understand that they are part of a unit and that their decisions, as well as the decisions of their family members affects the whole unit, they were able to see that simply because some of their family members were not "addicts or alcoholics" did not mean they were not symptomatic as well. Engaging with clients from this framework was beneficial but also difficult at times, as clients were observed wanting to maintain the image that their sibling or parents were absolved of any symptom development as a result of belonging to the larger emotional system. With continued explanation of symptom development and the discussion of relationships, clients were able to gain a sense of understanding.

In addition, discussing symptom development and where it developed provided some clients with a deeper awareness and insight to their emotional system.

Kerr and Bowen (1988) declared that knowing:

> *Where* a symptom occurs in a relationship system (in which family member or in which family relationship) is determined by the particular pattern or patterns of emotional functioning that predominate in that family system...the symptoms can be in the form of physical illness (defined conventionally as a "medical disorder"), emotional illness (defined conventionally as a "psychiatric disorder"), or social illness (defined conventionally as a "conduct disorder" or as a "criminal disorder"). (p. 163)

Clients who clung to pathology, labeling themselves as the problem, or their behavior as an issue were able to discover symptom development in varied forms. Clients were also educated on their functioning level and how it could be enhanced by "drugs. It can rise and fall quickly or be stabilized over long periods, depending largely on the status of central relationships". (Kerr & Bowen, 1988, p. 99)

Week 3: Defining the Self, Objectivity

Week 3 was remarkable for those who had attended the first two sessions. At this point in the curriculum, they now had the foundational work completed and were excited to discuss change, starting anew, making new decisions, and creating new pathways as opposed to following the same patterns that their parents, and their parents parents had made. The clients whom attended week 3, as their first session were provided an overview by peers who had attended the first two sessions.

While the adjustment occurred in the first half of the group, by the second half of the group, they were mostly on board as well for change.

Kerr and Bowen (1988) wrote:

> the process of change has been called "defining a self" because visible *action* is
>
> taken to which others *respond*. A change in basic level can be achieved while in
>
> relationship to emotionally significant others, but not when others are avoided or
>
> when one's actions disrupt a relationship. (p. 107)

Therapists worked with the clients by engaging in exercises on a whiteboard,

where clients were encouraged to identify themselves. They were also supported in

sharing how they would like to define themselves in the future and the action steps they

would take to become that self. Part of this exercise including applying objectivity.

According to Kerr and Bowen (1988) "more objectivity means one is better able to see

the ways in which he is *part of the system*: the ways in which he affects the emotional

functioning of others and the ways others affect his emotional functioning". (p. 272)

Week 4: Triangles, Family Roles

According to Kerr and Bowen (1988) the process of detriangling depends on

recognizing the subtle as well as more obvious ways in which one is triangle by others

and in which on attempts to triangle others". (p. 149)

Furthermore, I discussed that:

> if a person can achieve more neutrality or detachment while in contact with the
>
> triangles that he is most connected to emotionally and then act on the basis of
>
> neutrality, the tensions between the other two members in each triangle will be
>
> reduced. Emotional neutrality is reflected in a number of ways, two of which are
>
> especially relevant to triangles: first, the ability to see both sides of a relationship
>
> process between two others, and second, the ability not to have one's thinking

about that process clouded with notions about what "should" be. (Kerr & Bowen, 1988, p. 150)

Week 5: Emotional Cutoff, Claiming Personal Responsibility, Reactivity

Week 5 centered on understanding emotional cutoff, claiming personal responsibility, and observing reactivity. Clients were led in a discussion on emotional cutoff. I used Gilbert (2006) definition:

When a relationship becomes sufficiently emotionally intense, at some point, people will often cut off internally or geographically. Communications cease…it can be crept into, after years of more and more distancing, or it can be a sudden reaction to a conflict that has reached proportions that someone defines as untenable for the continuation of the relationship. It can be mutual, where both parties want it and participate, or it can be unilateral-desired by one person and not the other. (p. 58)

Clients were invited to discuss any cutoffs they were aware of engaging in, what led to the cutoff, or if they were planning to cutoff a family member as suggested by another such as their therapist or of their own volition. The facilitators discovered this discussion was significant as many clients were being informed to engage in emotional cutoff by peers, their therapist, and family members at home. We also discussed what lead to a cutoff and the ripple effect it can have in other areas of their lives. Gilbert (2006) informs us that similar to how they handle the relationship with their nuclear family is how they will manage cutoff in society, groups, and organizations. (p. 58) In addition, reviewing reactivity and objectivity from the previous weeks group was significant.

As Gilbert (2006) states that "systems thinking strives to look at the emotional process going on among people, while never losing sight of the facts of a given situation. Rather than trying for control or blaming the other, one tries always to better manage oneself and one's own contribution to the situation". (p. 2)

Week 6: Generational Patterns in Managing Anxiety, Over/Underfunctioning

Week 6 provided an opportunity to explore the ripple effect concept introduced in week 5. Clients were led in a discussion of generational patterns in managing anxiety in their family.

Clients were educated:

When anxiety is low, people are less reactive and more thoughtful. This tends to stabilize individual functioning and to decrease the pressure people put on one another that can impair someone's functioning. When anxiety is high people can become more reactive and less thoughtful; *system* functioning is prone to decline. The anxiety destabilizes individuals and increases the relationship focus. (Kerr and Bowen, 1988, p. 99)

Facilitators utilized the whiteboard to write the attributes of the over and underfunctioner:

"As one does well, the other falters more. The overfunctioner:

1. Knows the answers

2. Does well in life

3. Tells the other what to do, how to think, how to feel

4. Tries to help too much

5. Assumes increasing responsibility for the other

6. Does things for the other he or she could do for self

7. Sees the other as "the problem"

8. Demands agreement, bringing on "groupthink"

The underfunctioner:

9. Relies on the other to know what to do

10. Asks for advice unnecessarily

11. Takes all offered help, needed or not, becoming passive

12. Asks the other to do what he or she can do for self

13. Sees self as "the problem"

14. Is susceptible to "groupthink"

15. Eventually becomes symptomatic

16. Gives in on everything

In the family those involved in an overfunctioning/underfunctioning relationship may spend a great deal of time seeking and getting more and more help for the underfunctioner's symptoms. The more one tries to help, the more the other goes downhill". (Gilbert, 2006, p. 19)

Week 7: Recovery Process, Differentiation of Self

In Week 7, Clients were reminded that "basic differentiation is functioning that is *not dependent on the relationship process.* Functional differentiation is functioning that is *dependent on the relationship process*". (Kerr and Bowen, 1988, p. 98)

Facilitators also emphasized that "a person must be self-sustaining and living independently of his family of origin to be successful at modifying his basic level of differentiation in relationship to the family". (Kerr and Bowen, 1988, p. 98) While taking another look at differentiation of self, clients were also introduced to the concept of bridging the emotional cutoff.

Kerr and Bowen (1988) stated "it is possible for adults to bridge cutoffs with parents, siblings, and other members of the extended family and, in the process, to reactivate "old" patterns of interaction and "old" feelings that might have been dormant for many years". (Kerr and Bowen, 1988, p. 276)

Summary

Given the preceding discussion, the questions acknowledged in the proposed research will focus on using a Bowen lens to understand addiction and the relationships within the larger family emotional systems. There appears to be gaps in the research addressing how Bowen Family Systems can be used to educate individuals struggling with addiction to leading a life with a greater understanding of themselves, their relationships with others, and relationships in general.

According to O'Brien and Abel (2011)

> Clients in addiction treatment often need to enhance their coping to deal effectively with the underlying feelings that led to use in the first place. By rehearsing effective affect management in session, the client can avoid relapses caused by negative affect states. (p.128)

Furthermore, the primary focus is on adolescent family treatment, as this treatment is more cost-effective, as outlined above. In the next chapter, I will discuss the methodology of grounded research theory, the participants in the first cohort, and the curriculum provided to address the research questions posed.

CHAPTER III: METHODOLOGY

Self as The Researcher

As a child, I was raised in a family system with alcohol present, communication was lacking, and I also felt most of the anxiety, as I was often a binder for my parents. I remember consistently thinking of different ways to absorb the anxiety in my family: perfectionism, silence, and being an amazing athlete. However, these survival tactics didn't last, and I could still feel the anxiety.

As a result, I turned to drugs and alcohol to ease the anxiety I felt. This lasted for several years, despite using substances to "ease" my anxiety I was still outwardly successful. I attempted therapy but the therapist I worked with was not able to create a safe space for me to share. I now recognize that she was simply ill equipped to manage the anxiety and trauma I had experienced due to her own limited differentiation level. Eventually, I was invited to attend an experiential weekend doing hypnotherapy. After that weekend, I knew I found the tools to help me. I signed up to participate in their two-year internship program which included becoming certified as an advanced hypnotherapist. I decided to stop using substances to manage my anxiety and entered the recovery process. However, when I engaged in recovery, I found the fellowship to be lacking something that I needed, addressing my family system. I also attended ACA meetings as outlined in Chapter 2, however there still seem to be something missing. I realized I desired the opportunity to not only explore myself and my family system but improve my relationships as well. I share this to highlight my own personal biases in the study.

The development of the Family Dynamics Group was an inspired idea. It came from completing my own work around my family system through the hypnotherapy training which focused on inner child healing and re-parenting the self. I had a desire to bring this to the field of addiction while also bridging the gap with Bowen Family Systems Theory.

It was important to me that I continue to remain neutral while facilitating the Family Dynamics Group, to create a safe environment for the participants to share, and to openly express their own experiences. While being aware of my own experiences, I chose not to self-disclose unless it would directly help a participant become clear of their own experiences or expand their awareness. The focus of the group was on the participant and my focus for myself was to continue working on my level of differentiation which I attended to by continuing my training with the hypnotherapy program I mentioned early.

I am now at the Mentors level and have been for the last five years which further influences my ability to teach and guide others as I was, in the program at Nova Southeastern University and at the Wellness Institute in Seattle. I am aware that while conducting this researcher I had to keep my personal biases in check. The three participants who provided their interviews were not only part of the original cohort, but they also returned to many groups after to help the cohorts that followed, as part of a multigenerational process that emerged. I was able to watch them help others, develop a deeper connection with them, and remain in contact throughout the years.

Prior to the interviews, I recognized several assumptions I had of the study. The assumptions I recognized were that clients enjoyed having a small group size, as evidenced by clients informing group facilitators, they felt more comfortable divulging personal information in a smaller setting.

Another assumption was that educating clients on family systems theory and addiction as a symptom developed as a result of the larger emotional system having an impact on their recovery. The third assumption was clients being able to utilize the information and skills presented outside of the group setting and with their family members, as evidenced by their answers provided and analyzed in chapter four. I worked on my personal biases by keeping the questions clear and direct, not engaging in small talk outside of the study purposes, and documenting my notes thoroughly.

This Applied Clinical Project is a qualitative study which McMurran (2009) and Watson et al. (2013) note that generalizing the findings by comparing results of different studies, as attempted by some quantitative research, is extremely problematic as interventions themselves vary greatly in terms of the approach, the therapeutic style, the length of time, and the aims (whether they aim towards treatment adherence, drug reduction, drug substitution or total abstinence). (Rotarescu et al., 2016, p.20)

According to Carradice et al., (2002), "a qualitative approach would focus instead not on generalizability of the results, but more on the applicability of the findings to other similar situations". It is with this understanding that I employed a qualitative method to data gathering.

In addition, Bryman (2008) completed a "study [in] attempts to address these existing issues, and to respond to the main criticism of how quantitative research fails to consider the complexity of human experience and to attribute meaning to people's actions and environments". (pp. 20-21)

Rotarescu et al. (2016) completed a qualitative study on the lived experiences of five clients in recovery from drug addiction. "Adopting this approach enables the exploration of how personal and family circumstances and characteristics contribute to a relapse situation or to a successful rehabilitation". (Rotarescu et al., 2016, p. 21) In addition, Rotarescu et al. (2016) state the:

> findings highlight that the context and background of addiction is a mixture of negative personal, family and community factors. The same as the factors contributing to addiction, triggers for relapse have been identified as a mixture of negative internal and external factors". (p. 30)

Furthermore, Bowen (1974) states:

> a systemic approach that considers people and their dysfunctional behaviour not in isolation, but heavily anchored to a cultural, social, familial and community system is recommended as more effective in tackling addiction in the light of the present findings and in line to previous research. (p. 31)

Grounded Theory Methodology

This research study was conducted through a qualitative framework of grounded theory to develop themes and analyze the results of my data. "Grounded theory methodology (GTM) is designed to enable the discovery of inductive theory.

It "allows the researcher to develop a theoretical account of the general features of a topic while simultaneously grounding the account in empirical observations or data". (Martin and Turner 1986, p. 141)

"Grounded theorists evaluate the fit between their initial research interests and their emerging data. We do not force preconceived ideas and theories directly upon our data. Rather, we follow leads that we *define* in the data, or design another way of collecting data to pursue our initial interests". (Charmaz, 2010, p. 17) This was the preferential choice for this study, as it allows me as the researcher to conduct an original analysis and create the grounded theory upon analyzing the data.

I reviewed the data and identified five key themes that were present. "Grounded theories may be built with diverse kinds of data-fieldnotes, interviews, and information in records and reports" (Charmaz 2010, p. 14).

Given that there is limited research looking at addiction through a Bowenian lens for inpatient treatment centers, I believe grounded theory would be a great fit. "The method is particularly relevant for research on issues for which limited prior research has been conducted and for which theory building is needed". (Fernandez et al, 2004, p. 686)

Inclusion Criteria for Participants

Participants were sampled from an inpatient residential treatment center in Broward County, Florida. The group was mixed with men and women varying in age from 18 years of age to their early thirties. I developed the inclusion criteria that was provided to clinical staff at the development of the group and upon admittance of a new staff member to the facility.

Clients were recommended to the group by their primary therapist with final approval being granted by myself and the co-facilitator upon reviewing the information provided by their therapist.

At times, further review needed to be explored and clinicians would speak with clients prior to their admittance to the group to gain deeper awareness of the dynamics to be discussed and the goals the client desired to achieve.

1. Clients who have children affected by their substance use and addiction:

   "If a person gains more emotional objectivity about his family of origin and remains in contact with the family rather than cut off from it, the amount of anxiety and emotional distance in the relationships with his spouse, children, and important others will decrease. Seeing oneself as part of the system in one's original family enhances one's ability to see oneself as part of the system in one's nuclear family". (Kerr and Bowen, 1988, p. 273)

2. Client diagnosed with mental health disorder and personality disorders:

   "Personality traits such as obsessiveness and hysteria, impulsiveness and indecisiveness, passivity and aggressiveness, shyness and obtrusiveness, procrastination, perfectionism, paranoia, grandiosity, optimism and pessimism can also serve as anxiety binders". (Kerr and Bowen, 1988, p. 120)

3. Clients rebellious in the home environment:

   "Rebellion reflects the lack of differentiation that exists between him and his parents. The rebel is a highly reactive person whose self is poorly developed. He operates in opposition to his parents and others; they, in turn, are sufficiently unsure of themselves that they react automatically to his acting-out behavior.

Most of his values and beliefs are formed in opposition to the beliefs of others. Based more on emotional reactiveness than thinking, the beliefs are usually inconsistent". (Kerr and Bowen, 1988, p. 96)

4. Clients experiencing mistrust and difficulty building trust in their relationships: "Relationship tension that results from that unresolved attachment (fusion or undifferentiation) and the anxiety it engenders". (Gilbert, 2006, pp. 58-59) As well as, "regardless of family structure, the common denominator in the development of symptoms is a *disturbance (actual or threatened) in a person's most emotionally significant relationships*" (Kerr and Bowen, 1988, p. 175).

5. Clients reporting significant closeness or distance from parents (fusion/distance/separation):

   "In regard to significant closeness, *"when the anxiety in a system increases, people tend to do moreof what they have always done,* (increase their togetherness, with all its patterns and postures) creating a vicious cycle". (Gilbert, 2006, p. 110) However, when it comes to distance from parents this can create symptoms as well. As Gilbert (2006) states "the potential of cutoff in whatever form, for producing symptoms, is great. As anxiety in society and thus in families, increases, cutoff can be expected to take place more often, adding to the problem that families face, both from increased anxiety upon the cutoff and from the lack of resources a well-functioning extended family provides. Because the society is more anxious, and anxiety is infective, families are more anxious". (pp. 108-109)

6. Clients who used substances with their child/parent:

    The triangle between a client, their parent, and a substance has been often observed as an opportunity for bonding and a binding. Often, clients shared they feel closer to their parent as a result of using substances with them.

    However, upon entering residential treatment and being able to have distance from the relationship were they able to realize that the substance was simply a binder for the lack of stability in the relationship and to override the anxiety that was built as a result of the lack of common ground. Thereby making the substance the binder for their relationship and bond developed.

    Furthermore, I developed these criteria with an understanding of the literature geared towards addiction, addicts, and alcoholics, family systems theory, and working with addicts and alcoholics who reported a family generational pattern of substance use. A combination of Adult Child of Alcoholic traits, definitions of addiction, and family systems theory on symptom development were taken into consideration as well. The importance of this criteria was setting a foundation in which the group would be held. It allowed my coworker and me to create a group in which we would hold the client's anxiety in addressing family systems, redefining themselves, beginning to repair cutoffs, detriangling themselves, and focus on anxiety management as to decrease the possibility of relapsing in the future.

Data Collection

There were several benefits and factors to consider for the collection of the above-mentioned data. The focus of the interviews will be to gain a clear, direct, straightforward measure to discover what worked in the program.

According to Kerr and Bowen (1988) when,

armed with some knowledge of theory and a willingness to watch and listen. A

person can learn more about the emotional process in his family and his part in it.

If he can then act on that knowledge and understanding triangles in critically

important for planning that action, he can be more of a self in his family of origin.

He need not be a child for life. (p. 276)

The hope of data collection was to validate the above-mentioned statement by Kerr and

Bowen (1988).

The benefits to gathering and collecting the data was examining how the

education of the participants on Family Systems Theory proved to be significant in their

recovery process. Furthermore, there was a small group of clients that engaged in this

program. Over the course of the 7-week program, seven clients participated in the group.

Two years later, there were five clients who had survived addiction. Two clients died

from overdoses. I was interested in looking at the resiliency and coping mechanisms from

the remaining clients from the program. I also had a desire to explore their coping

mechanisms with addiction.

As I am no longer working at the residential treatment facility where the group

was conducted over a three-year period, my course of action was to complete interviews

with the first group of former clients whom participated in the Family Dynamics Group.

The participants were contacted via telephone and Facebook messenger to request their

agreement to be interviewed three years post completion of the group. Participants were

asked to sign an informed consent form (see Appendix B for Consent Form), upon

approval from the Institutional Review Board to begin interviews.

Research Questions Analysis and Analysis Process

The purpose of the study was 1) to help clients understand their role in the larger system, thereby, decreasing the assumption and expectation that upon completion of treatment, the "diseased individual" would be "cured" by the treatment center, 2) to increase understanding of a lifelong engagement in practicing tools and new patterns to ease anxiety and tension as a member of the larger emotional system while also defining their sense of self, and 3) to examine the long-term effects of resiliency and coping mechanisms though a Bowenian lens.

The Family Dynamics Group was conducted in a fully accredited Level 1 through 3 residential treatment facility as defined by the American Society of Addiction Medicine (ASAM) (Stevenson-Hinde & Shouldice, 1995) This facility is a for profit agency that provides co-occurring disorders treatment for men and women of the ages 18 and up.

The development of this group was unconventional as we were no longer viewing the individual as someone whom was diseased but as an individual in the larger emotional system. The co-facilitator and I were aware that in the field of addiction treatment,

> people become over involved in trying to fix problems in the name of helping others and on the basis of a belief that what is happening should not be happening. Fixers try to 'correct' the situation and put it on the 'right' track'. (Kerr and Bowen, 1988, p. 109)

Our goal to co-facilitate a group was geared towards understanding the family system, increasing individuality, and developing a sense of self outside the family system.

It was of the upmost importance that I completed a follow up with clients to validate the purpose of the group development and perhaps create a program that can be duplicated in other treatments centers to broaden the way the field of addiction not only views substance use but the family as well.

Upon completion of the interviews, I transcribed the digital audio recordings of the participants verbatim. It is important to note that:

> An interview is contextual and negotiated. Whether participants recount their concerns without interruption or researchers request specific information, the result is a construction- or reconstruction-of a reality. (Charmaz, 2010, p. 27)

While transcribing the interviews, I identified key phrases that were repeated in each one which is known as coding. "Coding means that we attach labels to segments of data that depict what each segment is about. Coding distills data, sorts them, and gives us a handle for making comparisons with other segments of data". (Charmaz, 2010, p. 3)

Summary

In this project, I delved into addressing addiction as a symptom developed as a result of experiences in the larger emotional family system. I explored the significance of approaching addiction from the lens of Bowen Family Systems Theory and how utilizing this theory assists individuals in gaining a more defined sense of self. The study focuses on the understanding and application of knowledge provided on differentiation of self, emotional cutoff, and triangles. There was an emphasis on how applying my education of Family Systems Theory may or may not have impacted the clients I worked with, the long-term effects of their survival, resiliency, and relationships in life.

CHAPTER IV: DATA FINDINGS

Participant Profiles

The findings were gathered from three participants who engaged in the 7-week Family Dynamics Group. The participants were one man and two women, ranging from the ages of 21-27 years of age. (see Table I for Participant Profiles, p. 67). All participants were admitted for substance use and mental health issues as a result of opioid dependence. All participants were recommended by their primary clinician to attend the Family Dynamics Group based on who fit the inclusion criteria.

The participants attended the 7-week group program consistently for its entirety. Upon completion of the program, all participants returned to the group to usher in the next cohort admitted. One of the participants had their sibling enter the group following their completion and shares on this in regard to their own individual process and the multigenerational process of being present in the group for their sibling.

Table 1. Participant Profiles

First Initial	K	A	M
Interview Number	1	2	3
Age	25	21	27
Gender	Female	Female	Male
Consent	Consented	Consented	Consented

Interview Process

The interviews were based on the following research questions:

1: What impact, if any did this program have on your life?

2: What were the long-term effects of being in the program?

3: Did participating in the group help to better understand resiliency?

4: How does education on the family system impact an individual's recovery process and relationships in life?

In addition, I added three follow up questions based on feedback provided in the applied project proposal defense. During the proposal defense, it was discussed that a multigenerational process was developed when the original cohort was permitted to return to the group facilitated by me, the researcher, and assist the new cohort in adjusting to the group. By allowing the original participants to come in and share with the new participants, a maintenance of the safe place developed in the group format occurred. This also provided an opportunity for participants from both groups to witness one another. Based on this discovery, the first follow-up question asked of the participant "How did returning to the group and participating in a different capacity impact, if at all, your view on your own family system?"

The second follow up question was developed to discuss resiliency. I wanted to address resiliency within the family system with the ability to recover quickly from unforeseeable events but also to address the resiliency as a participant in the group. The original cohort held 7 group members, however, as mentioned earlier, two died from drug overdoses.

Therefore, I deemed it was important to question the remaining living participants regarding resiliency. The questions "Being aware that there were seven people in the group and two of the participants passed away, how did their loss impact you, if at all". Followed by the question, "what do you believe you received from the group that led to you having a different outcome in your life?"

The participants responded to all questions posed during the interview process. Upon completion of the interviews, this writer completed the digital transcriptions and began to analyze the data.

While analyzing the data, a grounded theory started to develop, and emerging themes became transparent. In the next section, I will discuss the emerging themes that became apparent upon analysis and coding of the data.

Results of Data Analysis: Themes and Subthemes

The following categories were developed due to emerging themes and concepts related to each theme:

Theme One:

- Being honest

- Digging deep

- Safe place to share

Theme Two:

- Anger and resentment

Theme Three:

- Choices and actions

Theme Four:

- Connection

- Not Alone

- Helping others

- Facilitator role

Theme Five:

- Patterns and behaviors

- Peace of mind

- Feelings

While reviewing the transcriptions, the analysis showed five key themes forming from the data. The five themes that emerged were:

1. Communication

2. Boundaries

3. Resiliency

4. Relationships

5. Anxiety

Addiction as a Symptom of the Larger Emotional System

The grounded theory that developed upon review of the data analysis is when relationships in the family system are addressed, patterns and behaviors can change, which reduces the anxiety in the larger emotional system. The patterns and behaviors addressed were substance use, addiction, and mental health.

While communicating how anxiety plays a binding role for the family system through these patterns and behaviors, individuals can begin to look at making decisions that relate to choosing again and differently from the larger family emotional system. By increasing communication levels and educating individuals on anxiety management, relationships can shift while differentiation is achieved.

Communication

Communication is the first theme that emerged in the data analysis. Participants discussed how digging deep, being honest, and communicating openly as opposed to keeping secrets were essential components to their recovery process and learning in the group dynamic.

Interviewee #1 stated:

> "Honestly, I don't know if this counts for other people, but it worked for me. I think it was just the simple fact of needing to be honest. Of learning that this is what it is, this is what you feel, what you say and being taught that. I was never taught that before and I don't know if it makes sense to other people, but I think I mostly had anxiety my whole life about being honest with my feelings and I was taught that it was okay. Being able to identify [anxiety] and tell somebody because I was never able to do that before. It was a hush hush household, don't say, don't ask, don't tell. When I got into group and it was kind of "no you kind of have to", I slowly but surely learned that it was okay to do so.

While Interviewee #2 shared:

> "It definitely impacted me like, I'm not one that really digs deep with my family
> relationships, so, and neither is my family into any of those things. So, definitely
> when I was in the group it shed a light on my relationship with my dad, even the
> relationship with my mom and being able to understand kind of the reason behind
> the behaviors and the way we interacted with each other. Being able to take it into
> my life now has changed a lot of things".

In regard to digging deeper and being honest, Interviewee #2 stated:

> "I think having a bigger understanding. I just don't think about things very deeply
> and normally push things under the rug and don't think about them at all. So in
> that group it was all about digging deeper into how relationships really function.
> So now whenever something goes on between me and someone else like my mom
> or dad, instead of leaving it surface level, pushing it under the rug. I dig a little
> deeper to find a little bit more understanding about it and it helps me handle the
> situation better".

While also acknowledging that being honest and open with their communication within
the family system is also significant. It is one thing to be honest in a group setting outside
of the nuclear family system, but it is an entirely different decision to bring the
discussions and communications back to the family system.

Interviewee #3 shared:

> "My parents were not in that group so they have no idea what not to do unless I say this is how it's going to go. Maintaining what I learned and being able to verbalize and communicate where I'm at because without that, it just would have been the same".

In this excerpt, the value is seen in taking what is learned and applying it back within the family system to increase differentiation and create a shift in the dynamics. As we have discussed in chapter two, when an individual decides to change their role in the family system, they then change the way the family functions as a whole.

As a result, the family system shifts to accommodate the changes made. By shifting the flow of communication within the family system, Interviewee #3 is also shifting the relationship dynamics which dictate how the family can choose to interact with them moving forward.

Boundaries

The second theme that emerged in the data analysis was boundaries. This term came up in every interview without any prompting or guidance from the researcher.

Interviewee #1 shared:

> "I have created a lot better boundaries with my mother, which was a very big thing...I was able to say things honestly to her. It's gotten to the point now where I'll say something and she'll know because I have kept that boundary up with her".

Interviewee #1 also went on to share that the group had a way of

"Showing me different ways to create boundaries and keep the boundaries. Boundaries were weird because I had never done that with her before. I think without the people in that group like 2 and 3, or you, I would not have been able to do it and having you guys be there and talk me through it was huge".

Interviewee #2 shared:

"I think a lot of what I got out of that group was building boundaries with my family members as well. Being able to set boundaries with my mom when she asks for things that I don't really feel comfortable providing for her or can't provide for her".

The subtheme that emerged in this area was the anger and resentments present when reviewing the family system, patterns, and behaviors present. The interviewees shared their view on anger and resentments, specifically on how they addressed and released their anger and resentments towards loved ones by developing boundaries. Regarding addressing anger and resentments by creating boundaries, Interviewee #1 stated:

"I was able to get my family tree lined up and realize that my father was just sick too. And let go a lot of that resentment and not stay angry cuz I was angry for a long time.

Interviewee #2 shared:

> "With my dad I was really resentful of him for a long time but i think going through that group and being with everyone else in the group, it gave me more of an understanding of where he was at in that time in his life. I mean he's an addict too so it was the same thing that I go through now. And all that stuff with my brother, that was a weird relationship too. And just like my mom, I don't know".

Interviewee #3 reported:

> "It allowed me to use that kind of technique in every aspect of my life and see what relationships the same thing was happening in codependency, manipulation, stepping over the boundaries, it kind of allowed me to put that in every area of my life and now not letting other relationships kind of take me down as well. Being able to set that boundary or let someone else's recovery affect my own. If somebody's doing the wrong thing or something I don't like, I'm able to kind of just go in the other direction and not be in the trenches with them because it's not somewhere that I need to be. So it allowed me to set those boundaries for myself which absolutely is the main reason why I'm still sober".

The common undercurrent in this area is that by educating the participants on relationships, patterns, and behaviors they were able to understand that their family members were struggling with their own anxiety, their own manners of coping and addressing the anxiety, and by looking at the whole picture versus a small self-focused view, they were able to expand their insight and understanding of the larger family emotional system.

Resiliency

Resiliency is the third theme to become present. The questions asked about resiliency explored the ability to recover quickly from difficulties.

Interviewee #1 reported:

"Everything between my mom, my dad, the abuse, I mean addiction in general all of it. That group taught me patterns, behaviors, feelings, and coping mechanisms, and support groups. Everything! That group did more for me than the entire stay for treatment".

Interviewee #2 shared:

"It is crazy because a lot of the stuff I've been through or a lot of other people in that group, um, the stuff we all went through and seeing people bounce back from that stuff is crazy. Some of the stuff that I've been through especially to trust people is crazy and that's resilience especially family members and being able to place any type of trust in them".

Interviewee #3 stated:

"I had to stand my ground and tell them when it was too much or if it was crossing a boundary if my father was like "are you going to meetings?". It's like, it's none of your business. And because we had been so close or I had been financially dependent on him, it was actually his business because he was making some sort of commitment. I felt obligated, so yeah it absolutely allowed me to understand how to be resilient. I mean it took a lot of work and practice in not letting them give me this and that because I mean how easy is it to say yeah help me".

Meanwhile, resilience was not only analyzed within the family system but also in the group dynamic. The researcher added an additional question during the research process to analyze resilience in regards to two of the original group members passing away from drug overdoses. When discussing resilience amongst group members specifically the impact of having two group members who passed away,

Interviewee #1 stated:

"It has nothing to do with the group of why those two people passed away. It has to do with the choices and the actions that they made after the fact. I think that's why I didn't have the same outcome because I didn't choose to go the same way".

While Interviewee #2 shared:

"It sucks man. It definitely does turn you off. It sucks and made me think why was I getting this. I always think about their family and its terrible, a mom losing their" [child].

Interviewee #3 reported:

"Extremely. The one person had an extremely similar relationship to their family that I do and I'm still in communication with his family occasionally. I had to separate myself from them as well with them doing the same thing they did to him and what my parents were doing to myself with over-attachment and codependency. I grew a close relationship with that person in such a short span of time in relation to the grand scheme of my life, to then feeling responsible for this parents emotional stability on occasion".

Based on the answers provided, this researcher can conclude that the individuals were impacted by the loss of two group members over the three-year period. In addition, all three individuals expressed gratitude for their ability to make different choices and take action in their life which lead to a different path than previously taken.

Relationships

Relationships were the fourth theme that emerged in the data analysis. This was not surprising as when discussing the family system, we are bound to address relationships especially when the curriculum targeted the areas of emotional cutoff, differentiation of self, and triangles within the family system.

Interviewee #1 shared:

> **"**I'll never forget the day we went over my family history. I realized I followed a lot of male patterns in my family and being a gay female that was a big wake up call....I think that was my biggest breaking point that I had in my sobriety to turn inward to myself and look at the patterns and behaviors".

Interviewee #2 states:

> "I give that group a lot of credit for my recovery because my dad and my brother really messed me up with some things that happened especially around shame that I never would have looked at. I was not trying to look at that stuff. I wanted to push it under the rug and not talk about things but I did because I knew I couldn't carry it around. It feels better and I know I would not have stayed clean if I had carried that around and not talked about it".

Interviewee #3 shared:

> "It definitely made me look at how my family affected me, rather than just being biased or a preconceived notion of the standard of they're you're family, where you have to be close to them. It kind of allowed me to take a step back and see where I was, I guess not necessarily being manipulative but staying close in some regards for the benefits while being miserable because I had remained so close to them. Um, it definitely just made me separate and distance myself a little bit from them which did not diminish the love I had for them or appreciation. But gave me some of my sanity back because I was able to comprehend what was being talked about".

A subtheme that occurred in relationships, was the relationship with the researcher while the group was in session and the relationship that continued afterwards. Interviewee #1 discussed the relationship with the researcher stating:

> "The work that you did with me and the awareness you helped bring into my life. It's very complicated unless somebody knows you to understand the intense work that you do because it's so loving and so caring but its not overly so. I didn't need to be coddled when I came in and you were able to show me and teach me without babying me. Learning what to do with myself, my family, my thoughts, everything".

Interviewee #2 shared:

"I give you a lot of credit for my recovery because there's no bullshitting you, you know. But I needed that. I need someone to say that's not you and call me out. Being able to look at relationships was important and I never would have looked at that stuff if it wasn't for that group.

Regarding the multigenerational piece for participants coming back to assist the following group members, Interviewee #1 stated:

"There's some people from that group that I still talk to".

Interviewee #2 shared:

"It was definitely weird, especially because I went back in with my brother. I feel like when you're in a situation for yourself you can be kind of self-centered and not really think about other people or what's going on. But then you sit in there and it's not really about you, you're just observing and taking notes to yourself I guess. It's when you really start to see and look at things in a less self-centered type of way. You realize I'm not the only one that has issues in these areas".

Interviewee #3 reported:

"It helped me to see that what I was saying was baloney. Hearing someone else's excuses or rational was fake or made up or just some sort of excuse that i probably used myself as a defense mechanism, like go away it's my family, this reason, this reason, this reason, instead of being like they are my family but its not me. Although it may seem like it's a direct reflection of me, it doesn't have to be. I can't make those excuses because there are no excuses to make".

The significant piece to this theme is the awareness that relationships are layered. The group was able to address their relationships with their family members, with individual group members, and their relationship with the researcher. Seeing the layers of each of these components and how it impacted the lives of the participants was interesting to witness in the data analysis.

Anxiety

The last theme to emerge in the data analysis was the theme of anxiety. The emergence of this theme makes complete sense considering the study addressed addiction as an anxiety binder and impacting the influence on the family system. One of the ways that anxiety was addressed in the group specifically as a binder was in reviewing the family dynamics through the use of the genogram. The researcher utilized genograms in the group to be completed as a way to increase the awareness of anxiety and how to begin managing it in their daily life. During the interviews, the participants discussed how they manage anxiety three years post completion of the seven-week program. Interviewee #1 stated:

> "My first thought was this is my family, what do you expect. I realized how messed up my family system is on both sides. I realized that now i know all the mental health in my family. Two weeks, I was able to help my cousin who is now in treatment and explain to her how many people have mental illness in our family and it's so hush hush kept under the rug in our family that she didn't know. I wouldn't have the knowledge if I didn't look at my history".

Interviewee #2 shared:

> "Well, for me personally, a lot of the issues was me using with my family members. So, I really had to consider my family when thinking about doing this whole recovery process. How was I going to have a relationship with my dad now, how am I going to have a relationship with my brother, after using with them or in the same area as them. Maybe not necessarily together but we all knew what was going on but it caused a lot of tension and weirdness. . .Um, yeah it definitely did help a lot in the recovery process because family is a big deal".

Interviewee #3 reported:

> "I am able to separate myself and find a peace of mind other than feeding into the anxiety and letting it dictate my whole day. It can be an anxious moment versus being ridden with anxiety constantly. Um, because I am able to separate myself and analyze the situation and see what's going on and what's making me feel a certain type of way. And I can kind of hone in on it and accept that's how I'm feeling and that's all it is, it's a feeling".

Participants were asked to give themselves permission to look deeper into their family roles, dynamics, and behaviors during the group. When diving deeper into the family dynamics and behaviors, Interviewee #1 shared:

> "I realized my father was taught the same way I was. Looking at the board and seeing their addiction, their patterns, and my father's family. I mean the man has been married four times. Just looking at all that and seeing it in black and white in front of you, you see the patterns and no wonder you turned out like poop".

Interviewee #2 shared:

"Lack of communication, like I don't want to continue that. When I have kids, I want my kids to be able to say hey I'm hurt that you said that or I don't feel right about this and be able to feel okay saying that. I want my kids to be like that is my parent and that's a person that takes care of me. I don't want them to feel like they have to do things themselves".

Interviewee #3 shared:

"Being able to separate myself from my family. Like tonight when I was with them, I can kind of notice what will aggravate me or what qualities I don't like or don't want in myself in them. And rather than lash out, I can separate myself and analyze what's going on and I don't have to let that affect me. It's allowed me to have a better relationship with them, not being so close with them or in constant communication or some sort of, I don't even know the word for it, entanglement, you know in my personal relationships".

Summary

Upon review of the data analysis, the three participants recalled the information discussed three years prior. The main themes that emerged were Communication, Boundaries, Resiliency, Relationships, and Anxiety. The subthemes were digging deeper into themselves, having honesty in relationships, anger and resentments, and their relationship with me, the researcher. In addition, the participants were able to recall other Bowen topics such as: overfunctioning and underfunctioning, distance and separation. Next, I discuss the overview findings from the study, its implications for practice, future trainings, future research, and my personal reflections.

CHAPTER V: IMPLICATIONS OF THE STUDY

The purpose of this study was to analyze the implementation of a Family Dynamics Group in an inpatient residential substance abuse and mental health facility. As a reminder, this Applied Clinical Project focused on research questions pertaining to the impact this group potentially had on the participants lives, the long term effects of participating in the group, if participating in the group helped them understand resilience especially in regards to their own family system and other participants in the group, and how education on their family system affected their recovery process and relationships in life.

As mentioned in Chapters three and four, I utilized a Grounded Theory Methodology to analyze the data. The ethical considerations to be aware of for this study are the use of human subjects, informed consent for interviews were needed, an explanation of the principles and purpose of the study, having respect for anonymity and confidentiality, respect for privacy, skills of the researcher and working with a group of individuals whom were once vulnerable as evidenced by their recovering from addiction in a residential treatment center. The theory that developed was "Addiction as a symptom of the larger emotional family system" in order to manage the anxiety within.

The aim of the study was to identify a Grounded Theory based on emerging themes discovered through data analysis. The emerging themes included: communication, boundaries, resiliency, relationships, and anxiety. The grounded theory developed focuses on relationships improving as a basic level of family systems education was provided.

In regard to communication, the participants disclosed their communication levels improved and they felt they could openly inform their parents of how they felt while also digging deeper to address the patterns present. Olson (2000) explained that positive family communication skills were related to healthy family functioning. By improving communication skills, family members create more flexibility to adjust their family system as needed and pivot out of triangles that may attempt to reform.

Boundaries was the second theme to emerge. This was easily the most identified theme as each participant clearly utilized this keyword consistently. It is the researcher's assumption that although participants utilized the term boundaries in their responses, they were also discussing the process of over/underfunctioning in the family while also creating distance and separation versus closeness and togetherness as outlined by Bowen. McKay (2017) stated:

> Sustained overfunctioning in any relationship, beyond the dependency needs of an infant or child, creates a vulnerability to symptom development. Overfunctioning for others also creates a vulnerability to continuing to automatically underfunction for self. (p. 642)

As the participants described their patterns of over/under functioning within their family system prior to engaging in the Family Dynamics group, they were able to reflect on the shift in this area by improving communication, shifting their own responses to the family system, and maintaining a stance of healthy distance to continue functioning at their most optimal level.

Followed by discussing resiliency and the ability to recover quickly from difficulties. "The ability for a person to sustain emotional mature action in stressful situations is impacted by their degree of sensitivity or emotional reactivity to the distress, the need for attention, and expectations of, and affirmation from, others (Bowen, 1978; Kerr, 2008). This reactivity is influenced by two counteracting potencies of togetherness and individuality, which are evoked by the human imperatives to experience both "'love", approval, emotional closeness and agreement' as well as to be emotionally separate and autonomous (Bowen, 1978, p. 277).

The next theme to present itself was focused on relationships. Murray Bowen believed that a change in a family system occurs when one of the family members differentiates. (Park, 2001) Furthermore, "in a well-differentiated family, family members do not respond intensely, deal with other's needs and expectations flexibly, live in a complementary relationship and can reconcile the different opinions of the family members" (Kerr and Bowen, 1988). This study was an exploration of how an individual choosing to differentiate from their family creates a shift in the system as a whole. We also reviewed the degree of anger and resentments present when addressing the family system. "Emotional intensity is believed to be a core dimension of family relationships that influences interpersonal boundaries" (Bowen, 1978; Emery, 1994).

Furthermore, the impact of the researcher's relationship with the participants was highlighted by two out of the three participants. The participants shared that the role of the researcher assisted in their process of differentiation.

While McKay (2017) reports:

> Clinicians are charged with the responsibility of being available, consistent, and able to provide a reparative experience that is deemed crucial to reducing the often very severe internalising or externalising symptoms the client brings into the consulting room. (p. 638)

This researcher agrees with the above statement and also deems it appropriate that in order for this to occur effectively, clinicians would need to be in the process of differentiation of themselves. This would benefit both the clinician and the participants as it creates a space of openness, less likelihood for fusion with the participants, and the ability to remain neutral when assisting participants in addressing their family dynamics. Lerner (1989) discussed how "dysfunctional families tend to have lower levels of differentiation and those who have low levels of differentiation of self either seek excessively intimate relationships with others or excessively keep their distance from others".

Lastly, the final theme to emerge focused on anxiety. Bowen claimed that when a family member shows symptoms of physical, emotional or social dysfunction in a nuclear family, this implies that the family member is absorbing all the undifferentiated functions of all the nuclear family members. (Kerr and Bowen, 1988) Bowen believed that a low level of differentiation in the family creates emotionally dysfunctional individuals, while a high level of differentiation in a family decreases the use of dysfunctional responses in it (Kerr and Bowen, 1988). While, "anxiety significantly impacts a person's reactivity to the behaviour and emotional states of others. (McKay, 2017, p. 641)

Bowen family systems theory "widen[s] the focus to gain a multi-generational view of the family's emotional process. But, perhaps more integral to this challenging work, it increases the capacity of the therapist to reflect on their own reactions and anxious responses". (McKay, 2017, p. 649)

Limitations

This research study did have limitations present. The limitations to this study were no longer having access to client's data in their charts and records to follow their progress in real time while engaging in the seven-week program. Due to my decision to resign from the facility, I no longer had access to the client's medical charts when conducting the interviews after approval from the Institutional Review Board.

The diversity of the original cohort was small as there were 7 participants which included four males and three females in their early to mid-twenties. In addition, two of the males were deceased as a result of drug overdoses when the interviews were conducted. The size of the group is an important factor, as the facility in which the group was offered, had a sample size between 65-90 individuals admitted in the facility during the time. Due to the inclusion criteria developed and based on the discretion of the clinicians at the facility, the original cohort only had 7 participants recommended. However, it is important to note that in the duration of the three years the group was in session, there was an increase in participants up to 25 individuals pending recommendations from clinicians. My observations of the group at a larger size showed that increasing the group size affected the participants comfortability level in sharing and reviewing their family system.

The interviews are self-reported and three of the remaining five participants agreed to complete interviews. As the primary researcher, I would have liked to have done a pre and post interview on the participants knowledge of family systems and anxiety. This would be a recommendation for future researchers with a desire to expand on the research provided in this study.

Additional limitations that had the potential to arise was being resigned to collect data from individuals after a significant time has passed since participating and completing in the group three years ago. As well as, gathering information from clients that have stayed in contact with me and being mindful to keep any researcher biases in check while conducting interviews.

Clinical Implications of Addiction Treatment

At the start of this Applied Clinical Project, I discussed the common themes in addiction treatment were a lack of family systems theory, blaming the client for whose addiction or blaming the parents for their lack of ability to control the client's behaviors as opposed to understanding that substance use is an attempt to control and manage the anxiety in the family.

Clinicians working in an inpatient residential treatment center should be educated on family systems theory. By learning the way, a family system functions due to addiction as an anxiety binder, it would take emphasis off the individual experiencing symptoms and labeling them as the problem. This also allows for a space between the treatment center and the family to be engaged in the treatment process together while also discovering the optimal way to communicate as a system working to decrease symptomatology.

With clinicians increasing their understanding of the family system and approaching addiction from a different approach, there is potential to increase trustworthiness with the client that does not need to stem from self-disclosure. The process of self-disclosure in the field of addiction seems to be straightforward approach to building rapport instantaneously, if the clinician themselves are in recovery themselves. Initially, it appears to be the easiest way for them to connect with the client without probing to deeply into the client's background.

In addition, setting a safe place for clients to engage in group therapy while also addressing their family system proved to be impactful for the participants. By encouraging treatment centers to develop a thorough family program, participants are provided with an opportunity to have beneficial long-lasting tools that they can take with them upon leaving the treatment center.

Recommendations for Future Training

I have several recommendations I would include for future training of marriage and family therapists ready to take this work into the field of addiction. First, therapists should be aware that major problems can arise when they lose sight of their role in the process. The therapist should be mindful to not respond to the participants transference by diagnosing it. The therapist should also be aware that they are not facilitating the group to fix or cure the individual form addiction. The focus is to help them discover a more defined sense of self and explore relationship dynamics.

Second, the role of the facilitator is significant. The participants will model what they witness the facilitator is doing. When the therapist can recognize that the work that needs to be completed, is the work of the participant, not of the therapist, this creates trustworthiness and reliability in the relationship between the participants and facilitator. The field of addiction tends to focus on treatment being punitive and shaming. The approach comes across as it's my way or the highway. Therapists can avoid this approach to treatment by working on their own level of differentiation and creating a pathway for healthy relationships.

Third, creating a group environment that is safe for participants to feel comfortable openly sharing their experiences. This also includes minimal self-disclosure from the therapist that is facilitating the group. This links back to recommendation number two; the work is for the participants.

Lastly, keep the groups small so the participants can build relationships with one another. This will help to eliminate the feeling that they are alone and others cannot understand their experience. I found that a group size of up to twelve participants was ideal.

Recommendations for Future Research

Future research to elaborate on the information presented in this study would be valuable. I would recommend that researchers conduct a pre and post testing of the participants at the start and end of the curriculum provided. This would allow the researcher to measure the growth and awareness of anxiety and family systems thinking after completing the program.

My second recommendation would be to include more diversity. In this study, the original cohort had four men and three women. If the group were larger, I would like the diversity for gender to be similar and balanced. I would also like to see more diversity in race/ethnicity of the participants. In this study, all the participants were caucasian. In groups across the three-year span, the participants were mostly caucasian. In my experience working in addiction treatment over the last decade, many of the individuals are caucasian. Perhaps, branching out to different locations or even state-run facilities would warrant different statistics. This would be an area to explore in future research. In addition, as a Latina, I would love to see the responses of people of color in addressing their relationships within the family system.

Future research should also look at the significance of having a greater understanding of self through family systems thinking. By learning family systems theory, individuals can gain a deeper sense of self, improve their relationships with others, and learn more about relationships. I would like to see future researchers explore this in a larger study and collecting data from more participants.

Reflections of the Researcher

I learned so much about myself and my relationships with others while conducting this research. I witnessed a shift in perception when participants stopped viewing themselves as diseased individuals but as someone who could have healthy relationships in their life. The participants learned how to re-define their sense of self and create a new role in their family system. They also shared how proud they were of their coping mechanisms and resiliency over the years.

The biggest reward was seeing how much information the participants were able to retain over the course of the three years from their completion of the group. Also, it wasn't just the retainment of the education but also the application and integration of the skills taught into their day to day activities.

The goal was to develop a group towards understanding the family system, increasing individuality, and developing a sense of self outside the family system and I accomplished this. The feedback from the participants in their interviews was evidence that they received all that the group was intended to provide and more.

Reviewing the data and seeing the themes emerge was truly empowering. I also felt relieved because facilitating the group came with such ease for me, as I was talking in a language that promoted growth and exploration which the participants were receptive towards. I believe that other facilitators have an opportunity to bring this to other treatment centers with similar results however neutrality is a key factor.

The greatest component of this study is that it changes the way addiction and the family system can be viewed moving forward. A door has been cracked open for other individuals engaging in the recovery process to gain a deeper sense of self and no longer be labeled as diseased. In addition, participants and future researchers have an opportunity to demonstrate that there is a way to live a life outside of survival mode, resiliency as a shameful tool, and unhealthy relationships in life. This study provides others an opportunity to break generational patterns by exploring the layers of one's relationship to self and others.

Conclusions

This Applied Clinical Project focused on understanding resiliency and long-term effects on sobriety through a Bowenian lens. The themes that emerged focused on communication, boundaries, resiliency, relationships, and anxiety.

The findings demonstrated that a multigenerational element in the study helped participants develop a way to maintain the Family Dynamics curriculum in their day to day life. The findings in the study showcase the importance of incorporating family systems thinking in a residential treatment center. The group addressed how sobriety can lead to an increase in tension and anxiety in which clients would discuss healthy patterns to engage in to reduce their anxiety. The data analysis proved that clients gained an increased understanding of their behavioral patterns to ease anxiety which included abstaining from substance use. A benefit of the study is reinforcing that "the way a therapist thinks about a problem can be more important than what the therapist does in therapy" (Bowen, 1997, p. 186).

Another benefit was providing individuals an opportunity to differentiate from their family system while also decreasing the symptomatology of the system. Kerr and Bowen (1988) argued that greater differentiation of self was related to more positive individual, couple, and family functioning and that the concept of differentiation of self was universal. (as cited in Kim et al., p. 72) This study illuminates the impact of family systems theory on addiction and how it is a symptom of the larger emotional system. The study focused on three participants discussing their own differentiation levels and continued steps to remain differentiated from their family system.

As discussed by Kim et al. (2015),

> well-differentiated individuals can remain in close emotional contact with others, while at the same time maintaining their individuality. For this reason, they are able to be calm in important relationships, even when stressed, and maintain responsibility for their own thinking, feeling, and actions while simultaneously recognizing and honoring others' thoughts, feelings, and actions. (p. 73)

Given the data analysis, participants were consistently using the tools they learned in the program three years later and credit their maintenance of sobriety to the information they learned in the program. In conclusion, by adding family systems thinking to residential treatment centers, there is a possibility of assisting other individuals in decreasing their own symptomatology and improving overall relationships.

The overarching theme is that healthy relationships with open communication lead to better anxiety management, resiliency, and boundaries which shows a foundation of which new approaches to substance abuse treatment can be found. When an individual takes a deeper look within themselves with honesty, they are provided an opportunity to release anger and resentments. By releasing their anger and resentments, they can break generational patterns, begin the process of differentiation which leads to a greater relationship to the self. The result is an individual that is willing to consistently examine their relationships and create healthier pathways to connection outside of triangulation, projection, and enmeshment.

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Appendix A:

Curriculum of 7-week Family Dynamics Group

Week 1: Resistance, traditional concept of addiction, anxiety	By addressing resistance, rebellion, addiction and an understanding of anxiety, a foundation was laid between the clients and facilitators.
Week 2: Development of symptoms, substance use as a symptom of family anxiety	We discussed the development of symptoms as a result of belonging to the larger emotional systems and how substance use can be a symptom that develops as a result of belonging to that emotional system.
Week 3: Defining the self, objectivity	Discussed change, starting anew, making new decisions, and creating new pathways as opposed to following the same generational patterns present in the larger family system.
Week 4: Triangles, Family roles	Begin addressing triangles in the family and different family members roles in the emotional system. Clinicians discussed with client's triangles in their family system but also identified moments in the group format when clients were attempting to triangulate the therapists or their peers.
Week 5: Emotional Cutoff, Claiming responsibility, reactivity	Centered on understanding emotional cutoff, claiming personal responsibility, and observing reactivity. In addition, reviewing reactivity and objectivity from the previous weeks group was significant.
Week 6: Generational patterns in managing anxiety, over/underfunctioning	A discussion of generational patterns in managing anxiety in their family. Facilitators would ask for volunteers to complete their genograms on the whiteboard and review with group peers. In addition, during the second half of the group we discussed the concepts of over/underfunctioning in relationships.
Week 7: Recovery process, differentiation of self	We reviewed the concepts of differentiation of self and how it was the premise of their work moving forward. Clients were provided an opportunity to discuss what "old" patterns and feelings may resurface while also discussing the course of action they would take to manage their anxiety through these moments.

Appendix B:

Interview Questions

Question 1: What did you take away from the program?

Question 2: How have you utilized it in your life?

Question 3: What did you think was beneficial?

Question 4: How have you been able to maintain your sobriety?

Appendix C:

Consent Form

General Informed Consent Form

NSU Consent to be in a Research Study Entitled

Addiction and the Family: Substance Use as a Symptom of the Larger Emotional System

Who is doing this research study?

College: College of Arts, Humanities, and Social Sciences

  Department of Family Therapy

Principal Investigator: Alexis Mercado, Master of Science

Faculty Advisor/Dissertation Chair: Dr. Christopher Burnett, Psy. D.

Site Information: To be determined by convenience of participant

Funding: Unfunded

What is this study about?

This is a research study, designed to view how the education of addiction and family dynamics through Bowen family therapy impacted the lives of those in the group. The purpose of this research study is to bring an understanding of family systems theory into addiction treatment. The additional purpose is to examine the long-term effects of resiliency through Bowen therapy. The benefits of this study for others would be to teach the material to others in addiction treatment and potentially improve their way of thinking towards addiction, the recovery process, and relationships with others in their lives. The reason this study needs to be done is to bring awareness to other forms of therapy available for those undergoing addiction and mental health treatment regarding family relationships.

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

You are being asked to be in this research study because you participated in the original 7-week Family Dynamics group offered in May 2016.

This study will include about 5 people.

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

While you are taking part in this research study, I will interview you face to face once for up to an hour, at a location of your convenience.

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

-1 face to face interview for up to an hour

- Answer all interview questions

-Interview will be up to one hour

Are there possible risks and discomforts to me?

This research study involves minimal risk to you. To the best of our knowledge, the things you will be doing have no more risk of harm than you would have in everyday life.

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

You have the right to refuse to be in this research study. If you decide not to be in the study, you will not get any penalty.

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

There are no direct benefits from being in this research study. We hope the information learned from this study will help provide future services and/or support to those in addiction and mental health treatment and recovery. As well as provide them with tools to manage their anxiety, overwhelm, and stress in life and relationships.

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

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

Will it cost me anything?

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

How will you keep my information private?

Information we learn about you in this research study will be handled in a confidential manner, within the limits of the law and will be limited to people who have a need to review this information. Your name will be kept confidential and include a de-identifier, which means a number will be assigned to you and your data. This data will be available to the researcher, the Institutional Review Board and other representatives of this institution. If we publish the results of the study in a scientific journal or book, we will not identify you. All confidential data will be kept securely in my home in a locked safe. All data will be kept for 36 months from the end of the study and destroyed after that time by deleting the files and shredding notes taken.

Will there be any Audio or Video Recording?

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

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

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

Primary contact:
Alexis Mercado can be reached at 954-347-6742, that will be available during and after normal work hours.

Research Participants Rights

For questions/concerns regarding your research rights, please contact:

Institutional Review Board

Nova Southeastern University

(954) 262-5369 / Toll Free: 1-866-499-0790

IRB@nova.edu

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

Research Consent & Authorization Signature Section

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

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

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

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

Adult Signature Section

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

Printed Name of Participant	Signature of Participant	Date

| Printed Name of Person Obtaining Consent and Authorization | Signature of Person Obtaining Consent & Authorization | Date |

Appendix D:

Biographical Sketch

Alexis Mercado is a Licensed Marriage and Family Therapist, Masters Certified Addiction Professional, Advanced Certified Hypnotherapist, and Certified Reiki 1 Practitioner. She has worked in the field of Addiction since 2009 and specializes in repairing family systems as a Trauma Focused Practitioner since 2012. She has worked in a variety of settings including a behavioral health facility, inpatient treatment centers, and outpatient family programs. She has been published in Thrive Global and Elephant Journal. She currently runs her own business working with women to break generational patterns and be leaders in their careers.